

Custom Federal Regulations Service™

**This is an update
for your loose-leaf notebook:**

Medical

Book I

Title 38, Parts 17, 46, 47, 51–53,
58–64, 70, 71, and 200

Supplement No. 119

Covering period of *Federal Register* issues
through January 1, 2019

Copyright © 2019 Jonathan Publishing

Need Assistance?

Questions concerning **MISSING SUPPLEMENTS**, need for **ADDITIONAL BOOKS**, and other **DISTRIBUTION LIST** issues for this loose-leaf service should be directed to:

Department of Veterans Affairs
Veterans Benefits Administration
Administration
Mail Code: 20M33
810 Vermont Avenue, N.W.
Washington DC 20420
Telephone: 202/273-7588
Fax: 202/275-5947
E-mail: coarms@vba.va.gov

Questions concerning the **FILING INSTRUCTIONS** for this loose-leaf service,
or the reporting of **SUBSTANTIVE ERRORS** in the text,
may be directed to:

Jonathan Publishing
660 Laurel Street, B-103
Baton Rouge LA 70802
Telephone: 225-205-5873
Fax: 702-993-6003
E-mail: info@jonpub.com

Copyright © 2019 Jonathan Publishing

GENERAL INSTRUCTIONS

Custom Federal Regulations Service™

Supplemental Materials for *Book I*

Code of Federal Regulations

Title 38, Parts 17, 46, 47, 51–53, 58–64, 70, 71, and 200

Medical

Supplement No. 119

5 January 2019

Covering the period of Federal Register issues
through January 1, 2019

When **Book I** was originally prepared, it was current through final regulations published in the *Federal Register* of 15 January 2000. These supplemental materials are designed to keep your regulations up to date. You should file the attached pages immediately, and record the fact that you did so on the *Supplement Filing Record* which is at page I-8 of Book I, *Medical*.

**To ensure accuracy and timeliness of your materials,
it is important that you follow these simple procedures:**

1. Always file your supplemental materials immediately upon receipt.
2. Before filing, always check the Supplement Filing Record (page I-8) to be sure that all prior supplements have been filed. If you are missing any supplements, contact the Veterans Benefits Administration at the address listed on page I-2.
3. After filing, enter the relevant information on the Supplement Filing Record sheet (page I-8)—the date filed, name/initials of filer, and date through which the *Federal Register* is covered.
4. If as a result of a failure to file, or an undelivered supplement, you have more than one supplement to file at a time, be certain to file them in chronological order, lower number first.
5. Always retain the filing instructions (simply insert them at the back of the book) as a backup record of filing and for reference in case of a filing error.
6. Be certain that you *permanently discard* any pages indicated for removal in the filing instructions in order to avoid confusion later.

To execute the filing instructions, simply remove *and throw away* the pages listed under *Remove These Old Pages*, and replace them in each case with the corresponding pages from this supplement listed under *Add These New Pages*. Occasionally new pages will be added without removal of any old material (reflecting new regulations), and occasionally old pages will be removed without addition of any new material (reflecting rescinded regulations)—in these cases the word *None* will appear in the appropriate column.

FILING INSTRUCTIONS

**Book I, Supplement No. 119
January 5, 2019**

<i>Remove these old pages</i>	<i>Add these new pages</i>	<i>Section(s) Affected</i>
Do not file this supplement until you confirm that all prior supplements have been filed		
I-15 to I-16	I-15 to I-16	Book I Lead Material
I-19 to I-22	I-19 to I-22	Book I Lead Material
17.INDEX-1 to 17.INDEX-2	17.INDEX-1 to 17.INDEX-2	Part 17 Index
17.180-1 to 17.200-1	17.180-1 to 17.200-1	§§17.180 through 17.200
51.INDEX-1 to 51.59-2	51.INDEX-1 to 51.59-2	§§51.1, 51.2, 51.20, 51.30, 51.31, 51.32, 51.40, 51.42, 51.43, 51.50, 51.51, 51.52, 51.58, and 51.59
51.60-1 to 51.70-1	51.60-1 to 51.70-1	§51.60
51.110-3 to 51.140-2	51.110-3 to 51.140-2	§§51.120 & 51.140
51.200-3 to 51.210-9	51.200-3 to 51.210-9	§51.210
(none)	51.300-1 to 51.480-1	Adds Subparts E & F to Part 51
All of Part 52	Part 52 Cover Page	Removes Part 52

**Be sure to complete the
Supplement Filing Record (page I-9)
when you have finished filing this material.**

HIGHLIGHTS

Book I, Supplement No. 119 January 5, 2019

Supplement Highlights references: Where substantive changes are made in the text of regulations, the paragraphs of *Highlights* sections are cited at the end of the relevant section of text. Thus, if you are reading §17.100, you will see a note at the end of that section which reads: “Supplement *Highlights* references—37(1).” This means that paragraph 1 of the *Highlights* section in Supplement No. 37 contains information about the changes made in §17.100. By keeping and filing the *Highlights* sections, you will have a reference source explaining all substantive changes in the text of the regulations.

Supplement frequency: Beginning 1 January 2000, supplements for this Book I will be issued *every month* during which a final rule addition or modification is made to the parts of Title 38 covered by this book. Supplements will be numbered consecutively as issued.

Modifications in this supplement include the following:

1. On 28 November 2018, the VA published a final rule effective 28 December 2018, to adopt as final, with changes, proposed amendments to VA's regulations governing payment of per diem to States for nursing home care, domiciliary care, and adult day health care for eligible veterans in State homes. This rulemaking reorganizes, updates, and clarifies State home regulations, authorizes greater flexibility in adult day health care programs, and establishes regulations regarding domiciliary care, with clarifications regarding the care that State homes must provide to veterans in domiciliaries. Changes:

- Removed §§17.190 through 17.200,
- Revised §§51.1 and 51.2 in Part 51 – Subpart A,
- Revised §§51.20 through 51.32 in Part 51 – Subpart B,
- Revised §§51.40, 51.42, 51.43, 51.50 and 51.59 in Part 51 – Subpart C,
- Added §§51.51, 51.52, 51.58 in Part 51 – Subpart C,
- Revised §§51.120, 51.140, and 51.210 in Part 51 – Subpart D,
- Added new Part 51 – Subpart E,
- Added new Part 51 – Subpart F,
- Removed Part 52.

17.159 Obtaining vehicles for special driver training courses 17.159-1

Dental Services

17.160 Authorization of dental examinations 17.160-1
 17.161 Authorization of outpatient dental treatment 17.161-1
 17.162 Eligibility for Class II dental treatment without rating action 17.162-1
 17.163 Posthospital outpatient dental treatment 17.163-1
 17.164 Patient responsibility in making and keeping dental appointments 17.164-1
 17.165 Emergency outpatient dental treatment 17.165-1
 17.166 Dental services for hospital or nursing home patients and domiciled
 members 17.166-1
 17.169 VA Dental Insurance Program for veterans and survivors and
 dependents of veterans (VADIP) 17.169-1

Autopsies

17.170 Autopsies 17.170-1

Veterans Canteen Service

17.180 Delegation of authority 17.180-1

17.190 – 17.194 [Removed]

17.196 – 17.200 [Removed]

Grants to States for Construction or Acquisition of State Home Facilities

17.210 Definitions 17.210-1
 17.211 Maximum number of nursing home beds for veterans by State 17.211-1
 17.212 Scope of grants program 17.212-1
 17.213 Applications with respect to projects 17.213-1
 17.214 Disallowance of a grant application and notice of a right to hearing 17.214-1
 17.215 Recapture provisions 17.215-1
 17.216 General program requirements for construction and acquisition of and
 equipment for State home facilities 17.216-1
 17.217 Domiciliary and nursing home care program 17.217-1
 17.218 State home hospital program 17.218-1
 17.219 Preapplication phase 17.219-1
 17.220 Application phase 17.220-1
 17.221 Equipment 17.221-1
 17.222 General design guidelines and standards 17.222-1

Sharing of Medical Facilities, Equipment, and Information

17.230 Contingency backup to the Department of Defense..... 17.230-1
17.240 Sharing health-care resources 17.240-1
17.241 Sharing medical information services..... 17.241-1
17.242 Coordination of programs with Department of Health and
Human Services 17.242-1

Grants for Exchange of Information

17.250 Scope of the grant program 17.250-1
17.251 The Subcommittee on Academic Affairs..... 17.251-1
17.252 Ex officio member of subcommittee..... 17.252-1
17.253 Applicants for grants 17.253-1
17.254 Applications 17.254-1
17.255 Applications for grants for programs which include
construction projects..... 17.255-1
17.256 Amended or supplemental applications. 17.256-1
17.257 Awards procedures..... 17.257-1
17.258 Terms and conditions to which awards are subject..... 17.258-1
17.259 Direct costs..... 17.259-1
17.260 Patient care costs to be excluded from direct costs..... 17.260-1
17.261 Indirect costs. 17.261-1
17.262 Authority to approve applications discretionary 17.262-1
17.263 Suspension and termination procedures..... 17.263-1
17.264 Recoupments and releases 17.264-1
17.265 Payments 17.265-1
17.266 Copyrights and patents..... 17.266-1

17.804 Loan approval criteria 17.804-1
 17.805 Additional terms of loans..... 17.805-1

Health Care Benefits for Certain Children of Vietnam Veterans and Veterans with Covered Service in Korea—Spina Bifida and Covered Birth Defects

17.900 Spina bifida-provision of health care..... 17.900-1
 17.901 Definitions..... 17.901-1
 17.902 Preauthorization..... 17.902-1
 17.903 Payment..... 17.903-1
 17.904 Review and appeal process..... 17.904-1
 17.905 Medical records..... 17.905-1

Payment or Reimbursement for Emergency Services for Nonservice-Connected Conditions in Non-VA Facilities

17.1000 Payment or reimbursement for emergency services for nonservice-connected conditions in non-VA facilities 17.1000-1
 17.1001 Definitions..... 17.1001-1
 17.1002 Substantive conditions for payment or reimbursement..... 17.1002-1
 17.1003 Emergency transportation 17.1003-1
 17.1004 Filing claims..... 17.1004-1
 17.1005 Payment limitations 17.1005-1
 17.1006 Decisionmakers..... 17.1006-1
 17.1007 Independent right of recovery 17.1007-1
 17.1008 Balance billing prohibited..... 17.1008-1

Expanded Access to Non-VA Care Through the Veterans Choice Program

17.1500 Purpose and scope..... 17.1500-1
 17.1505 Definitions..... 17.1505-1
 17.1510 Eligible veterans..... 17.1510-1
 17.1515 Authorizing non-VA care..... 17.1515-1
 17.1520 Effect on other provisions..... 17.1520-1
 17.1525 Start date for eligible veterans 17.1525-1
 17.1530 Eligible entities and providers 17.1530-1
 17.1535 Payment rates and methodologies..... 17.1535-1
 17.1540 Claims processing system 17.1540-1
 17.2000 Vet Center services 17.2000-1

Home Improvements and Structural Alterations (HISA) Program

17.3100 Purpose and scope..... 17.3100-1
 17.3101 Definitions..... 17.3101-1
 17.3102 Eligibility..... 17.3102-1
 17.3105 HISA benefit lifetime limits..... 17.3105-1

I-20

17.3120 Application for HISA benefits..... 17.3120-1
17.3125 Approving HISA benefits applications..... 17.3125-1
17.3126 Disapproving HISA benefits applications..... 17.3126-1
17.3130 HISA benefits payment procedures..... 17.3130-1

**Part 46 — Policy Regarding Participation in
National Practitioner Data Bank**

Subpart A — General Provisions

46.1 Definitions 46.1-1
46.2 Purpose 46.2-1

Subpart B — National Practitioner Data Bank Reporting

46.3 Malpractice payment reporting..... 46.3-1
46.4 Clinical privileges actions reporting..... 46.4-1

Subpart C — National Practitioner Data Bank Inquiries

46.5 National Practitioner Data Bank inquiries..... 46.5-1

Subpart D — Miscellaneous

46.6 Medical quality assurance records confidentiality..... 46.6-1
46.7 Prohibitions concerning negotiations 46.7-1
46.8 Independent contractors 46.8-1

**Part 47 — Policy Regarding Reporting Health Care Professionals
to State Licensing Boards**

47.1 Definitions 47.1-1
47.2 Reporting to State Licensing Boards 47.2-1

**Part 51—Per Diem for Nursing Home, Domiciliary, or Adult Day
Health Care of Veterans In State Homes**

Subpart A—General

51.1 Purpose and scope of this part 51.1-1
51.2 Definitions..... 51.2-1

Subpart B— Obtaining Recognition and Certification for per Diem Payments

51.20 Recognition of a State home 51.20-1
51.30 Certification of a State home 51.30-1
51.31 Surveys for recognition and/or certification 51.31-1
51.32 Terminating recognition..... 51.32-1

Subpart C— Requirements Applicable to Eligibility, Rates, and Payments

51.40 Basic per diem rates 51.40-1
 51.41 Contracts and provider agreements for certain veterans
 With service-connected disabilities 51.41-1
 51.42 Payment procedures 51.42-1
 51.43 Drugs and medicines for certain veterans 51.43-1
 51.50 Eligible veterans--nursing home care..... 51.50-1
 51.51 Eligible veterans--domiciliary care 51.51-1
 51.52 Eligible veterans--adult day health care 51.52-1
 51.58 Requirements and Standards applicable for payment of per diem..... 51.58-1
 51.59 Authority to continue payment of per diem when veterans are relocated
 due to emergency 51.59-1

Subpart D— Standards applicable to the payment of per diem for nursing home care

51.60 Standards applicable for payment of per diem..... 51.60-1
 51.70 Resident rights 51.70-1
 51.80 Admission, transfer and discharge rights..... 51.80-1
 51.90 Resident behavior and facility practices 51.90-1
 51.100 Quality of life 51.100-1
 51.110 Resident assessment..... 51.110-1
 51.120 Quality of care..... 51.12p-1
 51.130 Nursing services..... 51.130-1
 51.140 Dietary services..... 51.140-1
 51.150 Physician services 51.150-1
 51.160 Specialized rehabilitative services 51.160-1
 51.170 Dental services..... 51.170-1
 51.180 Pharmacy services..... 51.180-1
 51.190 Infection control..... 51.190-1
 51.200 Physical environment..... 51.200-1
 51.210 Administration 51.210-1

Subpart E— Standards Applicable to the Payment of Per Diem for Domiciliary Care

51.300 Resident rights and behavior; State home practices; quality of life..... 51.300-1
 51.310 Resident admission, assessment, care plan, and discharge 51.310-1
 51.320 Quality of care..... 51.320-1
 51.330 Nursing care 51.330-1
 51.340 Physician and other licensed medical practitioner services 51.340-1
 51.350 Provision of certain specialized services and environmental requirements..... 51.350-1
 51.390 Administration 51.390-1

**Subpart F— Standards Applicable to the Payment of per Diem for
 Adult Day Health Care**

51.400 Participant rights 51.400-1
 51.405 Participant and family caregiver responsibilities 51.405-1
 51.410 Transfer and discharge 51.410-1

51.411 Program practices..... 51.411-1
51.415 Restraints, abuse, and staff treatment of participants..... 51.415-1
51.420 Quality of life 51.420-1
51.425 Physician orders and participant medical assessment..... 51.425-1
51.430 Quality of care..... 51.430-1
51.435 Nursing services 51.435-1
51.440 Dietary services 51.440-1
51.445 Physician services 51.445-1
51.450 Specialized rehabilitative services 51.450-1
51.455 Dental services 51.455-1
51.460 Administration of drugs 51.460-1
51.465 Infection control..... 51.465-1
51.470 Physical environment..... 51.470-1
51.475 Administration 51.475-1
51.480 Transportation 51.480-1

Part 52 — [REMOVED]

**Part 53 — Payments to States for Programs to Promote
the Hiring and Retention of Nurses at State Veterans Homes**

53.1 Purpose and scope..... 53.1-1
53.2 Definitions..... 53.2-1
53.10 Decision makers, notifications, and additional information 53.10-1
53.11 General requirements for payments 53.11-1
53.20 Application requirements..... 53.20-1
53.30 Payments 53.30-1
53.31 Annual report 53.31-1
53.32 Recapture provisions..... 53.32-1
53.40 Submission of information and documents..... 53.40-1
53.41 Notification of funding decision 53.41-1

Part 58 — Forms

58.10 VA Form 10-3567—State home inspection: staffing profile..... 58.10-1
58.11 VA Form 10-5588—State home report and statement of
Federal aid claimed 58.11-1
58.12 VA Form 10-10EZ—Application for health benefits 58.12-1
58.13 VA Form 10-10SH—State home program application for veteran
care—medical certification 58.13-1
58.14 VA Form 10-0143A—Statement of assurance of compliance with
Section 504 of the Rehabilitation Act of 1973..... 58.14-1

Part 17 — Medical

Authority: 38 U.S.C. 501, and as noted in specific sections.

Section 17.35 is also issued under 38 U.S.C. 1724

Section 17.38 is also issued under 38 U.S.C. 101, 501, 1701, 1705, 1710, 1710A, 1721, 1722, 1782, and 1786.

Section 17.125 is also issued under 38 U.S.C. 7304

Section 17.169 is also issued under 38 U.S.C. 1712C.

Sections 17.380, 17.390 and 17.412 are also issued under sec. 260, Pub. L. 114-223, 130 Stat. 857.

Section 17.410 is also issued under 38 U.S.C. 1787.

Section 17.415 is also issued under 38 U.S.C. 7301, 7304, 7402, and 7403.

Sections 17.640 and 17.647 are also issued under sec. 4, Pub. L. 114-2, 129 Stat. 30.

Sections 17.641 through 17.646 are also issued under 38 U.S.C. 501(a) and sec. 4, Pub. L. 114-2, 129 Stat. 30.

Section 17.417 also issued under 38 U.S.C. 1701 (note), 1709A, 1712A (note), 1722B, 7301, 7330A, 7401-7403, 7406 (note).

Section 17.655 also issued under 38 U.S.C. 501(a), 7304, 7405.

Ed. Note: Nomenclature changes to Part 17 appear at 61 FR 7216, Feb. 27, 1996

— Section Title Index —

Authority of Health Care Providers to Practice in VA

Full practice authority for advanced practice registered nurses	17.415-1
Health care providers practicing via telehealth	17.417-1

Automotive Equipment and Driver Training

Definition-adaptive equipment	17.157-1
Eligibility for automobile adaptive equipment	17.156-1
Limitations on assistance	17.158-1
Minimum standards of safety and quality for automotive adaptive equipment	17.155-1
Obtaining vehicles for special driver training courses	17.159-1

Autopsies
Autopsies 17.170-1

Breaking Appointments
Refusal of treatment by unnecessarily breaking appointments 17.100-1

Care During Certain Disasters and Emergencies
Provision of hospital care and medical services during certain disasters
and emergencies under 38 U.S.C. 178517.86

Ceremonies
Services or ceremonies on Department of Veterans Affairs hospital or
center reservations..... 17.112-1

Chaplain Services
Ecclesiastical endorsing organizations..... 17.655-1

Charges, Waivers, And Collections
Collection or recovery by VA for medical care or services provided or
furnished to a veteran for a non-service connected disability 17.101-1
Charges for care or services 17.102-1
Referrals of compromise settlement offers 17.103-1
Terminations and suspensions 17.104-1
Waivers 17.105-1

**Civilian Health and Medical Program of the Department of Veterans Affairs
(CHAMPVA)—Medical Care for Survivors and Dependents of
Certain Veterans**
Appeal/review process 17.276-1
Benefit limitations/exclusions..... 17.272-1
Claim filing deadline..... 17.275-1
Confidentiality of records 17.278-1
Cost sharing 17.274-1
Eligibility 17.271-1
General provisions 17.270-1
Preauthorization 17.273-1
Third party liability/medical care cost recovery..... 17.277-1

Community Residential Care
Approval of community residential care facilities 17.63-1
Approvals and provisional approvals of community residential care facilities 17.65-1
Availability of information 17.72-1
Definitions..... 17.62-1
Eligibility 17.61-1
Medical foster homes—general..... 17.73-1

Veterans Canteen Service**§17.180 Delegation of authority.**

In connection with the Veterans Canteen Service, the Under Secretary for Health is hereby delegated authority as follows:

(a) To exercise the powers and functions of the Secretary with respect to the maintenance and operation of the Veterans Canteen Service.

(b) To designate the Assistant Chief Medical Director for Administration to administer the overall operation of the Veterans Canteen Service and to designate selected employees of the Veterans Canteen Service to perform the functions described in the enabling statute, 38 U.S.C. ch. 78, so as to effectively maintain and operate the Veterans Canteen Service.

[20 FR 337, Jan. 14, 1955, as amended at 36 FR 23386, Dec. 9, 1971; 45 FR 6939, Jan. 31, 1980. Redesignated at 61 FR 21966, May 13, 1996, as amended at 62 FR 17072, Apr. 9, 1997; 79 FR 54616, Sep. 12, 2014]

Supplement *Highlights* reference: 86(1).

Next Section is §17.230

§§17.190—17.200 [Removed]

Part 51

**Per Diem for Nursing Home, Domiciliary, or Adult Day
Health Care of Veterans In State Homes**

Authority: 38 U.S.C. 101, 501, 1710, 1720, 1741-1743, 1745, and as follows.
 Section 51.20 and 51.30 also issued under 38 U.S.C. 511, 1742, 7104 and 7105.
 Section 51.42 also issued under 38 U.S.C. 510 and 1744.
 Section 51.43 also issued under 38 U.S.C. 1712.
 Section 51.310 also issued under 38 U.S.C. 1720(f).

Source: 65 Fed. Reg. 968, January 6, 2000, unless otherwise indicated.

— Section Title Index —

General

Definitions..... 51.2-1
 Purpose and scope of this part 51.1-1

Obtaining Recognition and Certification for per Diem Payments

Certification of a State home 51.30-1
 Recognition of a State home 51.20-1
 Surveys for recognition and/or certification 51.31-1
 Terminating recognition..... 51.32-1

Requirements Applicable to Eligibility, Rates, and Payments

Authority to continue payment of per diem when veterans are relocated due to emergency 51.59-1
 Basic per diem rates 51.40-1
 Contracts and provider agreements for certain veterans With service-connected disabilities 51.41-1
 Drugs and medicines for certain veterans 51.43-1
 Eligible veterans--adult day health care 51.52-1
 Eligible veterans--domiciliary care 51.51-1
 Eligible veterans--nursing home care..... 51.50-1
 Payment procedures 51.42-1
 Requirements and Standards applicable for payment of per diem..... 51.58-1

Standards applicable to the payment of per diem for nursing home care

Administration 51.210-1
 Admission, transfer and discharge rights 51.80-1
 Dental services 51.170-1
 Dietary services 51.140-1
 Infection control 51.190-1
 Nursing services 51.130-1
 Pharmacy services 51.180-1

Physician services 51.150-1
 Physical environment..... 51.200-1
 Quality of care..... 51.12p-1
 Quality of life 51.100-1
 Resident assessment..... 51.110-1
 Resident behavior and facility practices 51.90-1
 Resident rights 51.70-1
 Specialized rehabilitative services 51.160-1
 Standards applicable for payment of per diem..... 51.60-1

Standards Applicable to the Payment of Per Diem for Domiciliary Care

Administration 51.390-1
 Nursing care 51.330-1
 Physician and other licensed medical practitioner services 51.340-1
 Provision of certain specialized services and environmental requirements..... 51.350-1
 Quality of care..... 51.320-1
 Resident admission, assessment, care plan, and discharge 51.310-1
 Resident rights and behavior; State home practices; quality of life..... 51.300-1

Standards Applicable to the Payment of per Diem for Adult Day Health Care

Administration 51.475-1
 Administration of drugs 51.460-1
 Dental services 51.455-1
 Dietary services 51.440-1
 Infection control 51.465-1
 Nursing services 51.435-1
 Participant and family caregiver responsibilities 51.405-1
 Participant rights 51.400-1
 Physical environment..... 51.470-1
 Physician orders and participant medical assessment..... 51.425-1
 Physician services 51.445-1
 Program practices..... 51.411-1
 Quality of care..... 51.430-1
 Quality of life 51.420-1
 Restraints, abuse, and staff treatment of participants..... 51.415-1
 Specialized rehabilitative services 51.450-1
 Transfer and discharge 51.410-1
 Transportation 51.480-1

Part 51

Per Diem for Nursing Home, Domiciliary, or Adult Day Health Care of Veterans In State Homes

Authority: 38 U.S.C. 101, 501, 1710, 1720, 1741-1743, 1745, and as follows.
Section 51.20 and 51.30 also issued under 38 U.S.C. 511, 1742, 7104 and 7105.
Section 51.42 also issued under 38 U.S.C. 510 and 1744.
Section 51.43 also issued under 38 U.S.C. 1712.
Section 51.310 also issued under 38 U.S.C. 1720(f).

Source: 65 Fed. Reg. 968, January 6, 2000, unless otherwise indicated.

Subpart A — General

§51.1 Purpose and scope of this part.

The purpose of this part is to establish VA's policies, procedures, and standards applicable to the payment of per diem to State homes that provide nursing home care, domiciliary care, or adult day health care to eligible veterans. Subpart B of this part sets forth the procedures for recognition and certification of a State home. Subpart C sets forth requirements governing the rates of, and procedures applicable to, the payment of per diem; the provision of drugs and medicines; and for which veterans VA will pay per diem. Subparts D, E, and F set forth standards that any State home seeking per diem payments for nursing home care (subpart D), domiciliary care (subpart E), or adult day health care (subpart F) must meet.

[65 FR 968, Jan. 6, 2000; as amended at 83 FR 61271, Nov. 28, 2018]

Supplement *Highlights* references: 119(1).

§51.2 Definitions.

For the purposes of this part:

Activities of daily living (ADLs) means the functions or tasks for self-care usually performed in the normal course of a day, i.e., mobility, bathing, dressing, grooming, toileting, transferring, and eating.

Adult day health care means a therapeutic outpatient care program that includes one or more of the following services, based on patient care needs: Medical services, rehabilitation, therapeutic activities, socialization, and nutrition. Services are provided in a congregate setting.

Clinical nurse specialist means a licensed professional nurse with a master's degree in nursing and a major in a clinical nursing specialty from an academic program accredited by the National League for Nursing.

Director means the Director of the VA medical center of jurisdiction, unless the reference is specifically to another type of director.

Domiciliary care means the furnishing of a home to a veteran, including the furnishing of shelter, food, and other comforts of home, and necessary medical services as defined in this part. For purposes of the definition of “domiciliary care,” necessary medical services means the medical services subpart E of this part requires the State home to provide.

Eligible veteran means a veteran whose care in a State home may serve as a basis for per diem payments to the State. The requirements that an eligible veteran must meet are set forth in §§51.50 (nursing home care), 51.51 (domiciliary care), and 51.52 (adult day health care).

Licensed medical practitioner means a nurse practitioner, physician, physician assistant, or primary care physician.

Nurse practitioner means a licensed professional nurse who is currently licensed to practice in a State; who meets that State’s requirements governing the qualifications of nurse practitioners; and who is currently certified as an adult, family, or gerontological nurse practitioner by a nationally recognized body that provides such certification for nurse practitioners, such as the American Nurses Credentialing Center or the American Academy of Nurse Practitioners.

Nursing home care means the accommodation of convalescents or other persons who are not acutely ill and not in need of hospital care, but who require nursing care and related medical services, if such nursing care and medical services are prescribed by, or are performed under the general direction of, persons duly licensed to provide such care. The term includes services furnished in skilled nursing care facilities, in intermediate care facilities, and in combined facilities. It does not include domiciliary care.

Participant means an individual receiving adult day health care.

Physician means a doctor of medicine or osteopathy legally authorized to practice medicine or surgery in the State.

Physician assistant means a person who meets the applicable State requirements for a physician assistant, is currently certified by the National Commission on Certification of Physician Assistants as a physician assistant, and has an individualized written scope of practice that determines the authorization to write medical orders, to prescribe medications, and to accomplish other clinical tasks under appropriate physician supervision.

Primary care physician means a designated generalist physician responsible for providing, directing, and coordinating health care that is indicated for the residents or participants.

Program of care means any or all of the three levels of care for which VA may pay per diem under this part.

Resident means an individual receiving nursing home or domiciliary care.

State means each of the several States, the District of Columbia, the Virgin Islands, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, and American Samoa.

State home means a home recognized and, to the extent required by this part, certified pursuant to this part that a State established primarily for veterans disabled by age, disease, or otherwise, who by reason of such disability are incapable of earning a living. A State home must provide at least one program of care (i.e., domiciliary care, nursing home care, or adult day health care).

VA means the U.S. Department of Veterans Affairs.

Veteran means a veteran under 38 U.S.C. 101.

[65 FR 968, Jan. 6, 2000, as amended at 74 FR 19432, Apr. 29, 2009; 83 FR 61271, Nov. 28, 2018]

Supplement *Highlights* references: 47(1), 119(1).

Next Section is §51.20

Subpart B--Obtaining Recognition and Certification for per Diem Payments**§51.20 Recognition of a State home.**

(a) *How to apply for recognition.* To apply for recognition of a home for purposes of receiving per diem from VA, a State must submit a letter requesting recognition to the Office of Geriatrics and Extended Care in VA Central Office, 810 Vermont Avenue NW, Washington, DC 20420. The letter must be signed by the State official authorized to make the request. The letter will be reviewed by VA, in accordance with this section.

(b) *Survey and recommendation by Director.*

(1) After receipt of a letter requesting recognition, VA will survey the home in accordance with §51.31 to determine whether the facility and program of care meet the applicable requirements of subpart C and the applicable standards in subpart D, E, or F of this part. For purposes of the recognition process including the survey, references to State homes in the standards apply to homes that are being considered by VA for recognition as State homes.

(2) If the Director of the VA Medical Center of jurisdiction determines that the applicable requirements and standards are met, the Director will submit a written recommendation for recognition to the Under Secretary for Health.

(3) If the Director does not recommend recognition, the Director will submit a written recommendation against recognition to the Under Secretary for Health and will notify in writing the State official who signed the letter submitted under paragraph (a) of this section and the State official authorized to oversee operations of the home. The notification will state the following:

(i) The specific standard(s) not met; and

(ii) The State's right to submit a response to the Under Secretary for Health, including any additional evidence, no later than 30 calendar days after the date of the notification to the State.

(c) *Decision by the Under Secretary for Health.* After receipt of a recommendation from the Director, and allowing 30 calendar days for the state to respond to a negative recommendation and to submit evidence, the Under Secretary for Health will award or deny recognition based on all available evidence. The applicant will be notified of the decision in writing. Adverse decisions may be appealed to the Board of Veterans' Appeals (see 38 CFR part 20).

(d) *Effect of recognition.*

(1) Recognition of a State home means that, at the time of recognition, the facility and its program of care meet the applicable requirements of this part. The State home must obtain certification after recognition in accordance with §51.30.

(2) After a State home is recognized, any new annex, new branch, or other expansion in the size or capacity of a home or any relocation of the home to a new facility must be separately recognized.

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900-0161.)

[65 FR 968, Jan. 6, 2000, as amended at 74 FR 19432, Apr. 29, 2009; 83 FR 61272, Nov. 28, 2018]

Supplement *Highlights* references: 47(1), 119(1)

Next Section is §51.30

§51.30 Certification of a State home.

(a) *General certification requirement.* To be certified, the State home must allow VA to survey the home in accordance with §51.31. A State home must be certified no later than 450 calendar days after the State home is recognized. Certifications expire 600 calendar days after the date of their issuance.

(b) *Periodic certifications required.* The Director of the VA medical center of jurisdiction will certify a State home based on a survey conducted at least once every 270-450 calendar days, at VA's discretion, and will notify the State official authorized to oversee operations of the State home of the decision regarding certification.

(c) *Decreasing capacity for a program of care.* The State must report any decreases in the capacity for a particular program of care to the Office of Geriatrics and Extended Care in VA Central Office, 810 Vermont Avenue NW, Washington, DC 20420 no later than 30 calendar days after such decrease, and must provide an explanation for the decrease.

(d) *Provisional certification—*

(1) *When issuance is required.* After a VA survey, the Director must issue a provisional certification for the surveyed State home if the Director determines that all of the following are true:

(i) The State home does not meet one or more of the applicable requirements or standards in this part;

(ii) None of these deficiencies immediately jeopardize the health or safety of any resident or participant;

(iii) No later than 20 working days after receipt by the State home of the survey report, the State submitted to the Director a written plan to remedy each deficiency in a specified amount of time; and

(iv) The plan is reasonable and the Director has sent a written notice to the appropriate person(s) at the State home informing him or her that the Director agrees to the plan.

(2) *Surveys to continue while under provisional certification.* VA will continue to survey the State home while it is under a provisional certification in accordance with this section and §51.31. After such a survey, the Director will continue the provisional certification if the Director determines that the four criteria listed in paragraphs (c)(1)(i)-(iv) of this section are true.

(e) *Notice and the right to appeal a denial of certification.* A State home has the right to appeal when the Director determines that a State home does not meet the requirements of this part (i.e., denies certification). An appeal is not provided to a State for a State home that receives a provisional certification because, by providing the corrective action plan necessary to receive a provisional certification, a State demonstrates its acceptance of VA's determination that it does not meet the VA standards for which the corrective action plan was submitted.

(1) *Notice of decision denying certification.* The Director will issue in writing a decision denying certification that sets forth the specific standard(s) not met. The Director will

send a copy of this decision to the State official authorized to oversee operations of the State home, and notify that official of the State's right to submit a written appeal to the Under Secretary for Health as stated in paragraph (e)(2) of this section. If the State home does not submit a timely written appeal, the Director's decision becomes final and VA will not pay per diem for any care provided on or after the 31st day after the State's receipt of the Director's decision.

(2) *Appeal of denial of certification.* The State must submit a written appeal no later than 30 calendar days after the date of the notice of the denial of certification. The appeal must explain why the denial of certification is inaccurate or incomplete and provide any relevant information not considered by the Director. Any appeal that does not identify a reason for disagreement will be returned to the sender without further consideration. If the State home submits a timely written appeal, the Director's decision will not take effect and VA will continue to pay per diem to the State home pending a decision by the Under Secretary for Health.

(3) *Decision on appeal of a denial of certification.* The Under Secretary for Health will review the matter, including any relevant supporting documentation, and issue a written decision that affirms or reverses the Director's decision. The State will be notified of the decision, which may be appealed to the Board of Veterans' Appeals (see 38 CFR part 20) if it results in a loss of per diem payments to the State. VA will terminate recognition and certification and discontinue per diem payments for care provided on and after the date of the Under Secretary for Health's decision affirming a denial of certification or on a later date that must be specified by the Under Secretary for Health.

(f) *Other appeals.* Appeals of matters not addressed in this section will be governed by 38 CFR part 20.

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900-0161)

[65 FR 968, Jan. 6, 2000, as amended at 74 FR 19432, Apr. 29, 2009; as amended at 78 FR 51675, Aug. 21, 2013; 83 FR 61273, Nov. 28, 2018]

Supplement *Highlights* references: 47(1), 79(2), 119(1).

§51.31 Surveys for recognition and/or certification.

(a) *General.* Both before and after a home is recognized and certified, VA may survey the home as necessary to determine whether it complies with applicable regulations. VA will provide advance notice before a recognition survey, but advance notice is not required before other surveys. A survey, as necessary, may cover all parts of the home or only certain parts, and may include review, audit, and production of any records that have a bearing on compliance with the requirements of this part (including any reports from state or local entities), as well as the completion and submission to VA of all required forms. The Director will designate the VA officials and/or contractors to survey the home.

(b) *Recognition surveys.* VA will not conduct a recognition survey unless the following minimum requirements are met:

(1) For nursing homes and domiciliaries, the home has at least 20 residents or has a number of residents consisting of at least 50 percent of the resident capacity of the home;

(2) For adult day health care programs of care, the program has at least 10 participants or has a number of participants consisting of at least 50 percent of participant capacity of the program.

(c) *Threats to public, resident, or participant safety.* If VA identifies a condition at the home that poses an immediate threat to public, resident or participant safety, or other information indicating the existence of such a threat, the Director of the VA medical center of jurisdiction will immediately report this to the VA Network Director (10N1-22); the Office of Geriatrics and Extended Care in VA Central Office; and the State official authorized to oversee operations of the home.

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900-0160.)

[65 FR 968, Jan. 6, 2000; as amended at 83 FR 61271, Nov. 28, 2018]

Supplement *Highlights* references: 119(1).

§51.32 Terminating recognition.

Once a home has achieved recognition, the recognition will be terminated only if the State requests that the recognition be terminated, or if VA makes a final decision that affirms the Director's decision not to certify the State home.

[83 FR 61271, Nov. 28, 2018]

Supplement *Highlights* references: 119(1).

Next Section is §51.40

Subpart C— Requirements Applicable to Eligibility, Rates, and Payments**§51.40 Basic per diem rates.**

(a) *Basic rate.* Except as provided in §51.41, VA will pay per diem for care provided to an eligible veteran at a State home at the lesser of the following rates:

(1) One-half of the daily cost of the care for each day the veteran is in the State home, as calculated under paragraph (b) of this section.

(2) The basic per diem rate for each day the veteran is in the State home. The basic per diem rate is established by VA for each fiscal year in accordance with 38 U.S.C. 1741(a) and (c).

Note to paragraph (a): To determine the number of days that a veteran was in a State home, see paragraph (c) of this section.

(b) *How to calculate the daily cost of a veteran's care.* The daily cost of care consists of those direct and indirect costs attributable to care at the State home, divided by the total number of residents serviced by the program of care. Cost principles are set forth in Office of Management and Budget (OMB) regulations. 2 CFR 200.400-200.475.

(c) *Determining whether a veteran spent a day receiving nursing home or domiciliary care—*

(1) *Nursing homes.* VA will pay per diem for each day that the veteran is receiving nursing home care and has an overnight stay at the State home. Per diem also will be paid for a day when there is no overnight stay if the State home nursing home care program has an occupancy rate of 90 percent or greater on that day. However, these payments will be made only for the first 10 consecutive days during which the veteran is admitted as a patient for any stay in a VA or other hospital (a hospital stay could occur more than once in a calendar year once there is an overnight stay in the State home between hospital stays) and only for the first 12 days in a calendar year during which the veteran is absent for purposes other than receiving hospital care. Occupancy rate is calculated by dividing the total number of residents (including nonveterans) in the nursing home on that day by the total recognized nursing home capacity in that State home.

(2) *Domiciliaries.* VA will pay per diem for each day that the veteran is receiving domiciliary care and has an overnight stay at the State home. VA will also pay per diem during any absence of 96 or fewer consecutive hours for purposes other than receiving hospital care at VA expense, but VA will not pay per diem for any part of the absence if it continues for longer than 96 consecutive hours. Absences that are not interrupted by at least 24 hours of continuous residence in the State home are considered one continuous absence.

(d) *Determining whether a Veteran spent a day receiving adult day health care.* Per diem will be paid for a day of adult day health care. For purposes of this section a day of adult day health care means:

(1) Six hours or more in one calendar day in which a veteran receives adult day health care; or

(2) Any two periods of at least 3 hours each but less than 6 hours each in any 2 calendar days in the same calendar month in which the veteran receives adult day health care.

(3) Time during which the State home provides transportation between the veteran's residence and the State home or to a health care visit, or provides staff to accompany a veteran during transportation or a health care visit, will be included as time the veteran receives adult day health care.

[65 FR 968, Jan. 6, 2000, as amended at 74 FR 19432, Apr. 29, 2009; 83 FR 61274, Nov. 28, 2018]

Supplement *Highlights* references: 47(1), 119(1)

§51.41 Contracts and provider agreements for certain veterans with service-connected disabilities.

(a) *Contract or VA provider agreement required.* VA and State homes may enter into both contracts and provider agreements. VA will pay for each eligible veteran's care through either a contract or a provider agreement (called a “VA provider agreement”). Eligible veterans are those who:

(1) Are in need of nursing home care for a VA adjudicated service-connected disability, or

(2) Have a singular or combined rating of 70 percent or more based on one or more service-connected disabilities or a rating of total disability based on individual unemployability and are in need of nursing home care.

(b) *Payments under contracts.* Contracts under this section will be subject to this part to the extent provided for in the contract and will be governed by federal acquisition law and regulation. Contracts for payment under this section will provide for payment either:

(1) At a rate or rates negotiated between VA and the State home; or

(2) On request from a State home that provided nursing home care on August 5, 2012, for which the State home was eligible for payment under 38 U.S.C. 1745(a)(1), at a rate that reflects the overall methodology of reimbursement for such care that was in effect for the State home on August 5, 2012.

(c) *Payments under VA provider agreements.*

(1) State homes must sign an agreement to receive payment from VA for providing care to certain eligible veterans under a VA provider agreement. VA provider agreements under this section will provide for payments at the rate determined by the following formula. For State Homes in a metropolitan statistical area, use the most recently published CMS Resource Utilization Groups (RUG) case-mix levels for the applicable metropolitan statistical area. For State Homes in a rural area, use the most recently published CMS Skilled Nursing Prospective Payment System case-mix levels for the applicable rural area. To compute the daily rate for each State home, multiply the labor component by the State home wage index for each of the applicable case-mix levels; then add to that amount the non-labor component. Divide the sum of the results of these calculations by the number of applicable case-mix levels. Finally, add to this quotient the amount based on the CMS payment schedule for physician services. The amount for physician services, based on information published by CMS, is the average hourly rate for all physicians, with the rate modified by the applicable urban or rural geographic index for physician work, then multiplied by 12, then divided by the number of days in the year.

Note to paragraph (c)(1): The amount calculated under this formula reflects the prevailing rate payable in the geographic area in which the State home is located for nursing home care furnished in a non-Department nursing home (a public or private institution not under the direct jurisdiction of VA which furnishes nursing home care). Further, the formula for establishing

these rates includes CMS information that is published in the *Federal Register* every year and is effective beginning October 1 for the entire fiscal year. Accordingly, VA will adjust the rates annually.

(2) The State home shall not charge any individual, insurer, or entity (other than VA) for the nursing home care paid for by VA under a VA provider agreement. Also, as a condition of receiving payments under paragraph (c) of this section, the State home must agree not to accept drugs and medicines from VA provided under 38 U.S.C. 1712(d) on behalf of veterans covered by this section and corresponding VA regulations (payment under paragraph (c) of this section includes payment for drugs and medicines).

(3) Agreements under paragraph (c) of this section will be subject to this part, except to the extent that this part conflicts with this section. For purposes of this section, the term “per diem” in part 51 includes payments under provider agreements.

(4) If a veteran receives a retroactive VA service-connected disability rating and becomes a veteran identified in paragraph (a) of this section, the State home may request payment under the VA provider agreement for nursing home care back to the retroactive effective date of the rating or February 2, 2013, whichever is later. For care provided after the effective date but before February 2, 2013, the State home may request payment at the special per diem rate that was in effect at the time that the care was rendered.

(d) *VA signing official.* VA provider agreements must be signed by the Director of the VA medical center of jurisdiction or designee.

(e) *Forms.* Prior to entering into a VA provider agreement, State homes must submit to the VA medical center of jurisdiction a completed VA Form 10-10EZ, Application for Medical Benefits (or VA Form 10-10EZR, Health Benefits Renewal Form, if a completed VA Form 10-10EZ is already on file at VA), and a completed VA Form 10-10SH, State Home Program Application for Care—Medical Certification, for the veterans for whom the State home will seek payment under the provider agreement. After VA and the State home have entered into a VA provider agreement, forms for payment must be submitted in accordance with paragraph (a) of this section. VA Forms 10-10EZ and 10-10EZR are set forth in full at § 58.12 of this chapter and VA Form 10-10SH is set forth in full at § 58.13 of this chapter.

(The Office of Management and Budget has approved the information collection requirements in this section under control numbers 2900-0091 and 2900-0160.)

(f) *Termination of VA provider agreements.*

(1) A State home that wishes to terminate a VA provider agreement with VA must send written notice of its intent to the Director of the VA medical center of jurisdiction at least 30 days before the effective date of termination of the agreement. The notice shall include the intended date of termination.

(2) VA provider agreements will terminate on the date of a final decision that the home is no longer recognized by VA under § 51.30.

(g) *Compliance with Federal laws.* Under provider agreements entered into under this section, State homes are not required to comply with reporting and auditing requirements imposed under the Service Contract Act of 1965, as amended (41 U.S.C. 351,*et seq.*); however, State homes must comply with all other applicable Federal laws concerning employment and hiring practices including the Fair Labor Standards Act, National Labor Relations Act, the Civil Rights Acts, the Age Discrimination in Employment Act of 1967, the Vocational Rehabilitation Act of 1973, Worker Adjustment and Retraining Notification Act, Sarbanes-Oxley Act of 2002, Occupational Health and Safety Act of 1970, Immigration Reform and Control Act of 1986, Consolidated Omnibus Reconciliation Act, the Family and Medical Leave Act, the Americans with Disabilities Act, the Uniformed Services Employment and Reemployment Rights Act, the Immigration and Nationality Act, the Consumer Credit Protection Act, the Employee Polygraph Protection Act, and the Employee Retirement Income Security Act. (Authority: 38 U.S.C. 101, 501, 1710, 1720, 1741-1745; 42 U.S.C. 1395cc)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900-0160.)

[74 FR 19432, Apr. 29, 2009; as amended at 77 FR 72742, Dec. 6, 2012]

Supplement *Highlights* references: 47(1), 74(2).

§51.42 Payment procedures.*(a) Forms required—*

(1) *Forms required at time of admission or enrollment.* As a condition for receiving payment of per diem under this part, the State home must submit the forms identified in paragraphs (a)(1)(i) and (ii) of this section to the VA medical center of jurisdiction for each veteran at the time of the veteran's admission to or enrollment in a State home. If the home is not a recognized State home, the home must, after recognition, submit forms for Veterans who received care on and after the date of the completion of the VA survey that provided the basis for determining that the home met the standards of this part. The State home must also submit the appropriate form with any request for a change in the type of per diem paid on behalf of a veteran as a result of a change in the veteran's program of care or a change in the veteran's service-connected disability rating that makes the veteran's care eligible for payment under §51.41. Copies of VA Forms can be obtained from any VA Medical Center and are available on our website at www.va.gov/vaforms. The required forms are:

(i) A completed VA Form 10-10EZ, Application for Medical Benefits (or VA Form 10-10EZR, Health Benefits Renewal Form, if a completed Form 10-10EZ is already on file at VA).

Note 1 to paragraph (a)(1)(i): Domiciliary applicants and residents must complete the financial disclosure sections of VA Forms 10-10EZ and 10-10EZR, and adult day health care applicants may be required to complete the financial disclosure sections of these forms in order to enroll with VA. Although the nursing home applicants or residents or adult day health care participants do not complete the financial disclosure sections of VA Forms 10-10EZ and 10-10EZR, an unsigned form is incomplete, and VA will not accept the form.

(ii) A completed VA Form 10-10SH, State Home Program Application for Care--Medical Certification.

(2) *Form required for monthly payments.* Except as provided in paragraphs (b)(1) and (2) of this section, VA pays per diem on a monthly basis for care provided during the prior month. To receive payment, the State must submit each month to the VA a completed VA Form 10-5588, State Home Report and Statement of Federal Aid Claimed.

(b) Commencement of payments—

(1) *Per diem payments for a newly-recognized State home.* No per diem payments will be made until VA recognizes the home and each veteran resident for whom VA pays per diem is verified as being eligible; however, per diem payments will be made retroactively for care that was provided on and after the date of the completion of the VA survey that provided the basis for determining that the home met the standards of this part.

(2) *Per diem payments for capacity certified under §51.30(c).* Per diem will be paid for the care of veterans in capacity certified in accordance with §51.30(c) retroactive to the date of the completion of the survey if the Director certifies the capacity as a result of that survey.

(3) *Payments for eligible veterans.* When a State home admits or enrolls an eligible veteran, VA will pay per diem under this part from the date of receipt of the completed forms required by this section, except that VA will pay per diem from the date care began if the Director receives the completed forms no later than 10 calendar days after care began. VA will make retroactive payments of per diem under paragraphs (b)(1) and (2) of this section only if the Director receives the completed forms that must be submitted under this section.

(The Office of Management and Budget has approved the information collection requirements in this section under control numbers 2900-0091 and 2900-0160.)

[74 FR 19432, Apr. 29, 2009; as amended at 83 FR 61274, Nov. 28, 2018]

Supplement *Highlights* references: 47(1), 119(1)

§51.43 Drugs and medicines for certain veterans.

(a) In addition to the per diem payments under §51.40 of this part, the Secretary will furnish drugs and medicines to a State home as may be ordered by prescription of a duly licensed physician as specific therapy in the treatment of illness or injury for a veteran receiving nursing home care in a State home if--

(1) The veteran:

(i) Has a singular or combined rating of less than 50 percent based on one or more service-connected disabilities and needs the drugs and medicines for a service-connected disability; and

(ii) Needs nursing home care for reasons that do not include care for a VA adjudicated service-connected disability; or

(2) The veteran:

(i) Has a singular or combined rating of 50 or 60 percent based on one or more service-connected disabilities and needs the drugs and medicines; and

(ii) Needs nursing home care for reasons that do not include care for a VA adjudicated service-connected disability.

(b) VA will also furnish drugs and medicines to a State home for a veteran receiving nursing home, domiciliary, or adult day health care in a State home pursuant to 38 U.S.C. 1712(d), as implemented by §17.96 of this chapter, subject to the limitation in §51.41(c)(2).

(c) VA may furnish a drug or medicine under paragraph (a) of this section and under §17.96 of this chapter only if the drug or medicine is included on VA's National Formulary, unless VA determines a non-Formulary drug or medicine is medically necessary.

(d) VA may furnish a drug or medicine under this section and under §17.96 of this chapter by having the drug or medicine delivered to the State home in which the veteran resides by mail or other means and packaged in a form that is mutually acceptable to the State home and to VA set forth in a written agreement.

(e) As a condition for receiving drugs or medicine under this section or under §17.96 of this chapter, the State must submit to the VA medical center of jurisdiction a completed VA Form 10-0460 with the corresponding prescription(s) for each eligible veteran.

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900-0160.)

[74 FR 19432, Apr. 29, 2009; as amended at 77 FR 59230, Sep. 27, 2012; 78 FR 18240, Mar. 26, 2013; 78 FR 51675, Aug. 21, 2013; 80 FR 43322, July 22, 2015; 83 FR 61274, Nov. 28, 2018]

Supplement *Highlights* references: 47(1), 73(1), 79(2), 93(1), 119(1).

Next Section is §51.50

§51.50 Eligible veterans--nursing home care.

A veteran is an eligible veteran for the purposes of payment of per diem for nursing home care under this part if VA determines that the veteran needs nursing home care; is not barred from receiving care based on his or her service (see 38 U.S.C. 5303, 5303A), is not barred from receiving VA pension, compensation or dependency and indemnity compensation based on the character of a discharge from military service (see 38 CFR 3.12) and is within one of the following categories:

- (a) Veterans with service-connected disabilities;
- (b) Veterans who are former prisoners of war, who were awarded the Purple Heart, or who were awarded the medal of honor under 10 U.S.C. 3741, 6241, or 8741 or 14 U.S.C. 491;
- (c) Veterans who were discharged or released from active military service for a disability incurred or aggravated in the line of duty;
- (d) Veterans who receive disability compensation under 38 U.S.C. 1151;
- (e) Veterans whose entitlement to disability compensation is suspended because of the receipt of retired pay;
- (f) Veterans whose entitlement to disability compensation is suspended pursuant to 38 U.S.C. 1151, but only to the extent that such veterans' continuing eligibility for nursing home care is provided for in the judgment or settlement described in 38 U.S.C. 1151;
- (g) Veterans who VA determines are unable to defray the expenses of necessary care as specified under 38 U.S.C. 1722(a);
- (h) Veterans solely seeking care for a disorder associated with exposure to a toxic substance or radiation, for a disorder associated with service in the Southwest Asia theater of operations during the Persian Gulf War, as provided in 38 U.S.C. 1710(e), or for any illness associated with service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998, as provided and limited in 38 U.S.C. 1710(e);
- (i) Veterans who agree to pay to the United States the applicable co-payment determined under 38 U.S.C. 1710(f) and 1710(g).

Note 1 to paragraph (i): Neither enrollment in the VA healthcare system nor eligibility to enroll is required to be an eligible veteran for the purposes of payment of per diem for nursing home care.

[65 FR 968, Jan. 6, 2000; as amended at 83 FR 61275, Nov. 28, 2018]

Supplement *Highlights* references: 119(1).

§51.51 Eligible veterans--domiciliary care.

(a) A veteran is an eligible veteran for the purposes of payment of per diem for domiciliary care in a State home under this part if VA determines that the veteran is not barred from receiving care based on his or her service (see 38 U.S.C. 5303, 5303A), is not barred from receiving VA pension, compensation or dependency and indemnity compensation based on the character of a discharge from military service (see 38 CFR 3.12), and the veteran is:

(1) A veteran whose annual income does not exceed the maximum annual rate of pension payable to a veteran in need of regular aid and attendance; or

(2) A veteran who VA determines has no adequate means of support. The phrase "no adequate means of support" refers to an applicant for domiciliary care whose annual income exceeds the rate of pension described in paragraph (a)(1) of this section, but who is able to demonstrate to competent VA medical authority, on the basis of objective evidence, that deficits in health or functional status render the applicant incapable of pursuing substantially gainful employment, as determined by the Chief of Staff of the VA medical center of jurisdiction, and who is otherwise without the means to provide adequately for himself or herself, or be provided for in the community.

(b) For purposes of this section, the eligible veteran must be able to perform the following:

(1) Daily ablutions, such as brushing teeth, bathing, combing hair, and body eliminations, without assistance.

(2) Dress himself or herself with a minimum of assistance.

(3) Proceed to and return from the dining hall without aid.

(4) Feed himself or herself.

(5) Secure medical attention on an ambulatory basis or by use of a personally propelled wheelchair.

(6) Have voluntary control over body eliminations or have control by use of an appropriate prosthesis.

(7) Participate in some measure, however slight, in work assignments that support the maintenance and operation of the State home.

(8) Make rational and competent decisions as to his or her desire to remain in or leave the State home.

[83 FR 61275, Nov. 28, 2018]

Supplement *Highlights* references: 119(1).

§51.52 Eligible veterans--adult day health care.

A veteran is an eligible veteran for payment of per diem to a State for adult day health care if VA determines that the veteran:

(a) Is not barred from receiving VA pension, compensation or dependency and indemnity compensation based on the character of a discharge from military service (see 38 CFR 3.12);

(b) Is enrolled in the VA health care system;

(c) Would otherwise require nursing home care; and

(d) Needs adult day health care because the veteran meets any one of the following conditions:

(1) The veteran has three or more Activities of Daily Living (ADL) dependencies.

(2) The veteran has significant cognitive impairment.

(3) The veteran has two ADL dependencies and two or more of the following conditions:

(i) Seventy-five years old or older;

(ii) High use of medical services, i.e., three or more hospitalizations per calendar year, or 12 or more visits to an outpatient clinic or to an emergency evaluation unit per calendar year;

(iii) Diagnosis of clinical depression; or

(iv) Living alone in the community.

(4) The veteran does not meet the criteria in paragraph (d)(1), (2), or (3) of this section, but nevertheless a licensed VA medical practitioner determines the veteran needs adult day health care services.

(Authority: 38 U.S.C. 501, 1720(f), 1741-1743)

[83 FR 61275, Nov. 28, 2018]

Supplement *Highlights* references: 119(1).

§51.58 Requirements and Standards applicable for payment of per diem.

A State home must meet the requirements in subpart C and the standards in the applicable subpart to be recognized, certified, and receive per diem for that program of care:

- (a) For nursing home care, subpart D.
- (b) For domiciliary care, subpart E.
- (c) For adult day health care, subpart F.

[83 FR 61271, Nov. 28, 2018]

Supplement *Highlights* references: 119(1).

§51.59 Authority to continue payment of per diem when veterans are relocated due to emergency.

(a) *Definition of emergency.* For the purposes of this section, emergency means an occasion or instance where all of the following are true:

(1) It would be unsafe for veterans receiving care at a State home to remain in that home.

(2) The State is not, or believes that it will not be, able to provide care in the State home on a temporary or long-term basis for any or all of its veteran residents due to a situation involving the State home, and not due to a situation where a particular veteran's medical condition requires that the veteran be transferred to another facility, such as for a period of hospitalization.

(3) The State determines that the veterans must be evacuated to another facility or facilities.

(b) *General authority to pay per diem during a relocation period.* Notwithstanding any other provision of this part, VA will continue to pay per diem for a period not to exceed 30 calendar days for any eligible veteran who resided in a State home, and for whom VA was paying per diem, if such veteran is evacuated during an emergency into a facility other than a VA nursing home, hospital, domiciliary, or other VA site of care if the State is responsible for providing or paying for the care. VA will not pay per diem under this section for more than 30 calendar days of care provided in the evacuation facility, unless the official who approved the emergency response under paragraph (e) of this section determines that it is not reasonably possible to return the veteran to a State home within the 30-calendar-day period, in which case such official will approve additional period(s) of no more than 30 calendar days in accordance with this section. VA will not pay per diem if VA determines that a veteran is or has been placed in a facility that does not meet the standards set forth in paragraph (c)(1) of this section, and VA may recover all per diem paid for the care of the veteran in that facility.

(c) *Selection of evacuation facilities.* The following standards and procedures in paragraphs (c)(1) through (3) apply to the selection of an evacuation facility in order for VA to continue to pay per diem during an emergency. These standards and procedures also apply to evacuation facilities when veterans are evacuated from a nursing home in which care is being provided pursuant to a contract under 38 U.S.C. 1720.

(1) Each veteran who is evacuated must be placed in a facility that, at a minimum, will meet the needs for food, shelter, toileting, and essential medical care of that veteran.

(2) For veterans evacuated from nursing homes, the following types of facilities may meet the standards under paragraph (c)(1) of this section:

- (i) VA Community Living Centers;
- (ii) VA contract nursing homes;
- (iii) Centers for Medicare and Medicaid Services certified facilities; and

(iv) Licensed nursing homes.

Note 1 to paragraph (c)(2): If none of the above options are available, veterans may be evacuated temporarily to other facilities that meet the standards under paragraph (c)(1) of this section.

(3) For veterans evacuated from domiciliaries, the following types of facilities may meet the standards in paragraph (c)(1) of this section:

- (i) Emergency evacuation facilities identified by the city or State;
- (ii) Assisted living facilities; and
- (iii) Hotels.

(d) *Applicability to adult day health care programs of care.* Notwithstanding any other provision of this part, VA will continue to pay per diem for a period not to exceed 30 calendar days for any eligible veteran who was receiving adult day health care, and for whom VA was paying per diem, if the adult day health care facility becomes temporarily unavailable due to an emergency. Approval of a temporary program of care for such veteran is subject to paragraph (e) of this section. If after 30 calendar days the veteran cannot return to the adult day health care program in the State home, VA will discontinue per diem payments unless the official who approved the emergency response under paragraph (e) of this section determines that it is not reasonably possible to provide care in the State home or to relocate an eligible veteran to a different recognized or certified facility, in which case such official will approve additional period(s) of no more than 30 calendar days at the temporary program of care in accordance with this section. VA will not pay per diem if VA determines that a veteran was provided adult day health care in a facility that does not meet the standards set forth in paragraph (c)(1) of this section, and VA may recover all per diem paid for the care of the veteran in that facility.

(e) *Approval of response.* Per diem payments will not be made under this section unless and until the Director of the VA medical center of jurisdiction or the director of the VISN in which the State home is located (if the VAMC Director is not capable of doing so) determines, that an emergency exists and that the evacuation facility meets VA standards set forth in paragraph (c)(1) of this section.

[83 FR 61271, Nov. 28, 2018]

Supplement *Highlights* references: 119(1).

Subpart D— Standards applicable to the payment of per diem for nursing home care**§51.60 Standards applicable for payment of per diem.**

The provisions of this subpart are the standards that a State home and facility management must meet for the State to receive per diem for nursing home care.

Next Section is §51.70

§51.70 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. The facility management 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 management in exercising his or her rights.

(3) The resident has the right to freedom from chemical or physical restraint.

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

(5) In the case of a resident who has not been determined 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 management 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. Such notification must be made prior to or upon admission and periodically during the resident's stay.

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

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

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

(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;

(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 (b)(7) of this section; and

(5) The facility management 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 to be billed to the resident.

(6) The facility management must furnish a written description of legal rights which includes:

(f) *Discharge summary.* Prior to discharging a resident, the facility management must prepare a discharge summary that includes:

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

(2) A summary of the resident's status at the time of the discharge to include items in paragraph (b)(2) of this section; 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. (Authority: 38 U.S.C. 101, 501, 1710, 1741-1743)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900-0160.)

[65 FR 968, Jan. 6, 2000, as amended at 74 FR 19434, Apr. 29, 2009]

Supplement *Highlights* reference: 47(1)

Next Section is §51.120

§51.120 Quality of care.

Each resident must receive and the facility management 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) *Reporting of Sentinel Events.*

(1) *Definition.* A sentinel event is an adverse event that results in the loss of life or limb or permanent loss of function.

(2) Examples of sentinel events are as follows:

- (i) Any resident death, paralysis, coma or other major permanent loss of function associated with a medication error; or
- (ii) Any suicide of a resident, including suicides following elopement (unauthorized departure) from the facility; or
- (iii) Any elopement of a resident from the facility resulting in a death or a major permanent loss of function; or
- (iv) Any procedure or clinical intervention, including restraints, that result in death or a major permanent loss of function; or
- (v) Assault, homicide or other crime resulting in patient death or major permanent loss of function; or
- (vi) A patient fall that results in death or major permanent loss of function as a direct result of the injuries sustained in the fall.

(3) The facility management must report sentinel events to the director of VA medical center of jurisdiction within 24 hours of identification. The VA medical center of jurisdiction must report sentinel events by calling VA Network Director (10N 1-22) and Office of Geriatrics and Extended Care in VA Central Office within 24 hours of notification.

(4) The facility management must establish a mechanism to review and analyze a sentinel event resulting in a written report no later than 10 working days following the event. The purpose of the review and analysis of a sentinel event is to prevent injuries to residents, visitors, and personnel, and to manage those injuries that do occur and to minimize the negative consequences to the injured individuals and facility.

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

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

- (i) Bathe, dress, and groom;
- (ii) Transfer and ambulate;
- (iii) Toilet;
- (iv) Eat; and

(v) Talk or otherwise communicate.

(2) A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (b)(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, hydration, grooming, personal and oral hygiene, mobility, and bladder and bowel elimination.

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

(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.

(d) *Pressure sores.* Based on the comprehensive assessment of a resident, the facility management must ensure that:

(1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and

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

(e) *Urinary and Fecal Incontinence.* Based on the resident's comprehensive assessment, the facility management 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;

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

(3) A resident who has persistent fecal incontinence receives appropriate treatment and services to treat reversible causes and to restore as much normal bowel function as possible.

(f) *Range of motion.* Based on the comprehensive assessment of a resident, the facility management 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.

(g) *Mental and Psychosocial functioning.* Based on the comprehensive assessment of a resident, the facility management must ensure that a resident who displays mental or

psychosocial adjustment difficulty, receives appropriate treatment and services to correct the assessed problem.

(h) *Enteral Feedings*. Based on the comprehensive assessment of a resident, the facility management must ensure that:

(1) A resident who has been able to adequately eat or take fluids alone or with assistance is not fed by enteral feedings unless the resident's clinical condition demonstrates that use of enteral feedings was unavoidable; and

(2) A resident who is fed by enteral feedings receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, nasal-pharyngeal ulcers and other skin breakdowns, and to restore, if possible, normal eating skills.

(i) *Accidents*. The facility management 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.

(j) *Nutrition*. Based on a resident's comprehensive assessment, the facility management 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 a nutritional deficiency is identified.

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

(l) *Special needs*. The facility management 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.

(m) *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 management 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.

(n) *Medication Errors*. The facility management must ensure that:

(1) Medication errors are identified and reviewed on a timely basis; and

(2) strategies for preventing medication errors and adverse reactions are implemented. (Authority: 38 U.S.C. 101, 501, 1710, 1741-1743)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900-0160.)

[65 FR 968, Jan. 6, 2000, as amended at 74 FR 19434, Apr. 29, 2009; 83 FR 61276, Nov. 28, 2018]

Supplement *Highlights* reference: 119(1)

Next Section is §51.130

§51.130 Nursing services.

The facility management must provide an organized nursing service with a sufficient number of qualified nursing personnel to meet the total nursing care needs, as determined by resident assessment and individualized comprehensive plans of care, of all patients within the facility 24 hours a day, 7 days a week.

(a) The nursing service must be under the direction of a full-time registered nurse who is currently licensed by the State and has, in writing, administrative authority, responsibility, and accountability for the functions, activities, and training of the nursing services staff.

(b) The facility management must provide registered nurses 24 hours per day, 7 days per week.

(c) The director of nursing service must designate a registered nurse as a supervising nurse for each tour of duty.

(1) Based on the application and results of the case mix and staffing methodology, the director of nursing may serve in a dual role as director and as an onsite-supervising nurse only when the facility has an average daily occupancy of 60 or fewer residents in nursing home.

(2) Based on the application and results of the case mix and staffing methodology, the evening or night supervising nurse may serve in a dual role as supervising nurse as well as provides direct patient care only when the facility has an average daily occupancy of 60 or fewer residents in nursing home.

(d) The facility management must provide nursing services to ensure that there is direct care nurse staffing of no less than 2.5 hours per patient per 24 hours, 7 days per week in the portion of any building providing nursing home care.

(e) Nurse staffing must be based on a staffing methodology that applies case mix and is adequate for meeting the standards of this part. (Authority: 38 U.S.C. 101, 501, 1710, 1741-1743)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900-0160.)

[65 FR 968, Jan. 6, 2000, as amended at 74 FR 19434, Apr. 29, 2009]

Next Section is §51.140

§51.140 Dietary services.

The facility management 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 management must employ a qualified dietitian either full-time, part-time, or on a consultant basis.

(1) If a dietitian is not employed, the facility management must designate a person to serve as the director of food service who receives at least a monthly scheduled consultation from a qualified dietitian.

(2) A qualified dietitian is one who is qualified based upon registration by the Commission on Dietetic Registration of the Academy of Nutrition and Dietetics.

(b) *Sufficient staff.* The facility management 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.

(e) *Therapeutic diets.* Therapeutic diets must be prescribed by the primary care 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 the availability of breakfast the following day, except as provided in (f)(4) of this section.

(3) The facility staff 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.

(g) *Assistive devices.* The facility management 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. (Authority: 38 U.S.C. 101, 501, 1710, 1741-1743)

[65 FR 968, Jan. 6, 2000, as amended at 83 FR 61276, Nov. 28,2018]

Supplement *Highlights* reference: 119(1)

Next Section is §51.150

- (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. (Authority: 38 U.S.C. 101, 501, 1710, 1741-1743)

(i) (1) Incorporation by reference of these materials was approved by the Director of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. These materials incorporated by reference are available for inspection at the Department of Veterans Affairs, Office of Regulation Policy and Management (02REG), 810 Vermont Avenue NW., Room 1068, Washington, DC 20420, call 202-461-4902, or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to:

http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html

(2) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. (For ordering information, call toll-free 1-800-344-3555).

(i) NFPA 99, Health Care Facilities Code, Including all Gas & Vacuum System Requirements, (2012 Edition).

(ii) NFPA 101, Life Safety Code (2012 edition).

[65 FR 968, Jan. 6, 2000, as amended at 74 FR 19434, Apr. 29, 2009; 76 FR 11340, Mar. 2, 2011; 80 FR 44862, July 28, 2015]

Supplement *Highlights* references: 47(1), 61(3), 93(2).

Next Section is §51.210

§51.210 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) *Governing body.*

(1) The State must have a governing body, or designated person 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 or State official with oversight for the facility appoints the administrator who is:

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

(ii) Responsible for operation and management of the facility.

(b) *Disclosure of State agency and individual responsible for oversight of facility.* The State must give written notice to the Office of Geriatrics and Extended Care, VA Headquarters, 810 Vermont Avenue, NW, Washington, DC 20420, at the time of the change, if any of the following change:

(1) The State agency and individual responsible for oversight of a State home facility;

(2) The State home administrator

(3) The director of nursing services (or other individual in charge of nursing services); and

(4) The State employee responsible for oversight of the State home if a contractor operates the State home.

(c) *Required Information.* The facility management must submit the following to the director of the VA medical center of jurisdiction as part of the application for recognition and thereafter as often as necessary to be current or as specified:

(1) The copy of legal and administrative action establishing the State-operated facility (e.g., State laws);

(2) Site plan of facility and surroundings;

(3) Legal title, lease, or other document establishing right to occupy facility;

(4) Organizational charts and the operational plan of the facility;

(5) The number of the staff by category indicating full-time, part-time and minority designation (annual at time of survey);

(6) The number of nursing home patients who are veterans and non-veterans, the number of veterans who are minorities and the number of non-veterans who are minorities (annual at time of survey);

- (7) Annual State Fire Marshall's report;
- (8) Annual certification from the responsible State Agency showing compliance with Section 504 of the Rehabilitation Act of 1973 (Public Law 93-112) (VA Form 10-0143A, which is available at any VA medical center and at <http://www.va.gov/forms>);
- (9) Annual certification for Drug-Free Workplace Act of 1988 (VA Form 10-0143, which is available at any VA medical center and at <http://www.va.gov/forms>);
- (10) Annual certification regarding lobbying in compliance with Public Law 101-121 (VA Form 10-0144, which is available at any VA medical center and at <http://www.va.gov/forms>); and
- (11) Annual certification of compliance with Title VI of the Civil Rights Act of 1964 as incorporated in Title 38 CFR 18.1-18.3 (VA Form 10-0144A, which is available at any VA medical center and at <http://www.va.gov/forms>).

(d) *Percentage of Veterans.* The percent of the facility residents eligible for VA nursing home care must be at least 75 percent veterans except that the veteran percentage need only be more than 50 percent if the facility was constructed or renovated solely with State funds. All non-veteran residents must be spouses of veterans, or parents any of whose children died while serving in the Armed Forces of the United States.

(e) *Management Contract Facility.* If a facility is operated by an entity contracting with the State, the State must assign a State employee to monitor the operations of the facility on a full-time onsite basis.

(f) *Licensure.* The facility and facility management must comply with applicable State and local licensure laws.

(g) *Staff qualifications.*

(1) The facility management 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 management must have that service furnished to residents by a person or agency outside the facility under a written agreement described in paragraph (h)(2) of this section.

(2) Agreements pertaining to services furnished by outside resources must specify in writing that the facility management 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.

(3) If a veteran requires health care that the State home is not required to provide under this part, the State home may assist the veteran in obtaining that care from sources outside the State home, including the Veterans Health Administration. If VA is contacted about providing such care, VA will determine the best option for obtaining the needed services and will notify the veteran or the authorized representative of the veteran.

(i) *Medical director.*

(1) The facility management must designate a primary care physician to serve as medical director.

(2) The medical director is responsible for:

- (i) Participating in establishing policies, procedures, and guidelines to ensure adequate, comprehensive services;
- (ii) Directing and coordinating medical care in the facility;
- (iii) Helping to arrange for continuous physician coverage to handle medical emergencies;
- (iv) Reviewing the credentialing and privileging process;
- (v) Participating in managing the environment by reviewing and evaluating incident reports or summaries of incident reports, identifying hazards to health and safety, and making recommendations to the administrator; and
- (vi) Monitoring employees' health status and advising the administrator on employee-health policies.

(j) *Credentialing and Privileging.* Credentialing is the process of obtaining, verifying, and assessing the qualifications of a health care practitioner, which may include physicians, podiatrists, dentists, psychologists, physician assistants, nurse practitioners, licensed nurses to provide patient care services in or for a health care organization. Privileging is the process whereby a specific scope and content of patient care services are authorized for a health care practitioner by the facility management, based on evaluation of the individual's credentials and performance.

(1) The facility management must uniformly apply credentialing criteria to licensed practitioners applying to provide resident care or treatment under the facility's care.

(2) The facility management must verify and uniformly apply the following core criteria: current licensure; current certification, if applicable, relevant education, training, and experience; current competence; and a statement that the individual is able to perform the services he or she is applying to provide.

(3) The facility management must decide whether to authorize the independent practitioner to provide resident care or treatment, and each credentials file must indicate that these criteria are uniformly and individually applied.

(4) The facility management must maintain documentation of current credentials for each licensed independent practitioner practicing within the facility.

(5) When reappointing a licensed independent practitioner, the facility management must review the individual's record of experience.

(6) The facility management systematically must assess whether individuals with clinical privileges act within the scope of privileges granted.

(k) *Required training of nursing aides.*

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

(2) The facility management must not use any individual working in the facility as a nurse aide whether permanent or not unless:

- (i) That individual is competent to provide nursing and nursing related services; and
- (ii) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State.

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

(4) *Multi-State registry verification.* Before allowing an individual to serve as a nurse aide, facility management must seek information from every State registry established under HHS regulations at 42 CFR 483.156 which the facility believes will include information on the individual.

(5) *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.

(6) *Regular in-service education.* The facility management 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.

(l) *Proficiency of Nurse aides.* The facility management 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.

(m) *Level B Requirement Laboratory services.*

(1) The facility management 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 all applicable certification standards, statutes, and regulations for laboratory services.
- (ii) If the facility provides blood bank and transfusion services, it must meet all applicable certification standards, statutes, and regulations.
- (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 and meet certification standards, statutes, and regulations.
- (iv) The laboratory performing the testing must have a current, valid CLIA number (Clinical Laboratory Improvement Amendments of 1988). The facility management must provide VA surveyors with the CLIA number and a copy of the results of the last CLIA inspection.
- (v) Such services must be available to the resident seven days a week, 24 hours a day.

(2) The facility management must:

- (i) Provide or obtain laboratory services only when ordered by the primary physician;
- (ii) Promptly notify the primary 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.

(n) *Radiology and other diagnostic services.*

(1) The facility management 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 all applicable certification standards, statutes, and regulations.

- (ii) If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services. The services must meet all applicable certification standards, statutes, and regulations.
- (iii) Radiologic and other diagnostic services must be available 24 hours a day, seven days a week.

(2) The facility must:

- (i) Provide or obtain radiology and other diagnostic services when ordered by the primary physician;
- (ii) Promptly notify the primary 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.

(o) *Clinical records.*

(1) The facility management 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.

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

(4) The facility management 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;
- (iv) The resident or;
- (v) The resident's authorized agent or representative.

(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 services provided;
- (iv) The results of any pre-admission screening conducted by the State;
and
- (v) Progress notes.

(p) *Quality assessment and assurance.*

(1) Facility management must maintain a quality assessment and assurance committee consisting of:

- (i) The director of nursing services;
- (ii) A primary 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; and

(3) Identified quality deficiencies are corrected within an established time period.

(4) The VA Under Secretary for Health may not require disclosure of the records of such committee unless such disclosure is related to the compliance with requirements of this section.

(q) *Disaster and emergency preparedness.*

(1) The facility management 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 management 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.

(r) *Transfer agreement.*

(1) The facility management must have in effect a written transfer agreement with one or more hospitals that reasonably assures that:

(i) Residents will be transferred from the nursing home to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the primary 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 nursing home 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 an agreement with a hospital sufficiently close to the facility to make transfer feasible.

(s) *Compliance with Federal, State, and local laws and professional standards.* The facility management 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. This includes the Single Audit Act of 1984 (Title 31, Section 7501, *et seq.*) and the Cash Management Improvement Acts of 1990 and 1992 (Public Laws 101-453 and 102-589, see 31 USC 3335, 3718, 3720A, 6501, 6503)

(t) *Relationship to other Federal regulations.* In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other Federal laws and regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, national origin, handicap, or age (38 CFR part 18); protection of human subjects of research (45 CFR part 46), section 504 of the Rehabilitation Act of 1993, Public Law 93-112; Drug-Free Workplace Act of 1988, 38 CFR part 48; section 319 of Public Law 101-121; Title VI of the Civil Rights Act of 1964, 38 CFR 18.1-18.3. 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.

(u) *Intermingling.* A building housing a facility recognized as a State home for providing nursing home care may only provide nursing home care in the areas of the building recognized as a State home for providing nursing home care.

(v) *VA Management of State Veterans Homes.* Except as specifically provided by statute or regulations, VA employees have no authority regarding the management or control of State homes providing nursing home care. (Authority: 38 U.S.C. 101, 501, 1710, 1741-1743, 8135; Pub. L. 111-246)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900-0160.)

[65 FR 968, Jan. 6, 2000, as amended at 72 FR 30243, May 31, 2007; 74 FR 19432, 19434, Apr. 29, 2009; 76 FR 52275, Aug. 22, 2011; 78 FR 51675, Aug. 21, 2013; 83 FR 61277, Nov. 28, 2018]

Supplement *Highlights* references: 38(1), 47(1), 64(2), 79(2), 119(1).

Reserved

Subpart E--Standards Applicable to the Payment of Per Diem for Domiciliary Care

51.300 Resident rights and behavior; State home practices; quality of life..... 51.300-1
 51.310 Resident admission, assessment, care plan, and discharge 51.310-1
 51.320 Quality of care..... 51.320-1
 51.330 Nursing care 51.330-1
 51.340 Physician and other licensed medical practitioner services 51.340-1
 51.350 Provision of certain specialized services and environmental requirements..... 51.350-1
 51.390 Administration 51.390-1

§51.300 Resident rights and behavior; State home practices; quality of life.

The State home must protect and promote the rights and quality of life of each resident receiving domiciliary care, and otherwise comply with the requirements in §51.70, except §51.70(b)(9), (h)(1), and (m); §51.80, except §51.80(a)(2) and (4) and (b); §51.90; and §51.100, except §51.100(g)(2), (h), and (i)(5) through (7). The State Home must have a written procedure for admissions, discharges, and transfers. For purposes of this section, the terms "nursing home" and "nursing facility" or "facility" in the applicable provisions of the cited sections apply to a domiciliary.

(a) Notice of rights and services--notification of changes.

(1) Facility management must immediately inform the resident and consult with the primary care physician when there is

(i) An accident involving the resident that results in injury and has the potential for requiring physician intervention;

(ii) 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);

(iii) 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

(iv) A decision to transfer or discharge the resident from the facility as specified in paragraph (d) of this section.

(2) The facility management must also promptly notify the resident when there is

(i) A change in room or roommate assignment as specified in §51.100(f)(2); or

(ii) A change in resident rights under Federal or State law or regulations as specified in §51.70(b)(1).

(3) The facility management must record and periodically update the address and phone number of the resident's legal representative or interested family member, but the resident has the right to decide whether to have the State home notify his or her legal representative or interested family member of changes.

(b) *Work.* The resident must participate, based on his or her ability, in some measure, however slight, in work assignments that support the maintenance and operation of the State home. The State Home management must create a written policy to implement the work requirement. The resident is encouraged to participate in vocational and employment services, which are essential to meeting the psychosocial needs of the resident. The resident must perform work for the facility after the State home has accomplished the following:

(1) The facility has documented the resident's need or desire to work in the comprehensive care plan;

(2) The comprehensive care plan described in §51.310 specifies the nature of the work performed and whether the work is unpaid or paid;

(3) Compensation for work for which the facility would pay a prevailing wage if done by non-residents is paid at or above prevailing wages for similar work in the area where the facility is located; and

(4) The facility consulted with and the resident agrees to the work arrangement described in the comprehensive care plan.

(c) *Married couples.* The resident has the right, if space is available within the existing facility, to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement. If the State home determines existing space is not available to allow married residents to share rooms, the State home will make accommodations for the privacy of married residents.

(d) *Transfer and discharge—*

(1) *Definition:* Transfer and discharge includes movement of a resident to a bed outside of the 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 facility.

(2) *Transfer and discharge requirements.* The facility management 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, including because the domiciliary resident's health has improved sufficiently so the resident no longer needs the services provided by the domiciliary;

(ii) The resident is in need of a higher level of long term or acute care;

(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 a stay at the facility;

(vi) The domiciliary ceases to operate; or

(vii) The resident ceases to meet any of the eligibility criteria of §51.51.

(3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (vii) of this section, the primary care physician must document the transfer and circumstances in the resident's clinical record.

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

(i) Notify the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner he or she understands. The resident has the right to decide whether to have the State home notify his or her legal representative or interested family member of changes.

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

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

(5) *Timing of the notice.*

(i) The notice of transfer or discharge required by paragraph (d)(4) of this section must be made by the facility at least 30 calendar days before the resident is transferred or discharged, except when specified in paragraph (d)(5)(ii) of this section,

(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;

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

(C) The resident's health improves sufficiently so the resident no longer needs the services provided by the domiciliary; or

(D) The resident's needs cannot be met in the domiciliary.

(6) *Contents of the notice.* The written notice specified in paragraph (d)(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 official designated by the State; and

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

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

(e) *Notice of bed-hold policy and readmission--notice before transfer.* The State home must have a written bed-hold policy, including criteria for return to the facility. The facility management must provide written information to the resident about the State home bed-hold policy upon enrollment, annually thereafter, and before a State home transfers a resident to a hospital. A Resident has the right to decide whether to have the State home notify his or her legal representative or interested family member of transfers.

(f) *Resident activities.*

(1) The facility management 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 coordinator.

(g) *Social services.*

(1) The State home must provide social work services to meet the social and emotional needs of residents to attain or maintain the highest practicable mental and psychosocial well-being of each resident.

(2) The State home must have a sufficient number of social workers to meet residents' needs.

(3) The State home must have a written policy on how it determines qualifications of social workers. It is highly recommended, but not required, that a qualified social worker is an individual with

(i) A bachelor's degree in social work from a school accredited by the Council of Social Work Education (Note: A master's degree social worker with experience in long-term care is preferred), and

(ii) A social work license from the State in which the State home is located, if offered by the State, and

(iii) A minimum of one year of supervised social work experience in a health care setting working directly with individuals.

(4) The facility management must have sufficient support staff to meet patients' social services needs.

(5) Facilities for social services must ensure privacy for interviews.

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

(1) 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; and

(4) Private closet space in each resident's room, as specified in §51.200(d)(2)(iv).

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900-0160.)

[83 FR 61277, Nov. 28, 2018]

Supplement *Highlights* references: 119(1).

§51.310 Resident admission, assessment, care plan, and discharge.

The State home must conduct accurate, written, medical and comprehensive assessments of each resident's medical and functional capacity upon admission, annually, and as required by a change in the resident's condition. The comprehensive assessment will use information from the medical assessment, and both assessments will inform the comprehensive care plan. The State home must have a written policy to determine how to coordinate and complete the comprehensive assessment process, including how it will review, and revise the comprehensive assessment in implementing the comprehensive care plan. The State home must review comprehensive assessments annually, and promptly after every significant change in the resident's physical, mental, or social condition.

(a) *Admission orders and medical assessment.* At the time each resident is admitted, the State home must have physician orders for the resident's immediate care. A medical assessment, including a medical history and physical examination, must be performed by a physician, or other health care provider qualified under State law, and recorded in the medical record no later than 7 calendar days after admission, unless one was performed no earlier than 5 calendar days before admission and the findings were recorded in the medical record. The medical assessment will be part of the comprehensive assessment.

(b) *Comprehensive assessments.*

(1) The state home must complete a comprehensive assessment of each resident no later than 14 calendar days after admission, annually, and as required by a change in the resident's condition.

(2) Each comprehensive assessment must be conducted or coordinated by a registered nurse with the participation of appropriate healthcare professionals, including at least one physician, the registered nurse, and one social worker. The registered nurse must sign and certify the assessment. The comprehensive assessment is to determine the care, treatment, and services that will meet the resident's initial and continuing needs. It is an objective evaluation of a resident's health and functional status, describing the resident's capabilities and impairments in performing activities of daily living, strengths, and needs. The assessment gathers information through collection of data, observation, and examination.

(c) *Comprehensive care plans.*

(1) The State home must develop a comprehensive care plan for each resident based on the comprehensive assessment, and develop, review, and revise the comprehensive care plan following each comprehensive assessment. The comprehensive care plan must include measurable objectives and timetables to address a resident's emotional, behavioral, social, and physical needs, with emphasis on assisting each patient to achieve and maintain an optimal level of self-care and independence. The comprehensive care plan must describe the following, as appropriate to the resident's circumstances:

(i) The services that are to be furnished to support the resident's highest practicable emotional, behavioral, social rehabilitation, and physical well-being;

(ii) The specific work the resident agrees to do to share in the maintenance and operation of the State home upon consultation with the interdisciplinary team, and whether that work is paid or unpaid; and

(iii) Any services that would otherwise be required under §51.350 but are not provided due to the resident's exercise of rights under §51.70, including the right in §51.70(b)(4) to refuse treatment.

(2) A comprehensive care plan must be:

(i) Developed no later than 21 calendar days after admission; and

(ii) Prepared by an interdisciplinary team of health professionals that may include the primary care physician or a Licensed Independent Practitioner (or designated Physician's Assistant or Nurse Practitioner), a social worker, and a registered nurse who have responsibility for the resident, and other staff in appropriate disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident and the resident's family (subject to the consent of the resident) or the resident's legal representative, if appropriate;

(iii) Reviewed periodically and revised consistent with the most recent comprehensive assessment by a team of qualified persons no less often than semi-annually; and

(iv) Revised promptly after a comprehensive assessment reveals a significant change in the resident's condition.

(3) The services provided by the facility must

(i) Meet professional standards of quality; and

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

(d) *Discharge summary.*

(1) Prior to discharging a resident, the State home must prepare a discharge summary that includes

(i) A summary of the resident's stay, the resident's status at the time of the discharge, and the resident's progress on the comprehensive care plan in paragraph (b)(2) of this section; and

(ii) A post-discharge comprehensive care plan that is developed with the participation of the resident.

(2) A resident has the right to decide if he or she would like to involve his or her legal representative or interested family member in development of a post-discharge plan.

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900-0160.)

[83 FR 61278, Nov. 28, 2018]

Supplement *Highlights* references: 119(1).

§51.320 Quality of care.

The State home must provide each resident with the care described in this subpart in accordance with the assessment and comprehensive care plan.

(a) *Reporting of sentinel events.*

(1) A sentinel event is an adverse event that results in the loss of life or limb or permanent loss of function.

(2) Examples of sentinel events are as follows:

(i) Any resident death, paralysis, coma or other major permanent loss of function associated with a medication error;

(ii) Any suicide of a resident;

(iii) Assault, homicide or other crime resulting in resident death or major permanent loss of function; or

(iv) A resident fall that results in death or major permanent loss of function as a direct result of the injuries sustained in the fall.

(3) The State home must report sentinel events to the Director no later than 24 hours after identification. The VA medical center of jurisdiction must report sentinel events by notifying the VA Network Director (10N1-10N22) and the Director, Office of Geriatrics and Extended Care--Operations (10NC4) no later than 24 hours after notification.

(4) The State home must establish a mechanism to review and analyze a sentinel event resulting in a written report to be submitted to the VA Medical Center of jurisdiction no later than 10 working days following the event. The purpose of the review and analysis of a sentinel event is to prevent injuries to residents, visitors, and personnel, and to manage those injuries that do occur and to minimize the negative consequences to the injured individuals and the State home.

(b) *Activities of daily living.* Based on the comprehensive assessment of a resident, the State home must ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable, and the resident is given appropriate treatment and services to maintain or improve his activities of daily living. This includes the resident's ability to:

- (1) Bathe, dress, and groom;
- (2) Transfer and ambulate;
- (3) Toilet;
- (4) Eat; and
- (5) Talk or otherwise communicate.

(c) *Vision and hearing.* To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing, the State home 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.

(d) *Mental and psychosocial functioning.* Based on the comprehensive assessment of a resident, the State home must assist a resident who displays mental or psychosocial adjustment difficulty obtain appropriate treatment and services to correct the assessed problem.

(e) *Accidents.* The State home must ensure that:

- (1) The resident environment remains as free of accident hazards as possible; and
- (2) Each resident receives adequate supervision and assistive devices to prevent accidents.

(f) *Nutrition.* The State home must follow §51.120(j) regarding nutrition in providing domiciliary care.

(g) *Special needs*. The State home must provide residents with the following services, if needed:

- (1) Injections;
- (2) Colostomy, ureterostomy, or ileostomy care;
- (3) Respiratory care;
- (4) Foot care; and
- (5) Non-customized or non-individualized prosthetic devices.

(h) *Unnecessary drugs*. The State home must ensure that the standards set forth in §51.120(m) regarding unnecessary drugs are followed in providing domiciliary care.

(i) *Medication errors*. The State home must ensure that the standards set forth in §51.120(n) regarding medication errors are followed in providing domiciliary care.

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900-0160.)

[83 FR 61279, Nov. 28, 2018]

Supplement *Highlights* references: 119(1).

§51.330 Nursing care.

The State home must provide an organized nursing service with a sufficient number of qualified nursing personnel to meet the total nursing care needs of all residents within the facility, 24 hours a day, 7 days a week, as determined by their comprehensive assessments and their comprehensive care plans. The nursing service must be under the direction of a full-time registered nurse who is currently licensed by the State and has, in writing, administrative authority, responsibility, and accountability for the functions, activities, and training of the nursing service's staff.

[83 FR 61280, Nov. 28, 2018]

Supplement *Highlights* references: 119(1).

§51.340 Physician and other licensed medical practitioner services.

The State home must provide its residents the primary care necessary to enable them to attain or maintain the highest practicable physical, mental, and psychosocial well-being. When a resident needs care other than the State home is required to provide under this subpart, the State home is responsible to assist the resident to obtain that care. The State home must ensure that a physician personally approves in writing a recommendation that an individual be admitted to a domiciliary. Each resident must remain at all times under the care of a licensed medical practitioner assigned by the State home. The name of the practitioner will be listed in the resident's medical record. The State home must ensure that all of the following conditions in paragraphs (a) through (e) of this section are met:

(a) *Supervision of medical practitioners.* Any licensed medical practitioner who is not a physician may provide medical care to a resident within the practitioner's scope of practice without physician supervision when permitted by State law.

(b) *Availability of medical practitioners.* If the resident's assigned licensed medical practitioner is unavailable, another licensed medical practitioner must be available to provide care for that resident.

(c) *Visits.* The primary care physician or other licensed medical practitioner, for each visit required by paragraph (d) of this section, must

(1) Review the resident's total program of care, including medications and treatments;

(2) Write, sign, and date progress notes; and

(3) Sign and date all orders.

(d) *Frequency of visits.* The primary care physician or other licensed medical practitioner must conduct an in-person medical assessment of the resident at least once a calendar year, or more frequently based on the resident's condition.

(e) *Availability of emergency care.* The State home must assist residents in obtaining emergency care.

[83 FR 61280, Nov. 28, 2018]

Supplement *Highlights* references: 119(1).

§51.350 Provision of certain specialized services and environmental requirements.

The State home domiciliary care programs must comply with the requirements of §51.140, except §51.140(f)(2) through (4) concerning dietary services; §51.170 concerning dental services; §51.180, except §51.180(c) concerning pharmacy services; §51.190 concerning infection control; and §51.200, except §51.200(a), (b), (d)(1)(ii) through (x), (f), and (h)(3) concerning the physical environment. For purposes of this section, the references to "facility" in the cited sections also refer to a domiciliary.

(a) Dietary services.

(1) There must be no more than 14 hours between a substantial evening meal and the availability of breakfast the following day, except as provided in (a)(3) of this section.

(2) The facility staff must offer snacks at bedtime daily.

(3) Sixteen hours may elapse between a substantial evening meal and breakfast the following day when a nourishing snack is offered at bedtime.

(b) Pharmacy services.

(1) The drug regimen of each resident must be reviewed at least once every six months by a licensed pharmacist.

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

(c) Life safety from fire. The facility must meet the applicable requirements of the National Fire Protection Association's NFPA 101, Life Safety Code, as incorporated by reference in §51.200.

(d) Privacy. The facility must provide the means for visual privacy for each resident.

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900-0160.)

[83 FR 61280, Nov. 28, 2018]

Supplement *Highlights* references: 119(1).

§51.390 Administration.

The State home must follow §51.210 regarding administration in providing domiciliary care. For purposes of this section, the references in the cited section to nursing home and nursing home care refer to a domiciliary and domiciliary care.

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900-0160.)

[83 FR 61280, Nov. 28, 2018]

Supplement *Highlights* references: 119(1).

Subpart F--Standards Applicable to the Payment of per Diem for Adult Day Health Care

51.400 Participant rights 51.400-1

51.405 Participant and family caregiver responsibilities 51.405-1

51.410 Transfer and discharge 51.410-1

51.411 Program practices..... 51.411-1

51.415 Restraints, abuse, and staff treatment of participants..... 51.415-1

51.420 Quality of life 51.420-1

51.425 Physician orders and participant medical assessment 51.425-1

51.430 Quality of care..... 51.430-1

51.435 Nursing services 51.435-1

51.440 Dietary services 51.440-1

51.445 Physician services 51.445-1

51.450 Specialized rehabilitative services 51.450-1

51.455 Dental services 51.455-1

51.460 Administration of drugs 51.460-1

51.465 Infection control..... 51.465-1

51.470 Physical environment..... 51.470-1

51.475 Administration 51.475-1

51.480 Transportation 51.480-1

§51.400 Participant rights.

The State home must protect and promote the rights of a participant in an adult day health care program, including the rights set forth in §51.70, except for the right set forth in §51.70(m). For purposes of this section, the references to resident in the cited section also refer to a participant in this section.

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900-0160.)

[83 FR 61280, Nov. 28, 2018]

Supplement *Highlights* references: 119(1).

§51.405 Participant and family caregiver responsibilities.

The State home must post a written statement of participant and family caregiver responsibilities in a place where participants in the adult day health care program and their families will see it and must provide a copy to the participant and caregiver at or before the time of the intake screening. The statement of responsibilities must include the following:

- (a) Treat personnel with respect and courtesy;
- (b) Communicate with staff to develop a relationship of trust;
- (c) Make appropriate choices and seek appropriate care;
- (d) Ask questions and confirm your understanding of instructions;
- (e) Share opinions, concerns, and complaints with the program director;
- (f) Communicate any changes in the participant's condition;
- (g) Communicate to the program director about medications and remedies used by the participant;
- (h) Let the program director know if the participant decides not to follow any instructions or treatment; and
- (i) Communicate with the adult day health care staff if the participant is unable to attend adult day health care.

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900-0160.)

[83 FR 61280, Nov. 28, 2018]

Supplement *Highlights* references: 119(1).

§51.410 Transfer and discharge.

(a) *Definition.* For purposes of this section, the term "transfer or discharge" includes movement of a participant to a program outside of the adult day health care program whether or not the program of care is in the same facility.

(b) *Transfer and discharge requirements.* At the time of intake screening, the State home must discuss the possible reasons for transfer or discharge with the participant and, to the extent practicable and appropriate, with family members (subject to the consent of the participant) or the participant's legal representatives. In the case of a transfer and discharge to a hospital, the transfer and discharge must be to the hospital closest to the adult day health care facility that can provide the necessary care. The State home must permit each participant to remain in the program of care, and not transfer or discharge the participant from the program of care unless:

(1) The transfer and discharge is necessary for the participant's welfare and the participant's needs cannot be met in the adult day health care setting;

(2) The transfer and discharge is appropriate because the participant's health has improved sufficiently so that the participant no longer needs the services provided in the adult day health care program;

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

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

(5) The participant has failed, after reasonable and appropriate notice, to pay for participation in the adult day health care program; or

(6) The adult day health care program ceases to operate.

(c) *Notice before transfer or discharge.* Before an adult day health care program undertakes the transfer or discharge of a participant, the State home must:

(1) Notify the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner he or she understands. The resident has the right to decide whether to have the State home notify his or her legal representative or interested family member of changes;

(2) Record the reasons in the participant's clinical record; and

(3) Include in the notice the items described in paragraph (e) of this section.

(d) *Timing of the notice.*

(1) The notice of transfer or discharge required under paragraph (c) of this section must be made by the State home at least 30 calendar days before the participant is given a transfer or discharge, except when specified in paragraph (d)(2) of this section.

(2) Notice may be made as soon as practicable before a transfer or discharge when

- (i) The safety of individuals in the facility would be endangered;
- (ii) The health of individuals in the facility would be otherwise endangered;
- (iii) The participant's health improves sufficiently that the participant no longer needs the services provided by the adult day health care program of care; or
- (iv) The participant's needs cannot be met in the adult day health care program of care.

(e) *Contents of the notice.* The written notice specified in paragraph (c) of this section must include the following:

- (1) The reason for the transfer or discharge;
- (2) The effective date of the transfer or discharge;
- (3) The location to which the participant is taken in accordance with the transfer or discharge, if any;
- (4) A statement that the participant has the right to appeal the action to the State official responsible for the oversight of State home programs; and
- (5) The name, address and telephone number of the first listed of the following that exists in the State:
 - (i) The State long-term care ombudsman, if the long-term care ombudsman serves adult day health care facilities; or
 - (ii) Any State ombudsman or advocate who serves adult day health care participants; or
 - (iii) The State agency responsible for oversight of State adult day care facilities.

(f) *Orientation for transfer and discharge.* The State home must provide sufficient preparation and orientation to participants to ensure safe and orderly transfer or discharge from the State home.

(g) *Written policy.* The State home must have in effect written transfer and discharge procedures that reasonably ensure that:

(1) Participants will be given a transfer or discharge from the adult day health care program to the hospital when transfer or discharge is medically appropriate as determined by a physician; and

(2) Medical and other information needed for care and treatment of participants will be exchanged between the facility and the hospital.

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900-0160.)

[83 FR 61281, Nov. 28, 2018]

Supplement *Highlights* references: 119(1).

§51.411 Program practices.

(a) *Equal access to quality care.* The State home must establish and maintain identical policies and practices regarding transfer and discharge under §51.410 and the provision of services for all participants regardless of the source of payment.

(b) *Admission policy.* The State home must not require a third-party guarantee of payment as a condition of admission or expedited admission, or continued admission in the program of care. However, the State home may require a participant or an individual who has legal access to a participant's income or resources to pay for the care from the participant's income or resources, when available.

(c) *Hours of operation.* Each adult day health care program must provide at least 8 hours of operation 5 days a week. The hours of operation must be flexible and responsive to caregiver needs.

[83 FR 61281, Nov. 28, 2018]

Supplement *Highlights* references: 119(1).

§51.415 Restraints, abuse, and staff treatment of participants.

The State home must meet the requirements regarding the use of restraints, abuse, and other matters concerning staff treatment of participants set forth in §51.90. For purposes of this section, the references in the cited section to resident refer to a participant in this section.

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900-0160.)

[83 FR 61281, Nov. 28, 2018]

Supplement *Highlights* references: 119(1).

§51.420 Quality of life.

The State home must provide an environment that supports the quality of life of each participant by maximizing the participant's potential strengths and skills.

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

(b) *Self-determination and participation.* The State home must ensure that the participant 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 participant.

(c) *Participant and family concerns.* The State home must document any concerns submitted to the management of the program by participants or their family members.

(1) A participant's family has the right to meet with families of other participants in the program.

(2) Staff or visitors may attend meetings of participant or family groups at the group's invitation.

(3) The State home must respond to written requests that result from group meetings.

(4) The State home must listen to the views of any participant or family group and act upon the concerns of participants and families regarding policy and operational decisions affecting participant care in the program.

(d) *Participation in other activities.* The State home must ensure that a participant has the right to participate in social, religious, and community activities that do not interfere with the rights of other participants in the program.

(e) *Therapeutic participant activities.*

(1) The State home 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 participant.

(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who:

(i) Is licensed, if applicable, by the State in which practicing; and

(ii) Is certified as a therapeutic recreation specialist or an activities professional by a recognized certifying body.

(3) A critical role of adult day health care is to build relationships and create a culture that supports, involves, and validates the participant. Therapeutic activity refers to that supportive culture and is a significant aspect of the individualized comprehensive care plan. A participant's activity includes everything the individual experiences during the day, not just arranged events. As part of effective therapeutic activity, the adult day health care program must:

(i) Provide direction and support for participants, including breaking down activities into small, discrete steps or behaviors, if needed by a participant;

(ii) Have alternative programming available for any participant unable or unwilling to take part in group activity;

(iii) Design activities that promote personal growth and enhance the self-image and/or improve or maintain the functioning level of participants to the extent possible;

(iv) Provide opportunities for a variety of involvements (social, intellectual, cultural, economic, emotional, physical, and spiritual) at different levels, including community activities and events;

(v) Emphasize participants' strengths and abilities rather than impairments, and contribute to participants' feelings of competence and accomplishment; and

(vi) Provide opportunities to voluntarily perform services for community groups and organizations.

(f) *Social services.*

(1) The State home must provide medically-related social services to participants and their families.

(2) An adult day health care program must provide a qualified social worker to furnish social services.

(3) A qualified social worker is an individual with:

(i) A bachelor's degree in social work from a school accredited by the Council of Social Work Education (Note: A master's degree in social worker with experience in long-term care is preferred);

(ii) A social work license from the State in which the State home is located, if that license is offered by the State; and

(iii) A minimum of one year of supervised social work experience in a health care setting working directly with individuals.

(4) The State home must have sufficient social workers and support staff to meet participant and family social service needs. The adult day health care program must:

- (i) Provide counseling to participants and to families/caregivers;
 - (ii) Facilitate the participant's adaptation to the adult day health care program and active involvement in the comprehensive care plan, if appropriate;
 - (iii) Arrange for services not provided by adult day health care, and work with these resources to coordinate services;
 - (iv) Serve as an advocate for participants by asserting and safeguarding the human and civil rights of the participants;
 - (v) Assess signs of mental illness or dementia and make appropriate referrals;
 - (vi) Provide information and referral for persons not appropriate for adult day health care;
 - (vii) Provide family conferences, and serve as liaison between participant, family/caregiver and program staff;
 - (viii) Provide individual or group counseling and support to caregivers and participants;
 - (ix) Conduct support groups or facilitate participant or family/caregiver participation in support groups;
 - (x) Assist program staff in adapting to changes in participants' behavior;
- and
- (xi) Provide or arrange for individual, group, or family psychotherapy for participants with significant psychosocial needs.

(5) Space for social services must be adequate to ensure privacy for interviews.

(g) *Environment.* The State home must provide:

- (1) A safe, clean, comfortable, and homelike environment, and support the participants' ability to function as independently as possible and to engage in program activities;
- (2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;
- (3) Private storage space for each participant sufficient for a change of clothes. Upon request of the participant, the State home must offer storage space that can be secured with a lock;
- (4) Interior signs to facilitate participants' ability to move about the facility independently and safely;

- (5) A clean bed or reclining chair available for acute illness;
- (6) A shower for participants;
- (7) Adequate and comfortable lighting levels in all areas;
- (8) Comfortable and safe temperature levels; and
- (9) Comfortable sound levels.

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900-0160.)

[83 FR 61281, Nov. 28, 2018]

Supplement *Highlights* references: 119(1).

§51.425 Physician orders and participant medical assessment.

The State home must have a written policy to determine how to coordinate and complete the written initial and comprehensive assessment processes upon admission, annually, and as required by a change in the participant's condition. The State home must also outline in its policy how it will complete, implement, review, and revise the assessments.

(a) *Admission.* At the time each participant is admitted, the State home must have physician orders for the participant's immediate care. An initial medical assessment including a medical history and physical examination with documentation of tuberculosis screening must be completed by a physician or other health care provider qualified under State law no earlier than 30 calendar days before admission and no later than 7 calendar days after admission. The findings must be recorded in the participant's medical record.

(b) *Comprehensive assessments.* The State home must complete the comprehensive assessment no later than 14 calendar days after admission. The State home must develop a comprehensive care plan for each participant based on his or her comprehensive assessment. The State home must review comprehensive assessments annually, as well as promptly after every significant change in the participant's physical, mental, or social condition. The State home must immediately change the participant's comprehensive care plan after a significant change is identified. At minimum, the written comprehensive assessment must address the following:

- (1) Ability to ambulate,
- (2) Ability to use bathroom facilities,
- (3) Ability to eat and swallow,
- (4) Ability to hear,
- (5) Ability to see,
- (6) Ability to experience feeling and movement,
- (7) Ability to communicate,
- (8) Risk of wandering,
- (9) Risk of elopement,
- (10) Risk of suicide,
- (11) Risk of deficiencies regarding social interactions, and
- (12) Special needs (such as medication, diet, nutrition, hydration, or prosthetics).

(c) *Coordination of assessments.*

(1) Each initial and subsequent comprehensive assessment must be conducted and coordinated with the participation of appropriate health professionals.

(2) Each person who completes a portion of an assessment must sign and certify the accuracy of that portion of the assessment.

(3) The results of the assessments must be used to develop, review, and revise the participant's individualized comprehensive care plan.

(d) *Comprehensive care plans.*

(1) The State home must ensure that each participant has a comprehensive care plan no later than 21 calendar days after admission. A participant's comprehensive care plan must be individualized and must include measurable objectives and timetables to meet all physical, mental, and psychosocial needs identified in the most recent assessment. The comprehensive care plan must describe the following:

(i) The services that are to be provided as part of the program of care and by other sources to attain or maintain the participant's highest physical, mental, and psychosocial well-being as required under §51.430;

(ii) Any services that would otherwise be required under §51.430 but are not provided due to the participant's exercise of rights under §51.70, including the right to refuse treatment under §51.70(b)(4);

(iii) Type and scope of interventions to be provided in order to reach desired, realistic outcomes;

(iv) Roles of participant and family/caregiver; and

(v) Discharge or transition plan, including specific criteria for discharge or transfer.

(2) The services provided or arranged by the State home must

(i) Meet professional standards of quality; and

(ii) Be provided by qualified persons in accordance with each participant's comprehensive care plan.

(e) *Discharge summary.* Prior to discharging a participant, the State home must prepare a discharge summary that includes the following:

- (1) A summary of the participant's care;
- (2) A summary of the participant's status at the time of the discharge to include items in paragraph (b) of this section; and
- (3) A discharge/transition plan related to changes in service needs and changes in functional status that prompted transition to another program of care.

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900-0160.)

[83 FR 61282, Nov. 28, 2018]

Supplement *Highlights* references: 119(1).

§51.430 Quality of care.

Each participant must receive, and the State home 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 comprehensive care plan.

(a) *Reporting of sentinel events*—

(1) *Definition.* A “sentinel event” is defined in §51.120(a)(1).

(2) *Duty to report sentinel events.* The State home must comply with the duties to report sentinel events as set forth in §51.120(a)(3), except that the duty to report applies only to a sentinel event that occurs while the participant is under the care of the State home, including while in State home-provided transportation.

(3) *Review and prevention of sentinel events.* The State home must establish a mechanism to review and analyze a sentinel event resulting in a written report to be submitted to the VA Medical Center of jurisdiction no later than 10 working days after the event. The purpose of the review and analysis of a sentinel event is to prevent future injuries to participants, visitors, and personnel.

(b) *Activities of daily living.* Based on the comprehensive assessment of a participant, the State home must ensure that:

(1) *No diminution in activities of daily living.* A participant's abilities in activities of daily living do not diminish unless the circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the participant's ability to

- (i) Bathe, dress, and groom;
- (ii) Transfer and ambulate;
- (iii) Toilet; and
- (iv) Eat.

(2) *Appropriate treatment and services given.* A participant is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (b)(1) of this section.

(3) *Necessary services provided to participant unable to carry out activities of daily living.* A participant who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, hydration, grooming, personal and oral hygiene, mobility, and bladder and bowel elimination.

(c) *Mental and psychosocial functioning.* The State home must make counseling and related psychosocial services available for improving mental and psychosocial functioning of participants with mental or psychosocial needs. The services available must include counseling and psychosocial services provided by licensed independent mental health professionals.

(d) *Medication errors.* The State home must comply with §51.120(n) with respect to medication errors.

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900-0160.)

[83 FR 61283, Nov. 28, 2018]

Supplement *Highlights* references: 119(1).

§51.435 Nursing services.

The State home must provide an organized nursing service with a sufficient number of qualified nursing personnel to meet the total nursing care needs, as determined by participant assessments and individualized comprehensive care plans, of all participants in the program.

(a) There must be at least one registered nurse on duty each day of operation of the adult day health care program. This nurse must be currently licensed by the State and must have, in writing, administrative authority, responsibility, and accountability for the functions, activities, and training of the nursing and program assistants.

(b) The number and level of nursing staff is determined by the authorized capacity of participants and the nursing care needs of the participants.

(c) Nurse staffing must be adequate for meeting the standards of this part.

[83 FR 61284, Nov. 28, 2018]

Supplement *Highlights* references: 119(1).

§51.440 Dietary services.

The State home must comply with the requirements concerning the dietary services set forth in §51.140, except paragraph 51.140(f). For purposes of this section, the references in the cited section to resident refer to a participant in subpart F of this part. The State home adult day health care program will provide nourishment to participants on the following schedule:

(a) At regular times comparable to normal mealtimes in the community, each participant may receive and program management must provide at least two meals daily for those veterans staying more than four hours and at least one meal for those staying less than four hours.

(b) The program management must offer snacks and fluids as appropriate to meet the participants' nutritional and fluid needs.

[83 FR 61284, Nov. 28, 2018]

Supplement *Highlights* references: 119(1).

§51.445 Physician services.

As a condition of enrollment in adult day health care program, a participant must have a written physician order for admission. Each participant's medical record must contain the name of the participant's primary care physician. If a participant's medical needs require that the participant be placed in an adult day health care program that offers medical supervision, the primary care physician must state so in the order for admission. Each participant must remain under the care of a physician.

(a) *Physician supervision.* If the adult day health care program offers medical supervision, the program management must ensure that

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

(2) Another physician is available to supervise the medical care of participants when their primary care physician is unavailable.

(b) *Frequency of physician reviews.* If the adult day health care program offers medical supervision:

(1) The participant must be seen by the primary care physician at least annually and as indicated by a change of condition.

(2) The program management must have a policy to help ensure that adequate medical services are provided to the participant.

(3) At the option of the primary care physician, required reviews in the program after the initial review may alternate between personal physician reviews and reviews by a physician assistant, nurse practitioner, or clinical nurse specialist in accordance with paragraph (e) of this section.

(c) *Availability of acute care.* If the adult day health care program offers medical supervision, the program management must provide or arrange for the provision of acute care when it is indicated.

(d) *Availability of physicians for emergency care.* In case of an emergency, the program management must ensure that participants are able to obtain necessary emergency care.

(e) *Physician delegation of tasks.*

(1) A primary care physician may delegate tasks to

(i) A certified physician assistant or a certified nurse practitioner, or

(ii) A clinical nurse specialist who-

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

and

(B) Is under the supervision of the physician.

(2) The primary care physician may not delegate a task when the provisions of this part specify that the primary care physician must perform it personally, or when the delegation is prohibited under State law or by the State home's policies.

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900-0160.)

[83 FR 61284, Nov. 28, 2018]

Supplement *Highlights* references: 119(1).

§51.450 Specialized rehabilitative services.

(a) Provision of services. If specialized rehabilitative services such as, but not limited to, physical therapy, speech therapy, occupational therapy, and mental health services for mental illness are required in the participant's comprehensive care plan, program management must

(1) Provide the required services; or

(2) Obtain the required services and equipment from an outside resource, in accordance with §51.210(h), from a provider of specialized rehabilitative services.

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

[83 FR 61284, Nov. 28, 2018]

Supplement *Highlights* references: 119(1).

§51.455 Dental services.

(a) If the adult day health care program offers medical supervision, program management must, if necessary, assist the participant and family/caregiver

(1) In making dental appointments; and

(2) By arranging for transportation to and from the dental services.

(b) If the adult day health care program offers medical supervision, program management must promptly assist and refer participants with lost or damaged dentures to a dentist.

[83 FR 61284, Nov. 28, 2018]

Supplement *Highlights* references: 119(1).

§51.460 Administration of drugs.

If the adult day health care program offers medical supervision, the program management must assist participants with the management of medication and have a system for disseminating drug information to participants and program staff in accordance with this section.

(a) *Procedures.* The State home must

(1) Provide reminders or prompts to participants to initiate and follow through with self-administration of medications.

(2) Establish a system of records to document the administration of drugs by participants and/or staff.

(3) Ensure that drugs and biologicals used by participants are labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration dates when applicable.

(4) Store all drugs, biologicals, and controlled schedule II drugs listed in 21 CFR 1308.12 in locked compartments under proper temperature controls, permit only authorized personnel to have access, and otherwise comply with all applicable State and Federal laws.

(b) *Service consultation.* The State home must provide the services of a pharmacist licensed in the State in which the program is located who provides consultation, as needed, on all the provision of drugs.

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900-0160.)

[83 FR 61284, Nov. 28, 2018]

Supplement *Highlights* references: 119(1).

§51.465 Infection control.

The State home must meet the requirements concerning infection control set forth in §51.190. For purposes of this section, the references in the cited section to resident refer to a participant in this section.

[83 FR 61285, Nov. 28, 2018]

Supplement *Highlights* references: 119(1).

§51.470 Physical environment.

The State home must ensure that the physical environment is designed, constructed, equipped, and maintained to protect the health and safety of participants, personnel, and the public.

(a) *Life safety from fire.* The State home must meet the applicable requirements of National Fire Protection Association's NFPA 101, Life Safety from fire, as incorporated by reference in §51.200.

(b) *Space and equipment.*

(1) The State home must--

(i) Provide sufficient space and equipment in dining, health services, recreation, and program areas to enable staff to provide participants with needed services as required by this subpart F and as identified in each participant's comprehensive care plan; and

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

(2) Each adult day health care program, when it is co-located in a nursing home, domiciliary, or other care facility, must have its own separate designated space during operational hours.

(3) The indoor space for adult day health care must be at least 100 square feet per participant including office space for staff and must be 60 square feet per participant excluding office space for staff.

(4) Each program of care will need to design and partition its space to meet its needs, but the following functional areas must be available:

(i) A dividable multipurpose room or area for group activities, including dining, with adequate table-setting space.

(ii) Rehabilitation rooms or an area for individual and group treatments for occupational therapy, physical therapy, and other treatment modalities.

(iii) A kitchen area for refrigerated food storage, the preparation of meals and/or training participants in activities of daily living.

(iv) An examination and/or medication room.

(v) A quiet room (with a bed or a reclining chair), which functions to separate participants who become ill or disruptive, or who require rest, privacy, or observation. It should be separate from activity areas, near a restroom, and supervised.

(vi) Bathing facilities adequate to facilitate bathing of participants with functional impairments.

(vii) Toilet facilities and bathrooms easily accessible to people with mobility problems, including participants in wheelchairs. There must be at least one toilet for every eight participants. The toilets must be equipped for use by persons with limited mobility, easily accessible from all program areas, i.e., preferably within 40 feet from that area, designed to allow assistance from one or two staff, and barrier-free.

(viii) Adequate storage space. There should be space to store arts and crafts materials, wheelchairs, chairs, individual handiwork, and general supplies. Locked cabinets must be provided for files, records, supplies, and medications.

(ix) An individual room for counseling and interviewing participants and family members.

(x) A reception area.

(xi) An outside space that is used for outdoor activities that is safe, accessible to indoor areas, and accessible to those with a disability. This space may include recreational space and garden area. It should be easily supervised by staff.

(c) *Furnishings.* Furnishings must be available for all participants. This must include functional furniture appropriate to the participants' needs. Furnishings must be attractive, comfortable, and homelike, while being sturdy and safe.

(d) *Participant call system.* The coordinator's station must be equipped to receive participant calls through a communication system from:

(1) Clinic rooms; and

(2) Toilet and bathing facilities.

(e) *Other environmental conditions.* The State home must provide a safe, functional, sanitary, and comfortable environment for the participants, staff and the public. The facility management must

(1) Establish procedures to ensure that water is available to essential areas if 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, when available, 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.

[83 FR 61285, Nov. 28, 2018]

Supplement *Highlights* references: 119(1).

§51.475 Administration.

For purposes of this section, the references in the cited section to nursing home and nursing home care refer to adult day health care programs and adult day health care. The State home must comply with all administration requirements set forth in §51.210 except for the following if the adult day health care program does not offer medical supervision:

(a) *Medical director.* State home adult day health care programs are not required to designate a primary care physician to serve as a medical director, and therefore are not required to comply with §51.210(i).

(b) *Laboratory services, radiology, and other diagnostic services.* State home adult day health care programs are not required to provide the medical services identified in §51.210(m) and (n).

(c) *Quality assessment and assurance committee.* State home adult day health care programs are not required to comply with §51.210(p), regarding quality assessment and assurance committees consisting of specified medical providers and staff.

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900-0160.)

[83 FR 61285, Nov. 28, 2018]

Supplement *Highlights* references: 119(1).

§51.480 Transportation.

Transportation of participants to and from the adult day health care facility must be a component of the overall program of care.

(a)(1) Except as provided in paragraph (a)(2) of this section, the State home must provide for transportation to enable participants, including persons with disabilities, to attend the program and to participate in State home-sponsored outings.

(2) The veteran or the family of a veteran may decline transportation offered by the adult day health care program and make their own arrangements for transportation.

(b) The State home must have a transportation policy that includes procedures for routine and emergency transportation. All transportation (including that provided under contract) must be in compliance with such procedures.

(c) The State home must ensure that the transportation it provides is by drivers who have access to a device for two-way communication.

(d) All systems and vehicles used by the State home to comply with this section must meet all applicable local, State and Federal regulations.

(e) The State home must ensure that the care needs of each participant are addressed during transportation furnished by the home.

[83 FR 61285, Nov. 28, 2018]

Supplement *Highlights* references: 119(1).

End of Part 51

[Reserved]

Part 52

[Removed]

✕