



**National Association of State Long-Term Care Ombudsman Programs**

Andy Slavitt, Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Room 445-G, Hubert H. Humphrey Building  
200 Independence Ave., S.W.  
Washington, D.C. 20201

**RE: COMMENTS FROM THE NATIONAL ASSOCIATION OF STATE LONG-TERM CARE OMBUDSMAN PROGRAMS ON 42 CFR PARTS 405, 431, 447, ET AL., MEDICARE AND MEDICAID PROGRAMS; REFORM OF REQUIREMENTS FOR LONG-TERM CARE FACILITIES; PROPOSED RULE**

Dear Mr. Slavitt:

The National Association of State Long-Term Care Ombudsman Programs (NASOP) thanks the Centers for Medicare and Medicaid Services (CMS) for the opportunity to comment on the proposed rule. When suggesting new language, NASOP has underlined and italicized the text.

**General Comment on the term “Resident Representative”**

NASOP makes a general comment that for consistency, CMS include the phrase “or resident representative” when discussing the need to obtain consent, provide information, and other appropriate contexts.

**Part 483 – Requirements for State and Long Term Care Facilities**

**483.5 Definitions.**

The definition of abuse moves what was in the Interpretive Guidance (IG) into the regulation. NASOP suggests that instead of the phrase “It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology,” CMS use the phrase “It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology, social media, and other such platforms.” NASOP believes that this statement clarifies the intent of this definition.

We agree with the clarification at 2(v) that CMS prohibits the use of composite distinct parts to segregate residents by payment source or on a basis other than care needs.

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NASOP appreciates the definition of Misappropriation of resident property and Neglect, which moves what was in the IG into the regulation. We also are supportive of the more inclusive definition of Neglect that encompasses not only the facility, but also its employees or service providers.

We suggest that CMS revise the following definition to state “Person-centered care. For purposes of this subpart, person-centered care means to focus on the resident, *empower him or her* as the locus of control, and support the resident in making their own choices and having control over their daily lives.” This language is more active than merely having discussions center around the resident, but clearly specify that the resident should be directing those decisions.

NASOP is assuming that CMS wrote the last sentence of the definition of Resident representative before the recent U.S. Supreme Court decision on same-sex marriage. The sentence may no longer be necessary.

We suggest that CMS keep the current definition of sexual abuse which states “Sexual abuse” includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault. This definition seems more inclusive than the one in the proposed rule. NASOP also believes there should be some additional reference of the use of technology in sexually abusing a resident, e.g., *the definition of sexual abuse also includes the use of technology such as a camera to take unauthorized images of a resident used for sexual gratification or exploitative purposes.*

### **483.10 Resident rights.**

Subsections (a)(3)(i) and (ii) use the newly defined term “resident representative” in association with the resident’s right to designate a representative. Section (a)(4) states the resident’s wishes and preferences must be considered in the exercise of rights by the representative. NASOP supports this language because it reinforces the person retains basic rights when able to express them either through advance care planning documents, or stating a wish or preference. This is consistent with person-centered principles. Section 483.11(a)(3) and (4) are related requirements that aid in the person directing a representative to make decisions, while retaining the resident’s rights. NASOP also supports this language.

Section (b) Planning and implementing care includes detail about the responsibility of the facility to inform a person of treatment options, and specifies it is the resident’s right to choose care. Section (5) delineates rights related to care planning that are consistent with person-centered principles. To carry

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through with person-centered principles in Section (b), NASOP recommends the following edit to subsection (b)(5)(v):

“The right to see and have a copy of the care plan, including the right to sign ~~after~~ if the resident agrees to changes to the plan of care.”

Section (d)(5) adds the right to share a room with a roommate of the resident’s choice. This welcome addition recognizes the need for roommate compatibility and engagement of residents in roommate decisions for quality of life in a nursing facility. NASOP supports this language.

Section (f) Access to information includes the resident’s right to access medical records. Subsection (3)(i) states that access is within 24 hours, excluding weekends and holidays. As the resident’s home that provides care 24/7, access to a person’s own medical record should not be contingent on weekday staffing. NASOP recommends striking the parenthetical statement, “~~excluding weekends and holidays,~~” in this subsection. Also recommended is striking, “~~After receipt of his or her medical records for inspection,~~” from the beginning of subsection (3)(ii). Requiring receipt of the records, with a 24-hour delay, in addition to two working days for a copy of the record, creates additional and unnecessary delay to the resident’s right to access his or her own records. The detailed costs CMS proposes to allow in this section create an opportunity for a nursing facility to create a financial burden and barrier to a resident’s right to receive a copy of their own medical record. Supply costs, such as ink, paper, and postage, are reasonable costs to allow. Including labor costs would allow facilities to impose barriers to this right, especially on Medicaid-eligible residents. NASOP recommends that facilities provide on an annual basis, a copy at no charge to the resident, and otherwise, costs should be limited to supplies and postage. Similar language is found in 483.11(e)(1) and (2) Information and communication, and these comments apply to that section.

Section (g)(1) describes the resident’s right to personal privacy and confidentiality, including the right to privacy in verbal (spoken) communications. In light of technology options that might include electronic monitoring by a facility to monitor or record conversations and interactions in public or private areas of a facility, this language is a needed addition to protect privacy where a resident and visitors should reasonably expect to not be monitored or recorded.

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### 483.11 Facility responsibilities.

NASOP is supportive of the language at 483.11(a)(2) that states, “The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source.” We believe this improves access for residents who have behaviors sometimes associated with dementia, such as hitting or taking other resident’s belongings.

Because unclear regulations could lead to underreporting of suspicion of crimes, we suggest that language at 483.11(a)(5) be amended to read:

“If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility ~~may report such concerns as permitted and~~ shall report such concerns when and in the manner required under State law.”

NASOP supports proposed language in subsection (b)(1) as it supports person-centered care principles through individualized care planning.

At 483.11(b)(1)(i) we suggest replacing the word “facilitate” with a stronger term such as “maximize” or “promote and facilitate” as used in (d) Self-determination below.

NASOP suggests the language at 483.11(b)(2) seems to be out of place: “The interdisciplinary team, as defined by § 483.21(b)(2)(ii), is responsible for determining if resident self-administration of medications is clinically appropriate.” We suggest that CMS move this language to 483.5, Pharmacy services.

We suggest the language at 483.11(d)(1)(G)(iii), be amended to read:

“Provide immediate access to a resident by others who are visiting with the consent of the resident, subject to ~~reasonable clinical and safety restrictions and~~ the resident's right to deny or withdraw consent at any time.”

This proposed language at 483.11(d)(2) establishes the option for facility policies to impose visitation restrictions for “clinically necessary” reasons or “reasonable” limitations in compliance with (2)(i) – (iv). This language could unnecessarily remove the option of spontaneous visitation, yet, a nursing facility is a setting required to be homelike. The requirement that visitation is subject to the resident’s consent is ample restriction and consistent with person-centered principles. NASOP recommends striking language in 483.11(d)(2) as follows:

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~~“(2) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. A facility must meet the following requirements:”~~

NASOP questions the language at 483.11(d)(2)(ii) and wonders if it is still necessary to use the term “same-sex spouse”. A spouse is a spouse, regardless of gender.

NASOP suggests reversing the order of (A) & (B) at 483.11(d)(3)(iii) to help emphasize that although a response is required for every request, not every request has to be adopted as recommended.

We recommend that CMS clarify that language in 483.11(d)(5)(v) also precludes a facility from taking resident funds for past due balances before the facility conveys any personal funds to a resident or resident representative.

NASOP encourages CMS to return to use of “not more than the community standard” language at 483.11(e)(2)(iii). Allowing facilities to impose a fee based on labor, supplies, and postage may create an obstacle for residents, many of whom are on Medicaid, from accessing information about their care that is contained in their records.

We suggest amending language at 483.11(e)(5)(iv) to state: “If an adult individual is, ~~incapacitated~~ at the time of admission, ~~and is~~ unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.”

NASOP suggests adding language at 483.11(e)(10): The facility must:

(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of—

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

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(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

(C) A general statement that under the State Plan a Medicaid eligible resident may be required to contribute a portion of his/her income to the nursing facility;

(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (e)(10)(i)(A) and (B) of this section.”

Suggested new language makes clear to the resident and/or resident representative, there is an expectation of a share of cost that they must pay to the facility.

We suggest that language at 483.11(e)(11)(iii) and (iv) be moved to 483.11(d)(5)(v) as they seem more appropriate there.

NASOP suggests clearer language at 483.11(e)(13)(ii):

“The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, consistent with § 483.10(h), including reasonable access to: The Internet, to the extent available to the facility, through Wi-Fi for residents' personal computers or through a dedicated computer provided by the facility for residents to use.”

We suggest stronger language at 483.11(f)(3): The facility must facilitate and allow representatives of the Office of the State Long-Term Care Ombudsman to privately examine a resident's medical, social, and administrative records, including those maintained in electronic format, in accordance with State law.”

NASOP supports all of the proposed language in 483.11(h)(1)-(3).

### **483.12 Freedom from abuse, neglect, and exploitation.**

NASOP supports the addition of this section to emphasize the protection of residents from ANE. We appreciate the reference to chemical and physical restraints, and the inclusion of language that complies with the Affordable Care Act regarding the reporting of crimes. Further, NASOP supports the inclusion of violations in this section in the definition of substandard quality of care.

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### **483.15 Transitions of care.**

Proposed section 483.15 uses the title “Transitions of Care,” although it contains many provisions that are denominated as “Admission, transfer and discharge rights” in current 42 C.F.R. § 483.12. The proposed loss of the term “rights” is troubling, for two reasons.

First, the term “rights” emphasizes the fact that a nursing facility is home to its residents, and facilities should not deprive residents from that home except in rare circumstances. The term “transitions,” by contrast, suggests that a resident’s place of residence is not important and fluid as the resident “transitions” through levels of care.

Second, state nursing facility laws often incorporate the federal resident’s rights. If the federal rights in section 483.15 are no longer denominated as rights, these state law provisions may not incorporate federal law provisions, which would lessen the protection extended to nursing facility residents at the state level. Since federal regulations do not currently include inappropriate discharge as an SQC violation, states determine discharge violations, and this proposed change would further weaken resident protection from unnecessary and improper discharge.

We strongly support the addition of the word “request” in subsections (2)(i), (ii), (iii), and (3). Sometimes facilities attempt to evade current law by using contracts that “request” but purportedly do not “require” residents to take on certain unfair obligations. From a consumer’s perspective, these provisions are objectionable whether CMS phrases the provision as a request or requirement. In either case, the facility is drafting the contract, and the resident (or resident representative) is signing the contract with little understanding of its contents, and little or no ability to negotiate terms.

We strongly support subsection 483.15(a)(2)(iii). We recommend that CMS modify the language to reflect the relatively recent statutory provision that allows a continuing care retirement community to require residents to spend on their care resources declared for the purposes of admission before applying for medical assistance.

We support the provision that prohibits waivers of a facility’s liability for loss of personal property at 483.15(a)(2)(iii) , but do not understand why this provision should be limited to personal property. CMS should prohibit all waivers of liability, whether they relate to (for example) the loss of a resident’s clothing, or negligent care by facility staff. Courts across the country have concluded that consumer waivers of liability are improper in health care settings.

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NASOP supports new language added at 483.15(7) requiring facilities that are a composite distinct part to disclose in its admission agreement its physical configurations, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations.

NASOP appreciates the new language at 483.15(b)(i)(A) requiring facilities to establish, maintain and implement identical policies and practices regarding transfer, discharge, and the provision of services for all individuals regardless of source of payment.

NASOP supports the inclusion of new language at 483.15(b)(1)(iii) prohibiting the transfer or discharge of a resident while the appeal is pending, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility.

NASOP is in strong support of the new language added at 483.15(2)(i) et seq. requiring facilities to document in the resident's clinical record the basis for the transfer and the specific need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). We also support the new list of documents and information that the discharging facility must provide the receiving facility. NASOP agrees with CMS that this may discourage inappropriate discharges.

NASOP sees the value of new language at 483.15(b)(3) which would require the facility to send a copy of the discharge or transfer notice to a representative of the Office of the State Long-Term Care Ombudsman (with resident consent). However, we would like to point out that both the Health Insurance Portability and Accountability Act, Privacy Rule 45 CFR part 160 and 43 CFR part 164, subparts A and E and the federal rule for the Long-Term Care Ombudsman Program at 45 CFR Part 1327, subpart A, section 1327.11, treat the Long-Term Care Ombudsman Program (LTCOP) as a Health Oversight Agency. NASOP suggests that CMS add additional clarifying language that would allow for consent from the resident representative in those situations where the resident cannot provide informed consent. We also suggest that CMS require facilities to send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman when the resident cannot provide informed consent and there is no resident representative. This is consistent with LTCOP federal rule.

NASOP suggests that the new language added at 483.15(b)(5)(iv) that includes information about what needs to be in the notice, including the right to appeal the transfer or discharge to the State, how to file

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an appeal, be revised to state and the name, address and telephone number of the representative of the Office of the State Long-Term Care Ombudsman.

In subsection (b)(6), this new language appears to allow a facility to make changes to a notice of discharge letter. This could conceivably happen while a resident is awaiting appeal and searching for a new facility. It is unclear what changes can be made in such a reissued letter, and what impact that may have on a resident's appeal and time frame to remain in the facility. NASOP requests additional explanation regarding section 483.15(b)(6) in order to inform residents and facilities of this change. NASOP recommends that if the facility issues a new letter, CMS require that the 30-day time frame should restart in order to provide time for a proper transition of care with all required and accurate information included in the notice.

NASOP is supportive of new language at 483.15(c)(3)(ii) requiring a facility to notify in writing, a resident who is hospitalized or on therapeutic leave with an expectation of returning to the facility, when the facility determines that the resident cannot be readmitted to the facility, and the information provided in paragraphs (b)(5)(iv) of this section. We believe this may also reduce inappropriate discharges or transfers.

NASOP recommends creating a new subsection to 483.15(b)(5) to read as follows:

*"Readmission after state fair hearing. Following a discharge State fair hearing decision in favor of the resident to remain in or be readmitted to the facility, the facility must readmit the resident in their previous room if available or immediately upon the first availability."*

In addition, NASOP recommends adding new language in 483.15(b)(5) to the definition of substandard quality of care in 488.301 Definitions.

### **483.20 Resident assessment.**

NASOP agrees with the change in terminology at 483.20(xvi) to Discharge planning, rather than Discharge potential.

We are also supportive of the change made at 483.20(xviii) that would include direct access staff in the resident assessment.

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### **483.21 Comprehensive person-centered care planning.**

NASOP supports proposed rules regarding “baseline care plans” developed for residents within 48 hours until a comprehensive care plan is required. The rule language recognizes the importance of swift planning to meet the immediate, short-term needs of newly admitted residents and requires a facility to have a basic admission structure that focuses on an individual’s care needs.

### **483.25 Quality of care and quality of life.**

NASOP supports proposed language added to section (c) Activities (1) regarding an ongoing program to support residents in their choice of activities, both group and individual, and the requirement for a facility to encourage independence and interaction in the community.

483.25(d) Special care issues: NASOP recommends that CMS relocate the Restraints and Bed rails requirements to 483.11 Facility responsibilities, because restraints are not a special care issue and facilities should not promote them as special treatment or care. NASOP appreciates the effort to address the use of bed rails, but recommends that bed rails refer to the restraint section because some bed rails meet the definition. Because CMS lists bed rails separately from restraints, this may unintentionally imply that a bed rail is never a restraint.

NASOP supports the specificity of proposed rules regarding skin integrity, including foot care, and incontinence. NASOP also appreciates language added to (d)(8) regarding enteral feeding as it ensures a resident’s consent is required to consent to such medical action.

In addition to the 15 special care issues listed, NASOP recommends adding a new section (16) Dementia care as follows:

*“(16) Dementia care. If a facility markets itself or otherwise provides specialized care for people with dementia, the facility must provide care in accordance with person-centered care principles, sufficient staff to meet the needs of residents with dementia, and individualized care including a specialized activities program. If a facility uses locked doors that restrict access within the building or to the outdoors, the facility must ensure that restricted access does not diminish a resident’s mobility or quality of life, or meet the definition of involuntary seclusion.”*

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### **483.30 Physician services.**

NASOP supports new language at 483.30, which now allows a physician assistant, nurse practitioner or clinical nurse specialist to provide orders for the resident's immediate care and needs.

We are also supportive of new language at 483.30(e) et seq., which requires an in-person evaluation of a resident by a physician, a physician assistant, nurse practitioner, or clinical nurse specialist prior to transferring the resident to a hospital. We believe this will help alleviate inappropriate visits to the acute care hospital.

NASOP also is supportive of new language at 483.30(f), which would allow physicians to delegate the tasks of writing dietary orders to qualified dietitians or other qualified nutrition professionals, and the task of writing and therapy orders to a qualified therapist.

### **483.35 Nursing services.**

NASOP is supportive of new language at 483.25 requiring facilities to have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident based on resident assessment, plans of care and considering the number, acuity, and diagnoses of the residents. We would also encourage CMS to require facilities to have a registered nurse in the building 24 hours a day, seven days a week and to provide a minimum of 4.1 hours of nursing care per patient day.

### **483.40 Behavioral health services.**

NASOP is generally supportive of this section of the proposed rule, especially at (d) which requires the facility to provide medically related social services to attain or maintain the highest practicable mental and psychosocial well-being of each resident. Please see our suggestions on the position of social workers in 483.70, Administration.

### **483.45 Pharmacy services.**

NASOP believes this section strengthens the role of both the physician review and accountability in regards to psychotropic medications and adds additional oversight by the pharmacists.

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NASOP suggests the inclusion of a requirement for the physician, physician assistant, or nurse practitioner to seek the informed consent of the resident or resident representative before administering psychotropic drugs. We suggest language be added in a new section at 483.45(e)(5):

*“If the physician, physician assistant, or nurse practitioner for a resident in a skilled nursing facility prescribes, orders, or increases an order for psychotropic medication for the resident, the physician, physician assistant, or nurse practitioner shall do both of the following:*

*(a) Obtain the informed consent of the resident for purposes of prescribing, ordering, or increasing an order for the medication.*

*(b) Seek the consent of the resident to notify the resident’s interested family member, as designated in the medical record. If the resident consents to the notice, the physician, physician assistant, or nurse practitioner shall make reasonable attempts, either personally or through a designee, to notify the interested family member, as designated in the medical record, within 48 hours of the prescription, order, or increase of an order.”*

### **483.50 Laboratory, radiology, and other diagnostic services.**

NASOP is supportive of the new language 483.50 (i), which allows, in addition to the physician, physician assistants, nurse practitioners, or clinical nurse specialists to provide orders for laboratory services.

### **483.55 Dental Services.**

483.55 (a)(3) and (b)(4) prohibit a facility from charging a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility’s responsibility. NASOP suggests that this should be determined not by facility policy but by a thorough investigation. NASOP suggests the following language be used for (a)(3):

*“(3) May not charge a resident for the loss or damage of dentures determined by a thorough investigation by the facility, to be the facility’s responsibility;”*

*(b)(4): May not charge a resident for the loss or damage of dentures determined by a thorough investigation by the facility, to be the facility’s responsibility; and”*

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In 483.55 (a)(4) and (b)(2), proposed requirements add “if requested” to both sections. NASOP supports this additional language to ensure services are provided in accordance with resident preferences and not only based on judgment of staff as to necessity.

NASOP supports the addition of a timeframe for the referral at (a)(5) and (b)(3), as dental problems can be a cause of multiple problems such as nutritional deficiency, weight loss, and loss of dignity.

NASOP supports the addition of the affirmative duty of the facility at (b)(5) to access coverage and services. This requirement also supports our recommendation that a credentialed social worker should be required in all facilities.

### **483.60 Food and nutrition services.**

NASOP supports language requiring taking into consideration the preferences of “each” resident. This is important to creating an environment where person-centered care thrives. “Each” should be used throughout the regulation.

483.60(a) Staffing: The proposed requirements for qualifications of professional dietary personnel allow a five-year period to obtain the needed qualifications. NASOP believes this is too long and recommends a two-year period to implement.

In section 483.60 (a)(2)(iii), “... Receives frequently scheduled consultations...NASOP suggests changing “frequently” to” no less than quarterly.”

483.60(a)(3) Support staff. NASOP suggests defining who “support staff” includes.

NASOP recommends amendments to 483.60(c)(1) regarding menus to include the following deletion:

“Meet the nutritional needs of residents in accordance with established national guidelines ~~or industry standards.~~”

NASOP strongly objects to regulations allowing the industry to establish its own nutritional guidelines. As proposed, this regulation would be difficult or impossible to enforce.

483.60(i) Food safety requirements. NASOP supports and appreciates that CMS incorporated provisions allowing facilities to use produce grown in facility garden and explanation that the provision for food safety affirms the right of residents to consume foods not procured by the facility.

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### **483.65 Specialized rehabilitative services.**

NASOP appreciates the inclusion of respiratory therapists in the list of specialized rehabilitative services.

### **483.67 Outpatient rehabilitation services.**

NASOP appreciates the clarifications in this new section of the proposed rules. We feel this section offers adequate guidance for those facilities offering outpatient rehabilitation services. NASOP suggests that the reference in 483.67(a)(2) be changed from "residents" to "patients."

### **483.70 Administration.**

CMS requests comments on proposed rules that would restrict facilities from requiring a resident to sign an agreement as a condition of admission, and on binding arbitration agreements. While addressing this issue is needed, the proposed language would allow facilities to present such agreements at admission. The concept of a binding arbitration agreement is appropriate to introduce at the time of a dispute so the parties can consider the circumstances and weigh their options. Requesting a consumer to sign an arbitration agreement prior to any dispute arising is an action that unequally benefits the provider and limits options of the consumer. NASOP recommends that CMS restrict nursing facility providers from introducing such agreements at admission under any circumstances. Allowing such agreements to be offered to potential or new consumers of care is likely to create the impression that a consumer must sign in order to move into the facility, regardless of what is stated at that time by the provider. NASOP suggests that if the facility uses a binding arbitration agreement, a facility should be restricted from collecting such agreement at admission.

NASOP recommends a ratio of one full-time equivalent (FTE) social worker for up to the first 50 LTC residents and one FTE social worker for up to an additional 12 skilled nursing facility residents. We believe that CMS should eliminate the 120-bed rule, with additional qualified social work staff for additional residents. [1819(b)(7) and 1919(b)(7) of the Social Security Act, Page 42003] NASOP believes that the 120-bed rule is incompatible with the current and proposed regulations and skilled nursing facilities and NFs need different ratios of staff to residents to provide person-centered care. We recommend this ratio, as proposed by the National Nursing Home Social Work Network's Policy Committee.

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

NASOP was surprised that this subsection on Quality Assurance and Performance Improvement (QAPI) is not as robust as expected. NASOP recommends that facilities should be required to inform residents and families about their quality improvement plans, activities, and outcomes. We also note that the use of the word "program" may create an unintended institutional approach to QAPI.

### **483.80 Infection Control.**

NASOP suggests language at 483.80(a)(1): “(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to § 483.75(e) and following accepted national standards including, but not limited to guidelines from the Centers for Disease Control and Prevention;”

We recommend stronger language at 483.80(b) to make it clear that the individual designated is dedicated to infection prevention and control: “Infection prevention and control officer. The facility must designate one individual as the infection prevention and control officer (IPCO) for whom the IPCP at that facility is a ~~major~~ *primary* responsibility.

NASOP suggests the term “clinician” at 483.80(b)(1) should be defined in the final rule.

### **483.85 Compliance and ethics program.**

NASOP believes there needs to be some tangible observational process that survey and certification reviews while in the facility that will validate that facilities are providing compliance and ethics policies and procedures to staff and that governing bodies are implementing said policies and procedures.

NASOP suggests that all facilities should adhere to additional required components referenced at 483.85(d)(1), (2), and (3).

### **483.90 Physical environment.**

NASOP suggests language at 483.90(c)(1) that makes clear the facility should not have an institutional feel, but rather take on the characteristics of a home setting:

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“(1) Provide sufficient space and equipment in dining, health services, recreation, living (to reflect that this is the resident’s home and should not have an institutional or hospital like ambiance), and program areas to enable staff to provide residents with needed services as required by these standards and as identified in each resident’s assessment and plan of care and that residents can be afforded privacy in their accommodations and care; and”

We also suggest language at 483.90(d)(1)(i):

“Accommodate no more than ~~four~~ two residents. For facilities that receive approval of construction or reconstruction plans by State and local authorities or are newly certified after [effective date of final rule], bedrooms must either be private or accommodate no more than two residents, with an appropriate wall within the room to afford resident privacy. These additions would encourage new construction to plan rooms that offer real privacy, rather than encourage construction that is efficient and convenient for staff and owners.

NASOP is agreement with the language at 483.90(e) on having resident rooms equipped with toilets or located near toilet and bathing facilities.

NASOP also suggests language at 483.90(h)(5):

(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding the right of residents to smoke ~~smoking~~, including tobacco cessation, smoking areas and safety, including but not limited to non-smoking residents.

### **483.95 Training requirements.**

NASOP appreciates the new training requirements at 483.95, et seq. In particular, we applaud the inclusion of communication, resident’s rights and facility responsibilities, abuse, neglect, and exploitation, including activities that constitute abuse, neglect, and exploitation and misappropriation of resident property and procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property.

We suggest that an additional training requirement for all staff, not just nurse aides, should be dementia care.

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NASOP also believes that the annual compliance and ethics training referenced at 483.95(f)(2) apply to all facilities, regardless of size.

We also recommend that the annual continuing education requirement for nurse aides referenced at 483.95(g)(1) be increased from 12 to 24 hours.

**Part 488 – Survey, Certification, and Enforcement Procedures**

**488.301 Definitions. Substandard Quality of Care (SQC)**

While NASOP supports the inclusion of deficiencies' related to resident rights, freedom from abuse, neglect, and exploitation, and behavioral health services in the definition of SQC, we strongly encourage CMS to include transitions of care in this list. Facilities harm residents when they refuse to readmit residents back to their home and provide care to them, especially after an appeal has been successful. See related recommendation for the addition of 483.15(b)(5) to the definition of SQC.

NASOP thanks CMS and their staff for their work on these proposed rules. We believe that our suggestions and recommendations will further improve care for residents.

Sincerely,

Joseph Rodrigues, Chair  
NASOP Federal Policy Committee

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