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DEPARTMENT OF VETERANS AFFAIRS 8320-01

38 CFR Parts 17, 51, and 52

RIN 2900-A088

Per Diem Paid to States for Care of Eligible Veterans in State Homes

AGENCY: Department of Veterans Affairs.

ACTION: Final rule.

SUMMARY: This rulemaking adopts 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.

DATES: This rule is effective on [insert date 30 days after date of publication in the FEDERAL REGISTER].

FOR FURTHER INFORMATION CONTACT: Dr. George F. Fuller, Chief Consultant, Geriatrics and Extended Care Services (10NC4), Veterans Health Administration, 810 Vermont Avenue, NW., Washington, DC 20420, (202) 461-6750. (This is not a toll-free number.)

SUPPLEMENTARY INFORMATION: On June 17, 2015, VA proposed changes to parts 17, 51, and 52 of title 38 Code of Federal Regulations. 80 FR 34794. VA published technical corrections to the proposed rulemaking on June 24, 2015, 80 FR 36305. This final rule amends part 17 by deleting provisions that applied to State home hospitals, because there no longer are any, and moving to part 51 the other provisions that apply to State homes, including State home domiciliary care programs. It revises part 51 subparts A, B, and C to eliminate redundancy in the regulations governing the payment of per diem to State home nursing home, domiciliary, and adult day health care programs by combining similar regulations from part 17 and part 52. It amends several sections of the nursing home regulations in part 51 subpart D, and adds subparts E and F on domiciliary care and adult day health care, respectively, to part 51. Because of that, this rule eliminates the State home regulations from part 17 and part 52, and combines in part 51 all the regulations for a State home to establish and maintain qualification for receipt of VA per diem payments.

We invited interested parties to submit written comments on the proposed rule on or before August 17, 2015, and we received 32 public comments. Several commenters commended and supported revisions that reorganize, update, and clarify the regulations, particularly those that increase the State homes' ability to emphasize the independence of adult day health care participants. VA thanks these commenters for their support of the rule. We have responded to the rest of the comments recommending changes to the proposed rule under the heading of the sections with which the commenters expressed concern.

Technical Correction

The notice of proposed rulemaking proposed to amend 38 CFR part 51 under the part heading, "PART 51 – PER DIEM FOR NURSING HOME, DOMICILIARY, OR ADULT DAY HEALTH CARE OF VETERANS IN STATE HOMES." The correct heading of part 51 until this rulemaking becomes final is, "PER DIEM FOR NURSING HOME CARE OF VETERANS IN STATE HOMES." The notice of proposed rulemaking neglected to include amendatory language proposing to change the heading of part 51. We are correcting this omission by adding that amendatory language and the revised heading of part 51 below as amendatory action 3. We have renumbered all subsequent amendatory instructions accordingly.

Subpart A—General

51.1 Purpose and Scope of part 51

We have changed "rules" to "requirements" in the sentence of § 51.1 beginning, "Subpart C sets forth requirements governing . . . ." The term "rule" is commonly used as a synonym for "regulation" in federal rulemaking, as in the ACTION heading of this rulemaking. Avoiding its use in the text of a regulation eliminates a possible point of confusion. The term "requirements" better describes the function and scope of the regulations in subpart C of part 51.

51.2 Definitions

VA received comments related to the definition of domiciliary care, and concerns that the proposed definition, in addition to the standards in subpart E of the proposed

regulations imposing the entire nursing home program regulations on the domiciliary care program, would impose unnecessary and costly burdens on domiciliary programs that are inconsistent with their purpose and that would replicate nursing home care. Several commenters stated some States may have to close their domiciliary programs because of these costs. A commenter said that VA's proposed definition of "domiciliary care" needs to be clearer for the State homes to tell whether their programs fit the definition. Similarly, others said that States need a clearer definition of what domiciliary care is to know whether the per diem rate for that care will sustain their programs.

VA agrees that the application of whole regulations governing the nursing home care program to the domiciliary care program, as proposed §§ 51.300 and 51.350 would have done, would be excessively burdensome. We have revised those sections to eliminate the application of multiple nursing home provisions to the domiciliary care program. We discuss each change from the proposed rule in the discussion of §§ 51.300 and 51.350 below.

VA agrees that the definition of domiciliary care in proposed § 51.2 requires clarification. We have, therefore, added to it a description of what constitutes "necessary medical services" for purposes of State home domiciliary care, which are the services described in subpart E of this rulemaking. This updated definition, along with the revisions to the proposed domiciliary care requirements under subpart E of this rule, described in detail below, allows a user to tell whether a State home program fits the definition of domiciliary care.

A commenter said VA may need to clarify the definition of domiciliary care regarding whether domiciliary care is a temporary or permanent living arrangement so

State homes could assess whether their programs meet the definition. The commenter said that State home domiciliaries offer different types of programs, including retirement, independent living, transitional care, or permanent care programs. VA received other comments raising similar concerns about State homes' abilities to provide transitional care in domiciliaries under the proposed rules.

VA declines to change the definition of domiciliary care to differentiate between temporary and permanent services. We believe the revised definition provides necessary guidance, and also provides flexibility so that State homes can operate many variations of domiciliary care within the definition, including transitional services, as long as the State home meets VA's standards for per diem payment while the resident resides in the home. The changes to the definition of domiciliary care in § 51.2 and to the domiciliary requirements in subpart E of this rulemaking should resolve the issues raised by this comment. We therefore make no changes based on these comments.

Although not defined in this section, we noticed the terms "treatment plan," "care plan," and "plan of care" are used inconsistently throughout the proposed regulations to refer to the same thing: the regimen of care based on a comprehensive assessment that is offered in all State home programs of care. We changed all instances of these terms to "comprehensive care plan," which is also consistent with the regulations in part 51 that are not changed by this final rule.

We are also removing "primary physician" from the definition proposed as "primary physician or primary care physician," and changing all references to "primary physician" to "primary care physician" throughout part 51. Proposed part 51 had used

each about the same number of times. Though they mean the same thing, we think this part would be clearer if the definition defines a single term and uses that term consistently.

Subpart B – Obtaining Recognition and Certification for Per Diem Payments

51.20 Recognition of a State home

In §§ 51.20 and 51.30 of the proposed rule, we used some terms that make sense applied to residential programs—nursing home and domiciliary—that do not make sense applied to adult day health care programs. For example, "beds" is a useful term when referring to the number of residents in a nursing home care program or a domiciliary care program, but not when referring to the number of participants in an adult day health care program, which has no overnight operations. We have, therefore revised §§ 51.20 and 51.30 to speak of "capacity" of a program or facility, rather than of "beds."

We are changing proposed § 51.20(b) to explicitly include applicable requirements in subpart C in the list of requirements and standards that VA may evaluate in a survey of the State home. Subpart C contains requirements regarding eligibility, payment rates, and payment procedures that apply to State home programs of care. We do not consider this a substantive change, because State homes would clearly need to comply with subpart C under the proposed rule. This change makes § 51.20(b) complete regarding the scope of surveys.

We are clarifying proposed § 51.20(b)(3)(ii). As proposed, the paragraph provided for the State home to respond to a medical center director's recommendation to the Under Secretary for Health to not recognize a state home and to submit additional evidence with that response. The paragraph neglected to identify to whom the State home is to submit the response or additional evidence. We are adding language to the end of § 51.20(b)(3)(ii) providing that the State's submission of a response to a recommendation to not recognize a State home is to the Under Secretary for Health. This is consistent with current § 51.30(d), which provides for appeal from a recommendation against recognition, and inclusion of additional material with that appeal. This is not a change from the current regulation; it merely fills a gap in the proposed regulation.

We are further clarifying paragraph (b)(3)(ii) and multiple other proposed provisions of part 51 that measure time by qualifying the 30 days as "calendar" days. As proposed, part 51 inconsistently qualified the measure of time. We believe this inconsistency invites confusion. Qualifying time in calendar days generally provides certainty to the time allowed in provisions that prescribe deadlines. There are three exceptions in part 51 that measure time in "working" days. These codify long-standing practice with which VA and the State homes are accustomed. These are §§ 51.30(d)(1)(iii), time to provide a corrective action plan; 51.320(a)(4), time for a domiciliary care program to report a sentinel event; and 51.430(a)(3), time for an adult day health care program to report a sentinel event.

We are clarifying proposed § 51.20(c). As proposed, the paragraph provided, "After receipt of a recommendation from the Director, the Undersecretary for Health will

award or deny recognition based on all available evidence." Though it seems implicit, the proposed regulation does not explicitly say that "all available evidence" included any evidence the State home submits during the 30 calendar days the preceding paragraph allows for submission of a response or additional evidence. To make the regulation explicit, we are adding to paragraph (c), following "Director," the following: "and allowing 30 calendar days for the state to respond to the recommendation and to submit evidence…" As revised, the sentence reads, "After receipt of a recommendation from the Director, and allowing 30 calendar days for the state to respond to the recommendation and to submit evidence, the Under Secretary for Health will award or deny recognition based on all available evidence." We are also adding "in writing" at the end of the second sentence of paragraph (c) because the current regulation, § 51.30(e), requires the Under Secretary's decision to be written. We omitted this requirement from the proposed regulation.

We are removing the second sentence of proposed § 51.20(d)(2), which provided that changes in the use of particular beds between recognized programs of care and increases in capacity that are not the result of the expansion of the size of a home or relocation to a new facility will not require recognition. Those changes are the subject of § 51.30. We are adding "or capacity" following "size" in the remaining sentence of this paragraph to be clear that a recognized state home only needs a new recognition if there is an expansion in the physical size of the home, increased in the number of persons served, or relocation to a new facility. So, we do not need to explain in § 51.20 that the section on certification, § 51.30, addresses any changes that do not involve such an expansion or relocation. This is not a substantive change.

51.30 Certification of a State home

In § 51.30(a) and throughout part 51 wherever proposed, we are changing "within" as it pertains to numbers of days to "no later than." We believe one can be unsure whether "within" includes or excludes the last day of the period. "No later than" more clearly includes the last day of the period. If the regulation provides, as in § 51.30(a) for example, that something be done no later than 450 days after an event one can be sure on day 451 the deadline has been missed.

VA is eliminating from proposed § 51.30(c) the provisions that would have allowed precertification when State homes switch capacity between programs of care or increase capacity in a program of care. On further consideration, we have determined that the regular surveys described in paragraph (b) of this section are frequent enough, and the provisional certification process holds the State homes accountable enough, that the precertification process adds complexity with little benefit. Deleting it eliminates an administrative burden on the State homes and on VA. We are, therefore, deleting the precertification provisions in proposed § 51.30(c)(1).

One commenter applauded proposed § 51.30(c)(2), which eliminated the requirement that VA perform a new survey of a program upon reduction of the capacity of that program. We have retained this provision, but have redesignated it as § 51.30(c). For administrative convenience, in this final rule we have changed the destination to which the State home must send its report regarding decreases in capacity to the Office of Geriatrics and Extended Care in VA Central Office, from the

Director of the VAMC of jurisdiction, as proposed, which will keep the regulations consistent with longstanding practice.

VA is clarifying the function and purpose of the provisional certification provisions of proposed paragraph (d)(1). The paragraph serves two purposes: (1) To allow the State home to receive per diem payments while correcting deficiencies a survey reveals, and (2) to ensure VA does not pay per diem if a survey reveals a deficiency that is an immediate hazard to health or safety so great, and the need to remediate so urgent, it is unreasonable to continue per diem payments during the time until the next survey.

Specifically, VA is amending proposed § 51.30(d)(1)(ii), which would not allow VA to grant a provisional certification if the State home is deficient in a standard that would jeopardize the health or safety of any resident or participant. Because almost all of the standards in these regulations are aimed at promoting the health and safety of State home residents and participants, the regulation as proposed would prevent VA from issuing most provisional certifications, frustrating the purpose of provisional certifications. Though some commenters favored imposing the strictest possible State home compliance with all regulations, VA believes a provisional certification scheme resulting in frequent denial of provisional certification is not in the best interest of State home residents. Consequently, we clarify that the deficiencies for which VA will grant provisional certification are only those that will not jeopardize the health and safety of Veterans before the State home can remedy them. We are, therefore, adding the word

"immediately" so that this provision reads, "None of these deficiencies immediately jeopardize the health or safety of any resident or participant."

VA is eliminating the provisions that were proposed as § 51.30(d)(3), which detailed how VA would issue additional provisional certifications to a State home that already received a provisional certification. VA has determined that the proposed procedure is inconsistent with VA's practices of working with State homes on corrective action plans to ensure the programs are brought into compliance with these regulations under one provisional certification. The provisional certification procedures in this final rule are complete without that proposed provision.

51.31 Surveys for recognition and/or certification

We have changed proposed § 51.31(b)(1). We proposed, as a requirement for VA to conduct a recognition survey, that a State home nursing home care program or domiciliary care program must have at least 21 residents or have a number of residents consisting of at least 50 percent of the resident capacity of the home. We have reduced the residency number requirement from 21 to 20, while keeping the 50 percent alternative. We are making this change to facilitate recognition of homes using the small house model which is based on facilities of 20 beds.

We have removed "the Assistant Deputy Under Secretary for Health (10N);" from the list in paragraph (c) of persons the director of the VA medical center of jurisdiction must notify upon finding an immediate threat to safety in a State home. Through reorganization, Veterans Health Administration no longer has an officer with exactly that title. The other listed VA offices are sufficient to accomplish the necessary oversight of

State homes. Consequently, we remove the named VA officer without substitution of another.

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

We are revising the proposed heading of subpart C by inserting "Requirements Applicable to" before "Eligibility, Rates, and Payments", to read, "Subpart C— Requirements Applicable to Eligibility, Rates, and Payments". As revised, the heading describes the function and scope of subpart C better than the proposed heading.

51.40 Basic per diem rates

In proposed subpart F, VA proposed changes to requirements for State home adult day health care to reduce the requirements for medical supervision in the programs. VA received comments that VA should establish a two-tier per diem payment system for adult day healthcare programs under § 51.40(a) because of the higher cost of providing medical supervision and the lower cost of programs that do not. The commenters said that failure to provide separate rates for programs that offer medical supervision and for those that do not will negatively affect State homes providing adult day health care services with medical supervision and the veterans these programs serve. They noted the current medical supervision style of programs has a significant track record of keeping veterans out of hospital emergency rooms and hospitalizations; they care for veterans who would otherwise be institutionalized in a nursing home.

We explained in the proposed rule that VA would not pay different rates of per diem to State home adult day health care programs that provide medical supervision than to those that do not. We proposed to expand the definition of adult day health care, which had previously allowed only for the medical model of care, to afford State homes the flexibility to offer a social model of care, and thereby expand availability of adult day health care to more Veterans throughout the country. Though a State home may still choose to provide medical supervision, and must meet the standards in § 51.445 if it does, the method for calculating per diem payments will remain the same regardless of the type of care provided. If the veteran needs more medical care than the adult day health care program can provide, the State home must transfer the veteran to another appropriate care program. Even if VA were to implement, under 38 U.S.C. 1741, different rates for adult day health care programs that provide the medical model of care, the payment would still be subject to the statutory limit of no more than one half of the cost of the veteran's care. 38 U.S.C. 1741(b). We point this out on the assumption that the commenter is seeking a payment tier that provides higher payments for medical model participants than the current per diem payment, and not a lower payment tier for social model adult day health care participants. Because the statute describes the maximum basic per diem payment as a percentage of the cost of care, and because we see no value in tiered payments merely for the sake of tiering, we make no change based on this comment.

We note that since the publication of VA's proposed rule in June 2015, the President signed into law the State Veterans Home Adult Day Health Care Improvement Act of 2017. VA is working to implement this new authority; if any further revisions in

these regulations are needed because of this recently enacted legislation, VA will make them through subsequent rulemaking.

Another commenter addressed the cost of providing "primary care, medical services, and preventative care to domiciliary residents while restricting the payments to 'less than one half of the cost of care'" as inequitable and unrealistic. The commenter asserted the current reimbursement structure does not always cover the cost of the required care, and that the proposed new regulations would introduce more bureaucracy and "paper work" costs and shift the cost and much of the responsibility for the health care of domiciliary veterans from VA to the State homes.

By law, the basic per diem rate cannot exceed one-half the cost of the veteran's care in the State home. As such, per diem payments are not intended to serve as a reimbursement for all the costs of the care provided to veterans. We make no change based on this comment.

The per diem program does not shift costs of care or the responsibility for providing health care from VA to the State homes. Domiciliary care has long included all "necessary medical services" which essentially includes all outpatient care. See §17.30(b). So, by limiting the care that State home domiciliaries are required to provide, this rule could be seen as shifting the cost and responsibility for most medical services to VA. Regarding additional bureaucratic paper-work costs due to this rulemaking, the commenter did not identify any specific provisions that would have that effect. We refer the commenter to the discussions throughout this supplementary information describing multiple changes from the proposed rules this final rule makes to reduce administrative

and other costs. For example, see the discussion of changes from proposed § 51.300. We make no change based on this comment.

The same commenter expressed difficulty keeping track of the services covered by the different per diem payments. The commenter expressed the desire that VA publish a comprehensive list of services covered by the nursing home, domiciliary, and adult day care per diem payments for veterans with service-connected disabilities rated 70 percent or 100 percent disabling.

Per diem under 38 U.S.C. 1741 is paid under a VA grant program. VA makes the payments to the States to support the care of veterans in State homes; it is not "coverage" for specific services, like insurance. The States must meet certain standards as a condition of receiving VA per diem to ensure the State home provides for the health, safety, and well-being of veterans in its care. The rate of per diem paid for the nursing home care of veterans with service-connected disabilities rated 70 percent or more is the subject of § 51.41, Contracts and provider agreements for certain veterans with service-connected disabilities. VA published a notice of proposed rule; correction and clarification, 80 FR 36305 (June 24, 2015), acknowledging that VA omitted § 51.41 from the initial notice of proposed rulemaking proposing the rules this rulemaking finalizes. The notice of correction stated VA is not amending § 51.41 in this rulemaking, consequently comments based on it are beyond the scope of this rulemaking. We make no changes based on this comment.

Commenters objected that VA proposed to apply the same rule to payment of per diem for veterans absent from State home domiciliaries as it applies to payment of per diem for veterans absent from State home nursing homes. As proposed, § 51.40(c)

would allow VA to pay per diem for a day without an overnight stay if the State home domiciliary had an occupancy of rate of 90 percent or greater on that day. The per diem payments would be limited to the first 10 consecutive days the veteran was admitted to any hospital and the first 12 days in a calendar year for absences other than for the purpose of receiving hospital care. Specifically, the commenters objected to the requirement that the State home domiciliary care program be filled to 90 percent of capacity before VA will pay per diem for a veteran's absence. One comment said the requirement would have a major financial impact on State home domiciliaries, and that the limit for payments of 12 days in a calendar year for absences other than for hospital care would adversely affect the residents' quality of life. One commenter requested VA allow 24 days of leave other than for hospital care, arguing this would be good for the resident and consistent with the capacity for independence of domiciliary residents. Another asserted the regulation was vague as proposed and needed clarification. The commenter noted the proposed regulation omitted the "original" requirement that a resident not be absent from a State Home for more than 96 consecutive hours for the Home to receive per diem for that veteran, but the proposed section now states that per diem will be paid only for a veteran who has an overnight stay, or if the State Home has an occupancy rate of 90 percent or greater on that day. This commenter pointed out that domiciliary residents are independent and may choose to spend time away from the State home, which needs to guarantee their accommodations will be available when they return and should be reimbursed for that. These commenters said VA should continue the "96-hour" rule for payment of per diem during absences from the domiciliary for reasons other than hospitalization.

VA agrees that domiciliary residents require a different level of care and have more independence than nursing home residents, and imposing the same requirements for absences would impose an unfair burden on domiciliaries. State home domiciliary care programs are typically below 90 percent of capacity, but VA nonetheless believes that it is important to pay per diem during short absences to ensure that veterans who choose to take brief absences do not lose their spaces in State home domiciliaries. We agree that the 12-day cumulative absence rule is impracticable and overly burdensome for domiciliary care programs for the same reasons. In fact, even a 24-day rule, as one commenter requested, would allow less time away per year than the 96-hour rule some commenters recommended. Consequently, we are removing both the 90 percent and the 12-day requirements from the final rule. We are instead codifying the 96-hour rule for absences from domiciliaries in § 51.40(c), as it is currently in VHA Directive 1601SH.01. Under this rule, VA will pay per diem for any absence from the domiciliary of 96 or fewer consecutive hours, unless the absence is for hospital care at VA expense. VA will not pay per diem for any absence that lasts longer than 96 hours.

To effect these changes, we are revising the paragraph into two paragraphs: (c)(1), "Nursing homes" and (c)(2), "Domiciliaries."

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

As published in a notice of correction and clarification, 80 CFR 36305 (June 24, 2015), this rulemaking as proposed inadvertently omitted instructions for § 51.41. VA did not intend to propose any changes to that section, and we make none in this

rulemaking. We have provided amendatory language for subpart C to ensure inclusion of § 51.41 in 38 CFR part 51, and have added § 51.41 to the table of contents.

51.42 Payment procedures.

As proposed, § 51.42(a) read as a 147-word sentence. We have revised it to read as three sentences for clarity. We have also revised the proposed note to paragraph (a)(1)(i), redesignated "Note 1," to clarify who must complete the financial disclosure and that adult day health care participants are not to complete the financial disclosure, but they must sign the form to acknowledge financial responsibility. As revised, the note also makes clear that VA will reject the form as incomplete if submitted without the required signature.

VA had proposed expanding the deadline for VA to receive the forms from the State home identified in this section from 10 days to 12 days. The statute only allows 10 days, and we have no authority to allow a longer time. 38 U.S.C. 1743. VA will therefore maintain the 10-day deadline in this final rule by changing 12 to 10 in paragraph (b)(3) of this section. As discussed above, we are qualifying the time as 10 "calendar" days and defining the time limit as "no later than," rather than "within" as proposed, and adding "after care began", consistent with the statute. We have also made minor technical edits to this section. We have changed the heading of paragraph (b)(2) of this section by deleting "or precertified," because, as described above, § 51.30(c) will not establish a precertification procedure. We have deleted the first sentence of paragraph (b)(2) of this section for the same reason.

51.51 Eligible veterans—domiciliary care.

One commenter said that proposed § 51.51(b)(7) is ambiguous in requiring that a veteran must be able to "[s]hare in some measure, however slight, in the maintenance and operation of the State home" to be eligible for VA per diem payments, and this provision could violate the protection from involuntary servitude of the thirteenth amendment of the U.S. Constitution.

We disagree with the assertion that paragraph (b)(7) compels involuntary servitude. Residency in the State home domiciliary care program is itself voluntary. Any resident may leave. Paragraph (b)(7) describes an ability that, with the other eligibility criteria, ensures the enrollees on whose behalf VA pays per diem are appropriately in a domiciliary care program, and that VA pays the State home domiciliary care per diem only for such residents. Moreover, under revised § 51.310(c), the veteran is consulted and must agree to the work arrangement described in his or her comprehensive care plan, and § 51.300(b) requires that the resident be paid for work that the State home would need to pay others to perform. Together these provisions protect residents from involuntary servitude and from a State home otherwise taking unfair advantage of the resident through its work program.

Based on this comment, however, we are revising paragraph (b)(7) to read, "Participate in some measure, however slight, in work assignments that support the maintenance and operation of the State home." This makes clear the eligibility criteria include the ability to personally participate in the maintenance and operation of the State home. The addition also harmonizes this eligibility criterion with the role of resident work in the domiciliary care program as prescribed in §§ 51.300 and 51.310.

The specific work the resident chooses will be by agreement with the interdisciplinary team that develops the resident's comprehensive care plan, and the resident will be paid a competitive wage if the facility would otherwise pay a non-resident for such work. There is flexibility in how this may be implemented, as reflected in §§ 51.300(b) on residents' rights and behavior and 51.310(c) on comprehensive care plans, respectively.

Multiple commenters commented the State home should pay residents for work. Another objected to application through proposed § 51.300 of the nursing home regulation, § 51.70(h)(1), permitting a resident to refuse to work. This commenter asserted the State home should require each resident to work. In consideration of these comments we are revising proposed § 51.300 to require each resident's comprehensive care plan to specify whether a resident's work for the domiciliary is paid or unpaid.

51.52 Eligible veterans—adult day health care.

We have made non-substantive technical revisions to paragraph § 51.52(d)(3)(ii). As proposed, this provision may have been interpreted as requiring a minimum of 24 visits, 12 outpatient and 12 emergency, to be considered as a high user of medical services and thereby establish eligibility for adult day health care per diem payments. We intended 12 visits total, whether outpatient, emergency, or some combination, and have changed the provision in this final rulemaking to clarify that.

51.58 Requirements and Standards applicable for payment of per diem.

We are changing the heading of § 51.58, as shown, consistent with the changed heading of subpart C, discussed above, and other references to subpart C in this part. Similar to the change described above in § 51.20(b), we are changing proposed § 51.58 to make explicit in the introduction that State homes must meet the requirements of subpart C to receive per diem payments. Subpart C contains the eligibility requirements, payment rates, and payment procedures that apply to all State home programs of care. Although we do not consider this a substantive change, because the provisions of subpart C clearly apply to State homes receiving per diem, § 51.58 would be incomplete without it.

51.140 Dietary Services

This rulemaking makes a technical amendment to § 51.140(a)(2) that was not in the proposed rule. The paragraph refers to the "American Dietetic Association," which changed its name to the "Academy of Nutrition and Dietetics." This rulemaking updates that name.

Subpart E – Standards applicable to the payment of per diem for domiciliary care

VA received comments asking VA to collaborate with national associations representing State homes to revise the proposed regulations regarding domiciliary care and to retain the prior domiciliary rules in the interim, rather than implement the proposed rules.

VA is grateful to the State homes, and to all parties who submitted comments on this rulemaking. The rulemaking process we have followed allows all members of the

public to have a fair opportunity to participate in the rulemaking process, as the Administrative Procedure Act requires. 5 U.S.C. 553. VA has considered all comments it received, including the comments about the effects of the proposed domiciliary regulations submitted by national associations and individual State homes, and is making substantial changes to the domiciliary regulations in this final rulemaking. We therefore decline to retain the prior rules on per diem payments to domiciliaries while developing new regulations, but we welcome continuing feedback and opportunities to work with the State homes to improve services to veterans.

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

VA received a number of comments about § 51.300, which, as proposed, would have applied to State home domiciliaries the requirements of §§ 51.70, 51.80, 51.90, and 51.100. These regulations provide standards that apply to State home nursing home resident rights; admission, transfer and discharge rights; resident behavior and facility practices; and quality of life. In response to these comments and for other reasons, we have revised proposed 51.300 so it does not apply to the domiciliary care program all of the nursing home regulations we proposed to apply. We have changed the introduction to § 51.300 to specify which provisions of the nursing home sections will not apply to the domiciliary care program. Discussion of the specific comments and changes to § 51.300 follow.

Five commenters opined that compliance with §§ 51.70, 51.80, 51.90, and 51.100 may seem reasonable as they pertain to veterans' treatment and rights. They asserted, however, that compliance with these sections also imposes additional,

extensive "nursing home" standards on the domiciliary programs, creating new requirements that are not feasible under current operation and staffing models. The commenters noted, for example, that § 51.70 contains 14 major sections and multiple subsections of requirements, whereas the existing domiciliary care program regulations have only one standard "(13 Quality of Life)." The commenters asserted the other sections to which § 51.300 refers are similarly burdensome, citing as another example the § 51.100 requirement that social workers meet specific qualifications and that the domiciliary meet specific staffing requirements.

We deduce that the commenters' citations of various "existing regulations," e.g., "13 Quality of Life," refer to provisions of the VA Guide for Inspection of State Veterans Homes: Domiciliary Care Standards (Nov. 26, 1986) [hereafter 1986 Guide], because the citations are, verbatim, to headings of standards in the 1986 Guide. We disagree with assertions that the proposed regulations have many more provisions than the 1986 Guide, and with the implicit argument that more provisions means a greater burden of compliance. First, the commenters comparison of § 51.70 with the 1986 Guide, which incidentally does not comprise regulations, misstated the differences. Section 51.70 is one section comprising 14 paragraphs, (a)-(n), which each have multiple provisions. Section 13 of the 1986 Guide, "Quality of Life," comprises one section with six standards, each with one to four indicators of compliance, which in turn each has as many as 13 elements, and each standard one through six has a corresponding guideline paragraph. We further disagree that the number of provisions defines the burden of compliance. The number of provisions, as the commenters identify them, is

an organizational device to aid readability. It does not inherently correlate with the burden of compliance.

The commenters also expressed particular concern about the cost of applying these sections to domiciliary care programs that offer primarily transition services. Commenters said the proposed rules would have an adverse financial effect on the domiciliary programs, including potential closures, which would have an especially negative effect on the homeless population that some domiciliary care programs widely serve. Commenters said the proposed rules would treat otherwise homeless residents as patients and would medically institutionalize them, whereas the traditional domiciliary model encourages self-reliance. Some commented that nursing home standards would increase the nursing requirements for assisted-living domiciliaries. Some said that these requirements amounted to an unfunded mandate. Some said VA should either increase the per diem payment for domiciliary care, or eliminate or reduce the requirements.

We disagree that any requirement in this rulemaking is an unfunded mandate, even if compliance with some provisions increases a State's costs to run its program. An unfunded mandate, or a "Federal intergovernmental mandate" as defined in the Unfunded Mandates Reform Act of 1995, is, in pertinent part, "any provision in legislation, statute, or regulation that (i) would impose an enforceable duty upon State, local, or tribal governments—except (I) a condition of Federal assistance; or (II) a duty arising from participation in a voluntary Federal program." 2 U.S.C. 658(5). No Federal law imposes an enforceable duty on any the States to have a State home. VA's per diem program is a benefit the United States affords veterans through the States. This

rulemaking provides conditions of this VA assistance. Each State participates voluntarily. The cost of qualifying for VA per diem payments to State homes is not an unfunded mandate; it is simply a condition of Federal assistance or a duty arising from participation in a voluntary Federal program. We make no change based on this comment.

VA agrees that certain of the requirements we proposed in § 51.300 should not be applied to State home domiciliaries, and we have made a number of changes to that section in response to the commenters' recommendations. The standards VA will require State home domiciliary care programs to meet under this final rule are those we have determined are essential to the health, safety, and well-being of the residents and that will enable the State homes to continue providing services that foster veterans' independence. To that end, VA will apply some provisions of §§ 51.70, 51.80, 51.90, and 51.100 to domiciliaries, but we are excluding some and establishing more suitable standards in the place of certain paragraphs of each. From § 51.70, we are excluding § 51.70(b)(9), (h)(1), and (m); from § 51.80 we are excluding § 51.80(a)(2), (a)(4), and (b); and from § 51.100 we are excluding § 51.100(g)(2), (h), and (i)(5)-(i)(7). We have added provisions using the same or substantially similar headings as the excluded paragraphs and added provisions in language similar to the excluded provision, adapted and tailored to the needs of the domiciliary care program. For the most part, these changes implement changes commenters recommended or eliminate burdens commenters identified.

Some commenters approved of the proposed application of nursing home regulations to domiciliary care programs. They urged VA to apply all nursing home

regulations to domiciliary care programs. Some suggested specific changes to various provisions of §§ 51.70 and 51.100 as we proposed to apply them to domiciliary care programs. The suggested amendments are addressed under the headings for those provisions. One suggested a substantial rewrite of §§ 51.70 and 51.100, which we discuss under the Other Issues heading below.

A description of changes from the proposed regulations follows.

51.300(a) Notice of rights and services—notification of changes.

VA received comments that § 51.70(b)(9), Notification of changes, should not apply to domiciliary care program residents. The comments said that State homes do not currently notify families or legal representatives of changes to the domiciliary residents' medical status or room assignments. They noted that the State home often asks the residents to move from rooms with multiple residents to single rooms based on availability and seniority, and there is no need to inform family members in writing of such a change. One commenter further noted, "[T]here is no need to notify family members of changes in their medical conditions against their will in violation of their Health Insurance Portability and Accountability Act rights," and domiciliary residents are independent enough to oversee their own affairs. We interpret the comment referencing HIPAA to mean, if a State home were to notify family members of changes in the resident's medical condition over the resident's objection, that notice would violate the resident's rights under HIPAA, and therefore the proposed notice requirement violates HIPPA.

We agree that the requirement to notify a resident's legal representative or interested family member of changes to the resident's medical status or room assignment as § 51.70(b)(9) requires is not necessary for domiciliary care program residents for the reasons the commenters stated. We do not address whether the proposed notice requirement would violate HIPAA because we are eliminating the requirement to notify certain people. Instead, we have added a right to notice provision in § 51.300(a). In consideration of the comments for and against notice of certain outside persons, we are making changes intended to balance these conflicting concerns. Paragraph (a) of this section will provide that the domiciliary resident will have the right to decide whether to have the State home notify other people of changes to the resident's medical status or room assignment.

51.300(b) Work.

VA received comments objecting to applying to domiciliaries via proposed § 51.300 the nursing home rule that allows residents to refuse to work in § 51.70(h)(1). A commenter said that work programs allow residents to participate in their independent living communities and provide valuable therapy and skills for residents who will leave the facility. In contrast, VA also received comments that supported the proposed right to refuse to work for domiciliary residents.

We agree that sharing in some portion of the work to maintain the domiciliary is an essential part of domiciliary care programs. By longstanding practice, in the absence of comprehensive State home domiciliary regulations, State home domiciliary care programs have followed the same work requirement that applies to eligibility for VA's

domiciliary care program in §17.46(b). As described above, VA has adopted a requirement in § 51.51(b)(7) that to be eligible for per diem payments for State home domiciliary care the veteran must be able to participate in some measure, however slight, in work assignments that support the maintenance and operation of the State home. We have, therefore, also changed § 51.300 to eliminate the nursing home rule regarding the right to refuse work that VA had proposed to apply to State home domiciliary residents. As revised, § 51.300(b) now states explicitly, in part, "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." To ensure that the work has therapeutic value, § 51.300(b) also requires that the State home have a written policy to implement the work requirement, that each resident's comprehensive care plan describe the work the resident will perform, that the facility consulted with and the resident agrees to the work arrangement described in the comprehensive care plan, and that, if the resident is paid for the work he or she performs, payment will be at wages that meet or exceed the prevailing wages for similar work in the area. We have also included a provision to encourage the resident's participation in vocational and employment services, in addition to performing work.

VA received a comment saying that prevailing wages are not currently paid for participation in work therapy or volunteer programs. It's unclear whether the commenter means that State home domiciliaries should have authority to pay residents some other wage, or whether they should have authority to not pay residents for their work. VA believes a resident may perform volunteer work designed for its therapeutic value, even if the nature of the work is not one that an outside worker would typically be contracted

to perform. VA also believes, however, that domiciliary residents are entitled to fair payment for the work they perform for the maintenance and operation of the State home if the home would otherwise hire non-residents to do the work. This distinction protects the residents from being used under the guise of therapy to reduce the State homes' operating costs by substituting residents' labor for labor it would ordinarily hire at the prevailing wage in the local labor market. VA applies similar rules regarding work therapy to its own domiciliary and nursing home residents, and we see no difference between VA and State home programs to suggest residents should be paid different wages when doing work for which the State homes must pay. To make clear that State homes must pay residents the prevailing wage to perform work the State home would have otherwise hired non-residents to perform, we revised paragraph (b)(3) to read as follows: "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".

VA received comments saying the domiciliary residents should be compensated for all work they perform. VA disagrees; the work requirement does not preclude unpaid volunteer work, such as keeping one's room orderly or other housekeeping chores ordinarily to be expected of persons sharing a residence.

One commenter asserted VA's State home per diem regulations amount to a contract between State homes and VA requiring that State homes pay veterans Federal contract wages. The commenter cites an invalid World Wide Web address, https://www.dol.gov/ofccp/OFCCPRecoveryActPlan.htm, apparently referring to the Department of Labor Office of Federal Contract Compliance Programs (OFCCP). State

home compliance with VA per diem regulations are not subject to the oversight of the Department of Labor OFCCP. VA regulations on State home domiciliary residents' work requirements are not Federal contracts, either between VA and the State homes or between VA and the residents, and they do not subject the States to Federal contract law. We make no change based on this comment.

51.300(c) Married couples.

We received comments objecting to the proposed application to the domiciliaries of the nursing home requirement from § 51.70(m), which provides married couples have the right to share a room if they live in the same facility and both agree. One commenter noted that it operates one of the oldest State homes in the country and lacks the space or proper facilities to provide married living quarters in the domiciliary, and to do so would need renovations and the possible displacement of some unmarried residents. In contrast, one commenter supported the requirement that State home domiciliary care programs receiving VA per diem payments must provide shared living quarters for married veteran residents who wish them and who each meet the eligibility criteria for the program.

We agree that buildings might not always be able to accommodate married living quarters; however, there are ways that the State Home can make accommodations for married couples to have private space, even if temporarily. To accommodate the physical space limitations of certain State homes, but establish responsibility for programs to honor such requests to the extent possible, we have added § 51.300(c). This paragraph restates § 51.70(m), inserting "if space is available within the existing

facility" after "has the right" and adding the following sentence: "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."

51.300(d) Transfer and discharge.

We received comments that State homes should have a concise procedure for discharge of residents to prevent arbitrary discharge at the whim of management. One commenter stated there needs to be reasons for discharge and a right to contest the discharge in a speedy way. The commenter was particularly concerned about immediate discharges without any mechanism for immediate review, resulting in the resident having to abandon property and even personal effects. The commenters said a VA representative as well as a resident should be part of the process to ensure that residents' rights are not being violated. This comment pertains to the application of § 51.80, Admissions, transfer and discharge rights, to domiciliary care programs, under proposed § 51.300.

We agree that State home domiciliaries must have a clearly identified process for admissions, transfers, and discharges, and we have amended the introductory paragraph of § 51.300 to require the State home domiciliary have a written policy on the topic. Additionally, we have created § 51.300(a) to require the facility management to immediately inform the resident when there is a decision to transfer or discharge the resident, and a new paragraph (d)(6) to require the notice to include the resident's right to appeal and the contact information for the State long-term care ombudsman. These changes to the final rule give the residents a more defined process for discharge. We

understand the commenter's reference to a VA representative to mean a VA employee. Involving a VA employee in this process would impose an unnecessary burden on State homes. We therefore make only the changes described based on that comment.

We received a comment objecting to the application to domiciliary care programs of the transfer and discharge requirements from § 51.80(a)(2)(ii). Section 51.80(a)(2) requires the facility management to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless [circumstances meet one or more of a list of conditions]. Among the circumstances permitting transfer or discharge, § 51.80(a)(2)(ii) provides, "The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the nursing home.". The commenter distinguished domiciliary residents from nursing home patients, in that it is clear when nursing home patients no longer need nursing home services, but not clear when domiciliary residents no longer need domiciliary care, and domiciliary residents are not discharged just because of improved health. For that reason, it would be inappropriate to apply the nursing home requirements for discharge or transfer of a resident to the circumstances of most domiciliary residents.

We disagree with part of this comment. The structured, residential environment of domiciliary programs can foster personal and financial growth and accountability that allows residents to leave domiciliary care programs because of their improved circumstances. We believe therefore that it is appropriate to retain this provision with respect to discharges due to improved circumstances. The comment revealed a gap in the proposed rule, however. Focusing on transfer or discharge because of

improvement revealed the possibility transfer or discharge could be appropriate because the residents may have ceased to meet one or more of the eligibility criteria of § 51.51. For example, the veteran's annual income may have exceeded the maximum annual rate of pension. To fill this gap, we have added paragraph (d)(2)(vii) to the criteria for transfer or discharge in § 51.300 to read, "The resident ceases to meet any of the eligibility criteria of § 51.51." Section 51.51 provides eligibility criteria, but it does not address whether those criteria apply only to the applicant, or also to the resident. It is inconsistent with the function of the eligibility requirements, to ascertain whether someone is suitable for the domiciliary care program, to apply them at entrance and not during residency. A resident who ceases to meet an eligibility criterion would certainly meet a criterion for transfer or discharge.

We agree with the commenter that it is also important to include a requirement for when a resident needs to be moved to a higher level of care. We have, therefore, excluded domiciliaries from complying with § 51.80(a)(2), and instead establish domiciliary transfer and discharge requirements in § 51.300(d)(2), including the requirement in § 51.300(d)(2)(ii) that residents be discharged if they need a higher level of long term or acute care.

VA received comments objecting to the application in proposed § 51.300 of the requirement of § 51.80(a)(4) to notify a legal representative or family member of a transfer or discharge, and of the requirement of § 51.80(a)(5) to provide that notice 30 days in advance of the transfer or discharge. The commenters said these provisions eliminate flexibility necessary for managing an independent living environment and are inconsistent with the independence of the residents.

We have added § 51.300(d) in response to these comments. Regarding the requirement to notify a legal representative or family member, in § 51.300(d)(4) we have changed the regulation by eliminating the State home's requirement to notify and giving the resident the right to decide whether the state home notifies a legal representative or family member. This is similar to the changes we made in § 51.300(a) regarding notifications about medical status and room assignment changes. Regarding the 30-day advance notice of transfer or discharge, we disagree that the requirement is overly burdensome. New paragraph § 51.300(d)(5)(i) provides ample exceptions to the 30-day requirement to afford reasonable flexibility. The 30-day notice requirement, with the exceptions to make it practicable, affords the residents a reasonable safeguard against transfer or discharge without warning.

51.300(e) Notice of bed-hold policy and readmission—notice before transfer.

As proposed, § 51.300 would have applied the nursing home regulation on notice of bed-hold policy and readmission, § 51.80(b), to domiciliary care programs. Based on comments asserting this to be overly burdensome in the domiciliary care context, we have determined there is no need to apply the detailed notice of policy requirements to domiciliary care programs that § 51.80(b) applies to nursing home care programs. Domiciliary residents still need information about the availability of a bed if they return to the home from a period of hospital care. To achieve this, we have added paragraph (e) to proposed § 51.300, which provides, "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."

Additionally, we have added as the first sentence of the paragraph, "The State home must have a written bed-hold policy, including criteria for return to the facility." While we agree with the commenters that the domiciliary care program bed-hold policy does not need the degree of detail § 51.80(b) applies to the nursing home care program, we believe there must be a policy. This is a logical corollary to the requirement to provide a resident the bed-hold policy. While it may seem obvious that the State home must have a bed-hold policy to notify a resident of it, we believe the paragraph is clearer to explicitly require the State home to have a bed-hold policy. We also added a provision regarding a resident's right to decide whether to have the State home notify others of the change.

51.300(f) Resident activities, and (g) Social services.

Several commenters addressed social worker credentialing for domiciliary care programs, which we discuss below. In reviewing those comments, we concluded the commenters' reasoning about social workers' credentials applies as well to credentialing of therapeutic recreation specialists in domiciliary care programs. Unlike the nursing homes, the domiciliaries do not require a credentialed or licensed professional to oversee the residents' activities. We will not apply the credentials provisions of § 51.100(g) to the domiciliary care program as proposed. To effect that change, we have amended the introductory paragraph of § 51.300 to exclude § 51.100(g) and have added § 51.300(f), Resident activities, to adapt § 51.100(g) to the domiciliary care program. As adapted, § 51.300(f)(1) restates § 51.100(g)(1), and § 51.300(f)(2)

provides, “The activities must be directed by a qualified coordinator.” Section 51.300 applies no other provisions of § 51.100(g) to the domiciliary care programs.

VA received comments objecting to the proposed application of nursing home standards for social services from § 51.100(h), Social services, to domiciliary care programs under proposed § 51.300. One commenter objected only to the requirement of licensed social workers, another objected on the grounds that the proposed regulations mandate specific qualifications and staffing requirements that are not imposed upon domiciliary programs currently. Another noted that the State homes employ licensed and unlicensed social workers, with the latter providing only case management for domiciliary residents that do not require in-depth treatment, in keeping with a transitional model where the social worker’s job is to assist the resident with transitioning out of the domiciliary.

We agree the specific credential requirements of § 51.100(h) are not necessary for State home domiciliary care programs. We have added § 51.300(g) to provide more flexibility in social worker staffing for domiciliaries. Paragraph (g) provides that “[t]he 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;” that “[t]he State home must have a sufficient number of social workers to meet the residents’ needs”; and that “[t]he State home must have a written policy on how it determines qualifications of social workers.” Paragraph (g)(3) provides that “[i]t is highly recommended, but not required, that a qualified social worker is an individual with” the same qualifications as those required for nursing home social services providers.

One commenter noted the proposed regulation applying 51.100 to domiciliary care programs “references the number of required licensed social workers for the state veterans' home,” and that “clarity needs to be given as it relates to requirements for Social Workers assigned to the State Home Domiciliary.”

The regulation on the number of social workers, § 51.300(g)(2), provides, “The State home must have a sufficient number of social workers to meet residents’ needs.” We interpret the comment to be asking how the required number of social workers specified for nursing homes in § 51.100(h), Social services, applies to the domiciliary care program. As the introduction to final § 51.300 states, 51.100(h) is among the nursing home provisions this final rule does not apply to domiciliary care programs. Rather, § 51.300(g)(2) affords State homes flexibility in determining the number of social workers “sufficient” to meet the object of paragraph (g)(1). Additionally, though § 51.300(g)(3) strongly suggests the State home use licensed social workers, licensure is not required.

51.300(h) Environment.

VA received comments objecting to the application of § 51.100(i), Environment, to the domiciliary care program. These objected to the proposed closet space requirement and to maintaining temperatures at 71-81 degrees Fahrenheit. They commented that environmental requirements of § 51.100(i) that have not previously applied to domiciliary care facilities would pose extraordinary challenges to States operating older facilities that were not designed to meet these requirements. One commenter reported it would face significant and costly upgrades, especially to a 130

year old facility, if VA finalizes the proposed rule. The commenter requested VA "grandfather in" older facilities, permitting them not to make upgrades to meet the § 51.300 environment requirements. Another objected it could not provide private closet space without "massive renovations."

We agree that the temperature, sound, and lighting requirements VA proposed are unnecessary for the health and well-being of domiciliary residents, and we have eliminated them. We will not, however, remove the closet space requirement, or waive it for older facilities. VA has demonstrated its view of the importance of this requirement by including it among the requirements of its construction grant regulations. 38 CFR §§ 59.140, 59.150. A State may seek a part 59 grant to assist it to bring older facilities into compliance with these essential standards, or to replace facilities that cannot come into compliance, but VA will not "grandfather in," i.e., waive the requirement for, older facilities that currently lack the required closet space. To effect these changes, we have restated the provisions of § 51.100(i)(1)-(4) in § 51.300(h), and omitted the provisions of § 51.100(i)(5)-(7) from § 51.300(h).

51.300 – Other comments

VA received comments saying we should not apply State home nursing home requirements to State home domiciliaries that would require the domiciliary care programs to provide services they do not now provide. The commenters specifically mentioned access to an ombudsman. The commenters distinguished between the needs of nursing home residents, whom they described as an elder, very vulnerable population, and the domiciliary residents, who do not have the same vulnerabilities.

They said the domiciliary care program residents are able to tend to their own affairs, and an ombudsman is therefore not necessary.

VA also received comments asking VA to retain the proposed requirement that State home domiciliary residents have access to an ombudsman. The commenters asked VA to appoint or require the State to appoint an ombudsman or patient advocate. One commenter said that decisions would be less ad hoc, more thoughtful, and more considerate of residents' welfare if an ombudsman were available.

We agree with the commenters who asked VA to require domiciliary care program residents to have access to an ombudsman. We disagree with the commenters who argue the relative soundness of the domiciliary residents compared to nursing home residents means the domiciliary residents do not need an ombudsman. VA makes no change to the proposed application of the ombudsman requirement of § 51.70(j) to domiciliary programs. As some commenters pointed out, and VA believes, domiciliary residents face vulnerabilities and are entitled to have an advocate outside the facility who is able to advocate on their behalf or mediate situations between State home leadership and residents when necessary. State homes are already required to ensure that nursing home residents have access to the State long term care ombudsman. Extending that protection to domiciliary residents does not require the State to create any new position; it need only provide domiciliary residents with access to an existing State long term care ombudsman and information how to contact that ombudsman. Consistent with the application of the § 51.70(j) ombudsman rule to domiciliary residents, we are also adding paragraph 51.300(d)(6)(v) to require any

notice of transfer or discharge to include the name, address, and telephone number of the State long term care ombudsman.

One commenter requested that out of sensitivity to the unique needs of veterans, VA add to the quality of life regulations under 51.300 a requirement that State homes recruit and hire veterans for all positions in the State homes, and where veterans are unavailable, require special training of non-veterans in "veteranology" [sic], "or the study of veterans."

We decline to add the suggested requirement to the quality of life provisions of part 51. Though the commenter's ideas about the value of veteran employees or of special education for non-veteran employees at State homes have merit, the requirement sought would impose a substantial new personnel burden on the state homes, which may conflict with employment laws of these States. Rather than impose this requirement on the States, we would prefer to give the States discretion to hire the best employees for their Veterans. Further, the commenter's suggestion is beyond the scope of this final rulemaking. Consequently, we make no change based on this comment. Nevertheless, we call upon the States to consider the ideas of the commenter.

The same commenter urged VA to require the States, as a condition of receipt of VA per diem payments, to permit residents for whom VA pays per diem to apply for career professional employment at State homes as a "civil right." The commenter requested regulations providing specific employment practices. The commenter further requested VA to establish by regulation "a rating and employment system whereby residents of US VA Per Diemed [sic] State Veterans Home Domiciliary Programs [sic]

who are working professionals living in an SVH Domiciliary Program while seeking employment are registered as members of a new Federally protected class of veteran—'the SVH Domiciliary Veteran-Resident Career Professional.'"

The employment regulation the commenter seeks would conflict with 38 U.S.C. § 1742(b), which prohibits VA from having any authority over the management or control of any State home. While a resident is free to apply to any job, it is beyond the scope of this rulemaking to create "a new Federally protected class of veteran[s]." Further, as noted above, we would prefer to give the States discretion to hire whom they consider the best qualified employees for their Veterans.

Regarding creation of protected classes under Federal civil rights law, VA lacks authority to create protected classes of citizens under Federal civil rights laws. Creation of the protected class the commenter advocates would require legislation. Current statute prohibits VA authority over "the management or control of any State home," 38 U.S.C. 1742(b), and the establishment of a "rating and employment system," as the commenter described it, seems very likely to amount to management contrary to that statute. Even if VA had the authority to regulate as the commenter seeks, the commenter's suggestions are beyond the scope of this final rulemaking. We make no changes based on this comment.

One commenter noted a State home provides transitional domiciliary care to Veterans who are medically able to live fully independently, but who lack the financial means for subsistence. The commenter said that the proposed application of nursing home requirements for State home domiciliaries would threaten the State home's ability to maintain this practice "because the Veterans would not meet the new requirements of

domiciliary care," potentially resulting in some residents being without a housing alternative.

Though we are not making any changes in response to this comment, we should clarify that the new regulations do not change eligibility requirements for residents to require that they be in need of nursing home care, nor will the rule change eligibility requirements for any veterans receiving domiciliary care. Furthermore, as discussed above regarding specific nursing home requirements, we are easing the proposed application of multiple nursing home requirements on State home domiciliaries. This final rule will not require Veterans to be displaced in the manner the commenter described.

Another commenter asserted that VA should have regulations requiring all cash donations to a State home be made known to the residents, and that legacy accounts (accounts of deceased residents) be made known to the residents and to the public.

We disagree with this suggestion. Donations to the State home, and any disclosure, would be the subject of State law. All States have laws governing access to public records like this. If the commenter believes that State laws need to be changed, we recommend that the commenter seek action at the State level. Requiring States to change their laws governing such access is beyond the scope of this rulemaking. Regarding the commenters concern about legacy accounts, current regulations governing residents' funds are sufficient to regulate the State home's handling of those funds. Current regulation, 38 CFR 51.70(c) Protection of resident funds, applies to domiciliary care programs through final § 51.300. It provides for the handling and accounting for a resident's funds on deposit with a State home, including their final

accounting and conveyance upon a resident's death. The regulation also provides that each resident is to have personal control of the resident's funds, that the State home cannot require the resident to deposit the funds with the State home, that the State home account for the funds to the resident or to a resident's legal representative, and that the state make a final accounting and conveyance of funds to the individual or probate jurisdiction administering the resident's estate or other appropriate entity. These rules together are consistent with treating the residents' finances as a private matter, even after death. We make no change based on this comment.

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

We have made multiple changes to § 51.310. Some are in direct response to comments, and some simply improve organization, clarity, and readability. We have revised the heading to read, "Resident admission, assessment, care plan, and discharge", to be more descriptive of the scope of the section. We have rearranged provisions, grouping related provisions together and putting them in the sequence the State homes will generally apply them. This reduces the number of paragraphs in the section from the proposed introduction plus five paragraphs, (a) through (e), to introduction plus four paragraphs, (a) through (d). We have inserted the words "medical and comprehensive" before "assessments" in the introduction, and inserted "comprehensive" before "assessment" throughout the section, to indicate they are different. The medical assessment informs the State home of the new resident's medical status and immediate needs on admission. The comprehensive assessment incorporates the result of the medical assessment and builds on it by bringing together

multiple health professionals' assessments of the resident's physical, mental, and social needs. The comprehensive assessment, in turn, informs the comprehensive care plan. We discuss these assessments below. The introductory paragraph of § 51.310 introduces each of these assessments. We have also added a last sentence to the introduction, "The State home must review comprehensive assessments annually, and promptly after every significant change in the resident's physical, mental, or social condition." This sentence adds no new requirement to the proposed admission, assessment, and comprehensive care plan process. Rather it clarifies the ongoing relationship between the comprehensive assessment and the comprehensive care plan.

Three commenters asserted that the unknown cost of having physician's orders for each resident's immediate care and an assessment including medical history and physical examination within 72 hours of admission, as proposed § 51.310(a) required, would be excessive. The commenters compared the proposed requirements with the 1986 Guide, which required that the domiciliary provide and maintain a treatment plan for each domiciliary patient.

We partly agree and partly disagree. We agree that 72 hours is not always enough time to perform the assessment with medical history and examination. We have changed proposed § 51.310(a) to allow 7 calendar days for the medical assessment, which is consistent with VA practice for its domiciliary care program and will provide the State homes with ample time to perform an assessment of the resident. We have clarified that the assessment upon admission is a medical assessment, adding "and medical assessment" to the paragraph (a) heading, to read, "(a) Admission orders and medical assessment." This will distinguish this assessment from the

comprehensive assessment identified in the introductory paragraph and in paragraph (b). We have also added a last sentence to paragraph (a), "The medical assessment will be part of the comprehensive assessment." This makes clear that a medical assessment is part of the comprehensive assessment, consistent with the inclusion of a physician among the practitioners listed among those to do the comprehensive assessment described in paragraph (b) of this section.

Further, for clarity and certainty, we redesignated paragraph (b) to allow the State home 14 calendar days after admission to complete the comprehensive assessment and redesignated paragraph (c) to allow 21 calendar days after admission to develop the comprehensive care plan. As proposed, § 51.310(d)(2)(i) required a treatment plan be "Developed within 7 calendar days after completion of the comprehensive assessment," but there was no deadline for the comprehensive assessment. Without a deadline for the comprehensive assessment, the proposed rule was uninformative and afforded poor guidance and no certainty about when the treatment plan might be done. Compared to the proposed process from admission to care planning, these changes afford more overall flexibility while also providing more useful guidance to the State homes and more certainty for the State homes and for VA. Also, we have added "annually, and as required by a change in the resident's condition" at the end of paragraph (b)(1). Though this restates a phrase of the introduction to § 51.310, we feel it is necessary to avoid any impression that the paragraph (b)(1) requirement to do a comprehensive assessment on admission contradicts the requirement of annual and as needed comprehensive assessments in the introduction.

Paragraph (b)(2) describes the purpose of the comprehensive assessment to distinguish it from the medical assessment.

We disagree with the comment that physician orders for immediate treatment should not be required upon admission. Admitting a resident into a residential program with unknown current health needs is an unreasonable risk, both for the patient and for other residents of the domiciliary, although we recognize that this recommendation was made under the assumption that VA would require doctor orders and the complete assessment no later than 72 hours of admission. We have revised the section to distinguish between the medical assessment required shortly before or soon after admission and the subsequent comprehensive assessment, of which the medical assessment is part. As changed, the paragraph allows 7 calendar days after admission to complete the medical assessment. This clarification and other changes to this section provides the State homes with more flexibility in completing the medical assessment and makes the physician orders requirement perfectly reasonable in light of its importance. Consequently, we decline to eliminate the physician orders requirement. We have eliminated the proposed provision that "physician orders may be submitted when available" from § 51.310(a), because it is essential to know of immediate medical needs at the time of admission, and it is inconsistent with the changes in this final rule.

VA received comments saying the requirement that the medical assessment be performed by a physician rather than a nurse is overly burdensome and unnecessary because domiciliary residents are generally in better health and have fewer medical needs than nursing home residents. We agree that a physician need not perform the

resident's medical assessment upon entering a domiciliary care program. We have therefore changed proposed paragraph (a), Admission orders and medical assessment, to provide that "a physician, or other health care provider qualified under State law" must perform the assessment.

We have removed proposed paragraph (b), which provided, "The State home must use the results of the assessment to develop, review, and revise the resident's treatment plan." Initially proposed paragraph (c), "coordination of assessments," is redesignated paragraph (b) and renamed to place this provision in the context of comprehensive assessments. As restructured, the section now flows functionally from (a), admission and medical assessment, through (b), comprehensive assessment, to (c) comprehensive care plan, and finally (d) discharge report.

VA received comments saying that the proposed global nursing home assessment tool is inappropriate for domiciliary care programs. One commenter noted we based proposed § 51.310 on § 51.110, which requires nursing home care programs to use the Centers for Medicare and Medicaid Services Resident Assessment Instrument Minimum Data Set (MDS), Version 3.0. The commenter asserted the MDS 3.0 does not allow for assessing domiciliary residents.

We did not propose using a global nursing home assessment tool. It appears the commenters misread the notice of proposed rulemaking, which specifically explained there is no national tool for assessment of domiciliary residents as there is for nursing homes. Our intent was to provide State homes with reasonable flexibility in conducting the assessment, which is why proposed § 51.310 stated the assessment objectives and process without specifying an assessment tool.

VA received a comment that in a State with a State-established required assessment tool for domiciliary care, VA's assessment requirements would be duplicative, resulting in additional, unreimbursed costs. The commenter recommended VA allow each State to use its State required assessment tool and for VA to provide a tool for the use of States without a state-required tool.

VA disagrees. Section 51.310(a) does not require duplicative assessments, though it could require the State to augment its assessment procedure. The introduction to this section requires the State home to establish in a written policy how it will complete, implement, review, and revise comprehensive assessments. This allows the State home sufficient flexibility to use its existing assessment tool if it produces an assessment with sufficient information about the resident's emotional, behavioral, social, and physical needs to inform a comprehensive care plan targeted as meeting those needs. We will not change the regulation to explicitly provide that States may use any assessment tool it may have because there would be no assurance that the assessments would be comprehensive enough. Nor is it practicable for VA to review States' assessment tools for sufficiency, and then monitor them for continued sufficiency subsequent to any revision. We do not require the State homes to use an assessment tool specifically designed for nursing homes. We require the assessment to be adequate to inform the comprehensive care plan. We believe this section is flexible enough to enable the State to avoid the cost of duplicative assessments, while providing for the health and wellness of State home domiciliary residents. We make no change based on this comment.

In response to comments on § 51.51 about residents' work in the State home as part of a comprehensive care plan, discussed above, we have added paragraph (c)(1)(ii) to this section, providing that a comprehensive plan must describe: "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". This identifies with whom the resident agrees to perform certain work, and also that the agreement is about which work the resident will to do share in the maintenance and operation of the State home, not whether the veteran agrees to do some work.

We have changed the proposed description of the purpose of the comprehensive care plan. Proposed paragraph (d)(1) provided the comprehensive care plan is "to address the resident's physical, mental, and psychosocial needs". In light of comments received and described above about the role of mental health and other specialty care services in domiciliary care, we feel a change in terminology would allow State homes to better understand and implement this provision. As changed, redesignated paragraph (c)(1) says the comprehensive care plan is "to address a resident's emotional, behavioral, social, and physical needs." To allow care providers the flexibility to ensure the comprehensive care plan best reflects each resident's needs, we have also added to the last sentence of paragraph (c)(1) a provision that the comprehensive care plan must describe the items listed, "as appropriate to the resident's circumstances."

We have deleted the reference to § 51.350 in proposed paragraph (d)(1)(i), "as required under § 51.350;". The reference made sense as proposed, because § 51.350

would have applied all of multiple nursing home regulations to domiciliary care programs. As revised, § 51.350 does not apply most of those nursing home regulations to domiciliary care programs, and removing the reference is consistent with the flexibility we intend final rule § 51.310(c)(1)(i) to allow.

We have also changed the reference to "the resident's exercise of rights under § 51.300, including the right to refuse treatment" in proposed paragraph (d)(1)(ii). As revised and redesignated paragraph (c)(1)(iii), the paragraph reads, "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. This change provides the reader a more direct reference to the substantive provisions concerned. Though the proposed reference to § 51.300 is correct, it is indirect. Reference to § 51.300 requires the reader to ascertain that § 51.300 applies § 51.70, so the reader must then look to § 51.70 for the substantive provisions. This change of cross reference simplifies finding the provisions to which the paragraph refers.

In § 51.310, we changed proposed paragraph (d)(2)(i), which would have required the State home to complete a comprehensive care plan within 7 calendar days of completion of the assessment. As revised, redesignated paragraph (c)(2)(i) requires the State home to develop a comprehensive care plan no later than 21 calendar days after admission. This lets the State home manage time and resources better, potentially allowing more than 7 calendar days to complete the comprehensive care plan if the comprehensive assessment is completed in less than the time allowed. It also affords certainty about when the State home will have a comprehensive care plan for each resident.

Proposed paragraph (d)(2)(iii), redesignated paragraph (c)(2)(iii), provided for periodic review and revision of the comprehensive treatment plan. We determined that final paragraph (c)(2)(iii) would provide clearer guidance if it tied in with the introduction of paragraph (c)(1). Towards that end, we have changed the periodic review and revision to be "consistent with the most recent comprehensive assessment". With this change, paragraph (c)(2)(iii) reads, "Reviewed periodically and revised consistent with the most recent comprehensive assessment by a team of qualified persons no less often than semi-annually".

We also determined that redesignated paragraph (c)(2) did not complete the logical progression of the paragraph. The point of periodic review is to change the treatment plan if the review reveals it needs to change. We believe it is implicit in the § 51.310 introductory requirement to reassess a resident promptly after every significant change in condition that the comprehensive care plan must also change promptly in response to a significant change in the resident's condition. Consequently, we have added "; and" at the end of final paragraph (c)(2)(iii), followed by new paragraph (c)(2)(iv), which reads, "Revised promptly after a comprehensive assessment reveals a significant change in the resident's condition."

Proposed paragraph (e)(3) did not state as well as we intended the resident's right to control whether to include a legal representative or interested family member in discharge planning. We have restated that point in redesignated paragraph (d)(2) as an affirmative right.

51.330 Nursing care

One commenter requested clarification of the statement in the supplemental information of the proposed rule that the nursing care required in domiciliary care programs "would be similar to what is required in nursing homes, except that we would not require the same level of skilled nursing supervision." VA received comments that, as proposed, § 51.330 would require State homes to staff domiciliary care programs with the same amount of nursing staff VA requires State homes to provide for nursing home care programs. They commented that currently, State home domiciliary care programs require a licensed nurse as needed to meet the nursing care needs of the patient, citing section 5E of the 1986 Guide, whereas the proposed rule would require a licensed nurse for each shift, every day, around the clock. The commenters said that requirement could increase their costs for nursing supervision.

We agree the discussion was not clear about what "similar to" and "level of supervision" meant. We also agree that the proposed requirement could result in increased costs and that domiciliary care program residents may not require a licensed nurse on each shift, if the nursing care needs of the residents are met. We have, therefore, eliminated the proposed requirement that the director of the nursing service designate a licensed nurse as the supervising nurse for each tour of duty. Otherwise, the staffing requirements in this final rule are similar to the existing nursing care requirements for domiciliary care programs in section 5A of the 1986 Guide, which requires an organized nursing service of personnel qualified to meet the nursing care needs of the domiciliary patient. The final rule, however, clarifies that the residents' individual comprehensive assessments and comprehensive care plans determine their need for nursing services, and that need must be met 24 hours a day, 7 days a week.

We continue to believe this is a reasonable and necessary requirement for availability of nursing care.

One commenter said that some states have regulations prescribing staffing levels for State homes. The commenter described the staffing level required by its Residential Care Home Licensing Regulation. The commenter recommended VA permit states with regulatory staffing levels to follow those regulations and that VA provide a regulation for states without a State regulated staffing level.

We decline to make the commenter's recommended change. Section 51.330, as revised, articulates VA's view of the minimum safe staffing for nursing care in State home domiciliary care programs. VA would not be comfortable relying on staffing levels set by the State because they might not meet that minimum. So, to allow the exemption from § 51.330 the commenter seeks, VA would have to review each State's regulation to assure it requires staffing equivalent to the minimum level VA considers acceptable. Such a plan would require a way for VA to know if any State's regulation changed, to again review the regulation, and to maintain a procedure for disallowing states from the exemption if a change permitted an unacceptable level of nurse staffing. This is not a practicable scheme for VA. We believe that if a state's regulations require nurse staffing equivalent to the level VA considers minimally acceptable, the cost cannot be significantly different from the cost of compliance with § 51.330, and the state would not realize any cost savings from the exemption. Consequently, we make no change based on this comment.

One commenter asked whether facilities with "co-located" domiciliary care and nursing home care programs on the same property or in the same building must have a

director of nursing for each or if they may share a director of nursing. The commenter also asked whether the two programs can share the supervising nurse for each tour of duty, and whether a "tour of duty" is the same as a shift.

We intend the State homes to have the flexibility to staff their programs to ensure that all residents get the nursing care each resident's comprehensive assessment indicates each resident needs. The regulation does not preclude sharing a nursing director. A shared nursing director would comply with the regulation only, however, if the State home can ensure it meets the total nursing care needs of all residents in the facility. This final rule eliminates proposed § 51.330(b), which required a licensed supervising nurse for each tour of duty, so the questions about a shared nursing supervisor and whether a tour of duty is the same as a "shift" are moot.

51.340 Physician and other licensed medical practitioner services

VA received comments about the requirement in proposed § 51.340 that State homes provide necessary primary care to domiciliary residents. Commenters objected to the proposed requirement in this rule, and raised concerns about the definition of "primary care" in the VA General Counsel Precedent opinion ruling that State home domiciliary care programs must provide primary care to be entitled to per diem payments. VAOPGCPREC 1-2014 (Mar. 21, 2014). Some commenters objected to the General Counsel's inclusion of surgical services in primary care, and some objected to its inclusion of mental health services in primary care. The commenters said surgical services and mental health services are generally considered specialty care, and VA should define primary care in the same manner as Medicare.

We recognize the confusion about what is included in primary care, which has resulted from the General Counsel opinion and the proposed rule, and therefore clarify that we do not consider primary care as including comprehensive mental health or surgical services. We thus do not consider § 51.340 as requiring a State home to provide domiciliary residents either surgical or comprehensive mental health services—only to assist residents with obtaining these services. See also section 51.2 of this rulemaking, which defines domiciliary care as including "necessary medical services" that are described in subpart E. Nothing in subpart E requires State domiciliaries to provide either surgical or comprehensive mental health services. We note, however that under this subpart (§§ 51.300(f)-(g), 51.320(d), 51.340), the State home is required to provide basic mental health screening. We acknowledge that proposed § 51.340 was unclear about what mental health services the State home domiciliaries would be required to provide without many of the clarifications in this final rule. The final rule requires the State home to provide "its residents the primary care necessary to enable them to attain or maintain the highest practicable . . . mental, and psychosocial well-being." Though this could be misread to mean the domiciliary must provide all care necessary to attain or maintain mental health, we believe it is clear that it requires the domiciliary to provide only the necessary primary care. The State home discharges its obligation to enable its residents to attain or maintain mental and psychosocial well-being when it provides primary care. It further requires the State home to assist its residents to obtain other care when a resident needs care other than care the State home must provide. So, if the veteran needs mental health care other than that required by subpart E, the State home must assist the resident to obtain that care.

One commenter objected to the primary care requirement because it would substantially increase state expenses and undermine a resident's ability to obtain care from a physician of his or her choice. The commenter said the primary care requirement would require residents to abandon their existing physicians and mental health specialists, significantly reducing State home admissions and negatively affecting current residents.

One commenter stated medical care should be the veteran's choice when the veteran is capable of making the choice. The commenter did not address the comment to a specific provision, so it is not clear whether the commenter was addressing a right to choose among health care practitioners or a right to choose to refuse care.

This regulation will not prevent State home domiciliary residents from seeing the private health care providers they choose to see. The § 51.340 requirements do not mean a resident may not see a private physician of his or her choice or must abandon an existing relationship with a private healthcare provider. Further, domiciliary residents retain the right to receive care from their private physicians in the State home domiciliary, provided the physician is credentialed and privileged in the State home. If the commenter means the veteran should have the choice whether to receive medical care, the veteran may refuse treatment under § 51.300, which applies to domiciliary residents the right to refuse treatment as prescribed in § 51.70(b)(4). We make no change based on these comments.

Furthermore, it is unclear why the commenter believes costs would increase; it may be because of the assumption that VA intended to include mental health and surgical services in primary care. The guidelines under which the State home

domiciliary care programs have long operated required each resident to have a primary care physician responsible for the resident's medical care, and required that primary care medical services be provided for residents as needed. Section 51.340 imposes no additional primary care burdens or costs. Further, these regulations would not preclude States from charging the veteran's insurance for providing primary care. We make no changes based on this comment.

VA received a comment requesting a "thorough and explicit definition of what primary care entails." The commenter was "concerned that the proposed rules would transfer all medical costs associated with resident care to the state and nullify existing sharing agreements" with the local VA facility. Another commenter also raised essentially the same points about the extent of health care the proposed regulations require and about transferring costs and sharing agreements, asserting the burden of shifting primary care costs could make operating domiciliary care unsustainable.

The regulation, as proposed, does not specifically define primary care, and we believe the common dictionary definition VA General Counsel quoted in the precedent opinion cited above is sufficient and widely used. VA declines to define primary care with a list of specific medical services. We disagree that lack of definition of primary care could affect the commenter's primary care sharing agreement with a local VA medical facility. Under the final regulation, this arrangement may continue. The State currently pays for the primary care VA provides through a sharing agreement, so there is no cost to transfer to the State. We make no change based on this comment.

VA received a comment saying that providing additional medical services would be especially burdensome to some State homes that were built in remote locations to

care for veterans in underserved communities. Those homes, the commenter stated, currently experience hiring challenges and staffing shortages, and the new requirements would pose challenges and costs associated with hiring additional staff or contracting with outside providers.

We understand that staffing or otherwise obtaining the required services can be more difficult in some areas than others, whether because of remote location and a small labor pool, or because of a central, densely served market with stiff labor competition among employers. The primary care VA requires State homes provide is essential to the health, safety, and well-being of the domiciliary care residents. We will not eliminate or reduce the requirements in response to the vagaries of the local labor market. We make no change based on this comment.

VA received comments that the State home domiciliary care standards in the 1986 Guide, required that a resident be seen annually and as needed by the primary care physician or other licensed medical practitioner. The proposed rule, however, specified that the resident must be seen by the primary care physician or licensed medical practitioner at least every 30 days for the first 90 days after admission, and at least once annually thereafter, or more frequently based on the condition of the resident. The commenter said this requirement would result in a cost burden to the domiciliary, potentially a 100% increase in physician visit costs.

We agree with the commenter that more frequent primary care physician's visits than the State homes have been accustomed to providing will increase the State homes' costs. We also agree a domiciliary resident need not be seen every 30 days for the first 90 days of residency. The typical domiciliary resident's health does not require

the frequency of medical monitoring we proposed. We have changed the requirement in § 51.340(d) to require an annual medical assessment, restating the provision in the active voice to read, "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." Though redundant of the annual medical assessment § 51.310 requires, it is useful also to restate here to consolidate the requirements regarding physicians and other medical practitioner services. This change also eliminates the colloquial expression "be seen" in favor of the more precise term "assessment."

One commenter interpreted proposed paragraph (e) to mean the domiciliary must provide or arrange for physician or other licensed medical practitioner services 24 hours a day, 7 days a week, in case of an emergency. The commenter also asked for clarification whether the provider must be on site or may be on call.

We did not intend the commenter's interpretation of the provision, which states, "The State home must assist residents in obtaining emergency care." Though a State home certainly may staff its facility at all times, the provision does not require it. It requires only that the facility management be able assist the resident in obtaining emergency care. For example, a telephone call to local 911, if available, could comply with § 51.340(e). We make no change based on this comment.

51.350 Provision of certain specialized services and environmental requirements

Proposed § 51.350 would have applied all of the standards applicable to State home nursing homes at §§ 51.140, 51.170, 51.180, 51.190, and 51.200 to State home

domiciliary care programs. We are making multiple changes to this section. These correct errors in the proposed rule, respond to comments, and will serve the needs of State home domiciliary care programs and their residents better than would the proposed application of the whole of the sections we proposed to apply.

We are removing the phrase "nursing home and nursing facility" from the last sentence of the introduction to proposed § 51.350. Its use was an error. The cited regulations use the term "the facility," but not, "nursing home" or "nursing facility." As revised, the sentence reads, "For purposes of this section, the references to 'facility' in the cited sections also refer to a domiciliary."

VA received comments opposing the imposition of the whole of these regulations on domiciliary care programs and recommending the domiciliary program standards be more consistent and commensurate with the stated definition and purpose of domiciliary care. Multiple commenters recommended increasing per diem payments for domiciliary care, as one put it, "to be compensated for the increased requirements for our domiciliary care facility." This commenter specifically reported a $103,000.00 loss in its domiciliary care program in the past year, submitting a financial analysis.

We agree that certain standards that proposed § 51.350 would have applied to domiciliary care programs are impracticable or inappropriate. Consequently, we have revised proposed § 51.350, to exclude § 51.140(f)(2)-(4), § 51.180(c), and § 51.200(a), (b), (d)(1)(ii)-(x), (f), and (h)(3) from application to domiciliary care programs. In addition, we will exclude other provisions as discussed below. Though the mechanism for setting the rate of per diem payment is prescribed by statute, we anticipate these changes will also reduce the costs of compliance.

Section 51.140(f), Frequency of meals, requires nursing home residents to receive and nursing homes to provide three meals per day at regular times comparable to normal meal times in the community. Paragraph (f)(4) of that section allows an interval of 16 hours between dinner and breakfast if a nourishing snack "is provided" at bedtime. Consistent with comments about applying § 51.140 to domiciliaries that asserted the generally greater independence of domiciliary residents than nursing home residents, we have added § 51.350(a) to apply to domiciliaries instead of paragraph (f)(2)-(4). Paragraph (a)(1) requires no more than a 14-hour interval between the evening meal and breakfast. Paragraph (a)(2) requires the facility staff to offer snacks at bedtime daily, as does § 51.140(f)(3). Paragraph (a)(3) allows 16 hours between the evening meal and breakfast when the bedtime snack is nourishing. The difference between the domiciliary regulation and the nursing home regulation is the difference between whether the nourishing snack "is offered" or "is provided" to residents. This difference takes into account the greater independence of domiciliary residents, who can maintain adequate nutrition without the monitoring the nursing home requirement entails. It is, however, the nutritional character of the offered bedtime snack, not the resident's independence in whether to eat it, that affords the State home the additional two hours between the evening meal and breakfast.

Some commenters objected to the proposed monthly drug regimen review required under § 51.180(c)(1), saying that compared to the semiannual drug regimen review required for domiciliary residents in the 1986 Guide, the proposed rule would result in a significant cost increase.

VA agrees with the commenters. The intent of the proposal, to preserve the health and safety of State home domiciliary residents, can be met with a semiannual drug review. We have added § 51.350(b), which requires a drug regimen review at least once every six months and included the requirement in § 51.180(c)(2) requiring a report and action if any irregularities are found.

VA received comments objecting to the burdens of bringing State homes providing domiciliary care into compliance with the requirements of § 51.200, Physical environment. Multiple commenters said that transition-based programs are not currently required or able to meet many of the physical or plant features included in the nursing home standards. The commenters paraphrased or quoted provisions of § 51.200 to illustrate nursing home requirements they asserted domiciliary care facilities could not meet. Among these paraphrases or quotations were "provide adequate room space in most rooms," apparently based on § 51.200(d)(1)(i)-(iv); "provide sufficient privacy (ceiling suspended curtains extending around beds for total visual privacy) in rooms with more than one resident," apparently based on § 51.200(d)(1)(vii)-(viii); "provide prescribed storage space for residents," apparently based on § 51.200(d)(2)(iv); "have a resident calling system directly to nursing," apparently based on § 51.200(f); and "have corridors equipped with handrails," paraphrasing § 51.200(h)(3). We construe these comments as references to these provisions because we do not interpret the commenters to literally oppose providing "adequate privacy," or "sufficient privacy."

In response to the comments, we have excluded § 51.200(a), § 51.200(b), § 51.200(d)(1)(ii-x), § 51.200(f), and § 51.200(h)(3) from application to domiciliaries, as

noted above. In place of the privacy requirements in § 51.200(d), we have provided for "visual privacy" in § 51.350(d), which reads, "The facility must provide the means for visual privacy for each resident." This is based on § 51.200(d)(1)(vii), which requires nursing home bedrooms "[b]e designed or equipped to ensure full visual privacy for each resident." Section 51.200(d)(1)(viii) further specifies that the nursing home bedrooms (other than private rooms) must have "ceiling-suspended curtains," further specifying their placement and specifying other furnishings of the room to ensure "visual privacy." We intend this § 51.350(d) to afford the State homes reasonable flexibility in finding a way to let the domiciliary resident sleep or change clothes or do other ordinarily private things without being watched or in open view of other residents.

While many of these requirements are essential to the health, safety, and well-being of the domiciliary residents, we agree with the commenters that some would pose an excessive burden to State home domiciliaries and are more appropriate for nursing home care than domiciliaries, because domiciliary residents remain more independent. For those reasons, in this final rule, we will not apply to domiciliaries the following environmental requirements: § 51.200(d)(1)(ii-x) regarding resident bedrooms; § 51.200(f) regarding resident call systems; and § 51.200(h)(3) regarding handrails. All of these requirements are more aligned with skilled nursing home care then they are with domiciliaries, and they are not requirements in VA domiciliaries.

VA received a comment that the cost of renovations and upgrades to meet the environmental requirements would total hundreds of millions of dollars nationwide, and the facilities would be forced to compete for funding with the limited resources in VA's State home construction grant program. We agree as discussed above that some of

the proposed requirements were too burdensome, and we revised the regulation accordingly. We also agree that applications for grants from VA to meet the cost of complying with a § 51.350 requirement might compete with applications to fund other projects in the construction grant program, but life and safety projects are given priority over all other types of construction when VA determines whether to award construction or acquisition grants. (See 38 CFR part 59 for regulations governing grants to States for construction or acquisition of State homes.) We have revised the final rule to ease the burden of compliance with the specialized services and physical requirements for State home domiciliaries; the rest of the requirements under § 51.350 are essential to the health, safety, or well-being of domiciliary residents and cannot be eased or removed.

One commenter asked VA to "grandfather in" (i.e., waive the requirements for) older facilities that have not needed to comply with environmental requirements of § 51.100 and 51.200 that have traditionally applied only to nursing homes, citing the high costs of making the needed upgrades. Because these provisions are essential to the health, safety, and well-being of domiciliary residents, we will not waive the requirements for older facilities. We make no changes based on this comment.

VA received a comment that imposing the nursing home fire safety standards of § 51.200 would "drive many homes out of business," saying State homes would have to reconsider providing domiciliary care altogether and perhaps provide only nursing home care.

We agree that some of the fire safety rules that apply to nursing home care programs are inappropriate for domiciliary care programs, because of the differences in

the services they provide. Specifically, we will not require State home domiciliary care programs to meet NFPA 99, Health Care Facilities Code, as § 51.200(a) requires of State nursing home programs. We are, therefore, changing proposed § 51.350 by adding a new paragraph (c) that only requires State home domiciliaries to meet the "applicable" requirements of NFPA 101. We have changed the introduction to § 51.350 to exclude § 51.200(a) from application to domiciliaries.

We have also determined it would be inappropriate to apply the nursing home emergency power requirements of NFPA 99 to domiciliary facilities. NFPA 99 prescribes emergency generator specifications for nursing homes. It is not necessary or appropriate to require State home domiciliaries to have emergency power generating equipment that meets the NFPA 99 specifications of the sort appropriate to nursing homes and specified in § 51.200(b). The applicable provisions of NFPA 101 regarding emergency power will apply instead under § 51.350(c). We have thus changed the introduction to § 51.350 to exclude § 51.200(b) from application to domiciliaries.

General Concerns Regarding Domiciliary Regulations

One commenter, observing the proposed rule appeared to require a level of care for domiciliary residents that mirrors nursing home care, suggested it would have been beneficial to review assisted living regulations across the country because most State home domiciliaries are also licensed by their state's assisted living regulatory licensure and compliance.

We disagree about the benefit of reviewing State assisted living regulations. State assisted living regulations are not pertinent to VA's program of payment of per

diem for veterans in State home domiciliary care programs. VA does not pay for assisted living. Veterans residing in a State home must meet the eligibility criteria either for a nursing home care program or for a domiciliary care program. The State home must meet VA's standards for receipt of per diem for those veterans. Moreover, VA must administer a nation-wide program. Consequently, we choose to have regulations of uniform, nation-wide application. These may be like some State assisted living regulations and unlike others, but State assisted living regulations are not an appropriate model for VA per diem regulations. We make no change based on this comment.

VA received a comment reporting grievances about conditions at State home domiciliary programs and asking VA to apply all of the regulations governing per diem payments to State home nursing home care programs to State home domiciliary care programs. The commenter urged VA to afford domiciliary care program residents the same care provided nursing home residents. The commenter requested that VA effect that change by issuing a VA General Counsel opinion. The commenter argued for immediate implementation of this opinion as a "regulatory instrument" until VA publishes domiciliary per diem regulations. Specifically, the commenter recommended as the "holding" of the opinion, "[I]n order for a State to receive per diem payments from the VA for a resident in its State home domiciliary, the home must provide domiciliary care to the resident (or residents) in accordance with 38 CFR 51, the current VA regulation outlining long-term care of veterans in state nursing homes." The commenter requested specific VA officers implement the suggested General Counsel opinion.

Another commenter reported that a specific State home conducts residents' room inspections, threatens sanctions for [resident] non-compliance with the State home rules, schedules re-inspections, and then fails to follow through. The commenter stated this lack of follow through "leaves us dangling," and demonstrates the "ad hoc" management of the State home.

Another commenter expressed grievances about a State's administration of a State home, including concerns that the domiciliary housed veterans unable or unwilling to meet the personal hygiene requirements for residency, allegations of failure to maintain the facility, allegations of failure to spend VA per diem payments on or on behalf of the residents, or of diverting the funds into the State's general fund. The commenter requested VA to regulate specific oversight, staffing, financial accounting, and expenditure requirements. Specifically, the commenter requested a regulation requiring "all monies that the VA gives to the States for these Homes be placed in a separate account that can only be used for the Home."

We decline to add a regulation to implement the suggestion regarding dedicated accounts. VA monitors each State home's census and its expenditures on nursing home, domiciliary, and adult day health care services. The State home must report the census of each program and submit a claim for per diem payments monthly on VA Form 10-5588. See § 51.42 of this rulemaking. By statute, VA "shall have no authority over the management or control of any State home." 38 U.S.C. 1742(b). We believe establishing the regulation the commenter seeks would constitute management or control of State homes, contrary to the statute, and would violate that law. We make no change based on this comment.

Regarding the commenters' grievances relating to specific State homes, VA takes reports of grievances from residents of State home domiciliaries seriously; however, VA is unable to adjudicate the grievances in this rulemaking. The commenters are encouraged to voice their grievances directly with the State homes, which are better able to address such grievances. We note that § 51.300 now makes the nursing home standards regarding grievances applicable to State domiciliary care programs and these standards include the resident's right to voice grievances and have the facility implement prompt efforts to resolve these grievances. We further note that State homes must satisfy these standards to receive per diem. Again, specific allegations are best raised directly with the State home. VA therefore makes no changes based on this comment.

Regarding application of all of the State home nursing home program regulations to State home domiciliary care programs, we decline to do so for the reasons previously stated in this preamble. To briefly reiterate, many nursing home regulations would provide little benefit to domiciliary residents, or even be a detrimental burden, while imposing excessive operational constraints and costs on the States. This rulemaking, however, applies to the domiciliary care programs those nursing care program regulations necessary to the health, safety, and well-being of domiciliary residents. See, for example, the discussion of § 51.300, above. VA therefore makes no changes based on this comment.

We decline to implement the request the commenter submitted in the form of a suggested VA General Counsel opinion the commenter authored seeking to have the Secretary of Veterans Affairs assign certain named VA officers to implement the

requested changes. The Secretary's statutory authority includes delegation of certain authority to certain subordinate VA officers, but direct assignment of responsibilities to specific VA officers is beyond the scope of this rulemaking. VA therefore makes no changes based on this comment.

VA received comments recommending that part 51 "further define the sovereign powers of the Resident Councils." The commenter proposed the creation of a National Association of State Veterans Homes Domiciliary Residents' Councils under the auspices of VA Geriatric and Extended Care Services. The commenter provided some details as to how the relationship should be between council members, residents and a VA liaison. The commenter also requested that VA provide whistleblower protections for State home residents who report unethical, illegal, or criminal conduct by a State home or VA employee or office, so that State homes cannot evict residents for speaking up.

Although we decline to make the specific changes this commenter requested, this rulemaking does implement protections for State home domiciliary residents that formerly applied only to nursing home residents. Section 51.300 requires domiciliaries to apply the provisions of §§ 51.70 and 51.100 not otherwise excluded from § 51.300. Among these are § 51.70(b)(6)(ii) requiring the State home to notify residents of the right to file complaints; § 51.70(j)(1)(iv) guaranteeing access to the State long term care ombudsman; § 51.100(c) requiring the State home to document any concerns the resident council submits; and § 51.100(d)(6) requiring the State home to listen to the views of any resident or family group, including the resident council, regarding policy and operations decisions affecting resident care and life in the facility. State home

domiciliary residents thus will now have recourse for redress of grievances. We therefore make no change based on this comment.

Subpart F - Standards applicable to the payment of per diem for Adult Day Health Care Adult Day Health Care

51.410 Transfer and discharge.

We have clarified the language of proposed § 51.410(b), which provides the residents' right to be informed about the possible reasons for a transfer or discharge from the program. We make no substantive changes.

We have changed the proposed heading of paragraph (c) to read, "Notice before transfer or discharge.", to be more descriptive of the text of the paragraph.

VA received comments asking to revise paragraph (c)(1), which requires the State home to notify the participant or his or her legal representative prior to a transfer or discharge. The commenters wanted "or" in the first sentence to be revised to "and/or". VA believes that the intent of this recommendation is to allow the State homes to notify, or ensure the State homes notify, both participants and their legal representatives. In fact, the requirement to notify the participant or the representative does not preclude the State home from notifying both if that is the participant's choice. The "and" alternative of "and/or" would, however, permit the provision to be read as requiring notice to the participant "and" to the representative. We intend to afford the participant control of whether the State home notifies a legal representative, a family member, or both. On further review, we see that as written, "Notify the participant or the

legal representative of the participant," could permit the State home to notify someone other than the participant and not notify the participant. To make clear the participant's right to decide who besides the participant the State home notifies of a transfer or discharge, we are revising § 51.410(c)(1) to read as does the revision to the domiciliary notice of transfer or discharge provision, discussed above. As revised, paragraph (c)(1) reads, "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.".

VA received a comment requesting changes to § 51.410(e)(5), which as proposed read, "The name, address and telephone number of the State long-term care ombudsman." The commenter stated the Older Americans Act Ombudsman program did not apply to adult day health care programs and recommended paragraph (e)(5) be revised as follows: "The name address and telephone number of the State home's State Department of Health and/or the appropriate State Department of Social Services representative."

The commenter raised the prospect that a State might not have an ombudsman who advocates for participants in a State home adult day health care program. The proposed requirement derives from § 52.70(h)(1)(iii), which requires State home program management to provide the State long-term care ombudsman with immediate access to participants. The object of proposed § 51.410(e)(5) was to ensure the notice of transfer or discharge includes information how to seek help if the participant objects to the transfer or discharge. We are changing § 51.410(e)(5) to address the possibility

that a State does not have a long-term care ombudsman or any ombudsman responsive to State home adult day health care participants. We decline to use the "and/or" construction the commenter suggested, because it would permit the State to provide the contact information only for an impersonal state agency possibly difficult to navigate instead of providing the contact information of an ombudsman or other known advocate. We acknowledge, however, that the proposed requirement could be insufficient. We are changing paragraph (e)(5) by adding "the first listed of the following that exists in the State:" following "The name, address and telephone number of". We are further revising the paragraph by adding after the paragraph (e) introductory language, the following: "(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." We intend the order of precedence and other changes to afford the participants the intended protection, with little additional burden to the State homes. These changes are a logical outgrowth of the comment.

We have removed from proposed paragraph (g)(1) the phrase ", and ensured of timely admission to the hospital". We have also changed "and" to "or" in both instances of the phrase "transfer and discharge." The State home will transfer "or" discharge a participant, as circumstances require. There is no action called "transfer and discharge." As revised, the paragraph reads, "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". Neither VA nor the State home can ensure timely admission to a hospital; timeliness of admission is

beyond VA and the State home's control. In practice, a transfer or discharge to a hospital will result in admission, observation, or other action according to the participant's medical condition and the usual medical and business practice of the hospital.

51.420 Quality of life

VA received comments objecting to the storage requirement of § 51.420(g)(3), saying that in the State homes' experience, adult day health care participants need lockable storage on a very limited basis because they do not live at the State home. They recommended the participants be made aware that lockable storage is available, and that the homes provide it upon request. They suggested a locked closet with individual storage bins would be sufficient to secure a participant's change of clothes, and that the State home should also provide a coat closet for daily storage of coats, etc.

We agree that the proposed individually lockable storage is not necessary in the adult day health care setting. We proposed that each private storage space be lockable to afford security for wallets, purses, and the like, and we agree the availability of locked storage for those who wish to use it is sufficient. Accordingly, we have changed § 51.420(g)(3) to read, "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."

51.425 Physician orders and participant medical assessment

As proposed, this section provided for two types of assessments, and as a result of the comments we received we have changed the names of these assessments in the final rule for clarity and to distinguish the initial medical assessment to determine that the veteran is suitable for and well enough to participate in the program and the subsequent assessment done to inform the comprehensive care plan. The assessment that was proposed in paragraph (a) is now called the "initial medical assessment" and the assessment in § 51.425(b) is now called the "comprehensive assessment" throughout the paragraph.

VA received comments that the requirement of § 51.425(a) for new adult day health care participants to have tuberculosis (TB) screening no sooner than 30 days before admission to the program would be an undue hardship on the participant or the participant's care giver because screening can take multiple doctor's office visits. The commenters, referencing an unpublished report of the Centers for Disease Control and Prevention, acknowledged that "elderly nursing home residents are at greater risk for [TB] than elderly persons living in the community." They noted current VA practice is to allow TB screening upon admission. The commenters requested VA also allow the TB screening to be performed at the adult day health care program no later than 30 days after admission, which would reduce care-giver burden and facilitate admission by eliminating a potential cause of delay.

We agree that allowing the TB screening to be performed after admission to the adult day healthcare program could reduce the veteran and caregiver's burden and facilitate admission. We disagree, however, that 30 days after admission is an appropriate timeframe to complete screening because of the increased risk of TB

among the participant population that the commenter identified. We also believe it is unsafe to have a participant in the program any longer than that with his or her medical history and current condition unknown. To allow more flexibility than the proposed rule allowed, while also requiring the history and physical examination with TB testing be done expeditiously, we have changed § 51.425(a) to allow them to be done no later than 7 calendar days after admission.

VA received comments regarding proposed § 51.425(b), which describes the State home adult day health care program's responsibility to conduct comprehensive assessments for each participant, and lists factors the program should consider in each assessment. The commenters recommended that instead of the assessment guidelines in this regulation, VA should allow each State with an established adult day health care program assessment tool to use it, and that States without assessment tools should work with a select group of members of the National Association of State Veterans Homes to develop an assessment tool to adopt as a national standard and submit to VA as an alternative. The commenters noted that the existing regulation requires each adult day health care program use the MDS-HC assessment tool, even though it is not an "industry standard" among adult day healthcare programs, and creating a new tool would solve the existing problem of the lack of a nationally recognized assessment tool and better serve the programs and veterans.

As with the assessments for domiciliary care programs, VA will not change the regulation to explicitly allow State home adult day health care programs to use State-mandated assessment tools, though the homes may do so if those tools meet the requirements in paragraph § 51.425(b). While we appreciate the offer to collaborate on

a national tool, we believe that § 51.425(b) provides the States with necessary flexibility to create policies to meet their state's regulatory requirements or their program's needs, while ensuring the health and well-being of participants. We have added an introduction requiring the State home to establish in a written policy how it will complete, implement, review, and revise assessments. In addition to affording the State homes flexibility in devising their methods of assessment, the introduction helps to distinguish between the initial medical assessment and the subsequent comprehensive assessment.

VA received comments recommending that programs should make every effort to coordinate the participant's comprehensive care plan with any existing VA or community provider's comprehensive care plans, as appropriate. The commenters noted many participants seek admission to the State home adult day health care program without prior use of VA services, and often prefer and plan to continue to use their community physician for primary care. Because the State home is ultimately responsible for the care and services provided to each participant, the commenters said they should develop a comprehensive care plan that includes the recommendations of other agencies, including VA.

We agree with these comments. We believe it is consistent with the State home's responsibility to develop the comprehensive care plan that those plans include the recommendations of others providing care to the participant. We believe § 51.425 allows the State home to include the use or adaptation of existing care plans in its assessment and comprehensive care plan policy. We make no change based on this comment.

Based on the comments regarding § 51.425(b) pointing out that some participants enter State home adult day health care programs without a current care plan, we are removing the requirement from proposed § 51.425(b) that the participant have an individualized comprehensive care plan on "the participant's first visit" because the requirement is unnecessarily burdensome. Instead, we are requiring that the State home complete the comprehensive assessment no later than 14 calendar days after admission.

Consistent with the comment that residents might not have a comprehensive care plan upon admission, we are revising proposed paragraph (d) to allow up to 21 calendar days after admission for the State to write a comprehensive care plan for each participant.

We changed certain word choices and phrasing in paragraph (c), but none has substantive effect. We pluralized the word "assessment" in the section heading, and rephrased the first sentence of paragraph (c)(1) to clarify that the assessments must be both conducted and coordinated with the appropriate health care professionals. We changed "the assessment" to "an assessment" in (c)(2) to ensure all assessments are certified. We added (c)(3), "The results of the assessments must be used to develop, review, and revise the participant's individualized comprehensive care plan." This provision makes clear the ongoing relationships among the participant's assessments, changing condition, and comprehensive care plan.

51.430 Quality of care

We are making technical corrections to proposed paragraph (a)(2) of this section. We are removing ", review, and prevent" from the paragraph heading to more accurately state the topic of the paragraph. As proposed, the heading "Duty to report, review, and prevent sentinel events" commingled the topics of paragraphs (a)(2) and (a)(3). We are also striking from § 51.430(a)(2) the phrase ", review, and prevent", because § 51.430(a)(2) is solely a notice provision, as is § 51.120(a)(3) from which it derives. We are also removing the reference to § 51.120(a)(4) from proposed § 51.430(a)(2) because § 51.120(a)(4) is the review, analysis, and prevention provision applicable to nursing homes. The mandate to review, analyze and prevent sentinel events in adult day health care programs derives from § 52.120(a)(4) and is restated in proposed § 51.430(a)(3). Additionally, § 51.120(a)(4) has a final sentence we did not intend to apply to § 51.430(a)(3). We referred to § 51.120(a)(4) in proposed § 51.430 erroneously.

51.440 Dietary services

We have changed the second sentence of proposed § 51.440 so the references in § 51.140 to "resident" apply to a participant "in subpart F." This clarifies the scope of the application of § 51.140 to the adult day health care program. Because of the other changes we are making to this section, discussed below, the text proposed as § 51.440 is now the introductory paragraph of the section.

To make the per diem regulations more concise and to eliminate repetition between current parts 51 and 52 of title 38 Code of Federal Regulations, we proposed that § 51.440 would apply the nursing home dietary service provisions of current

§ 51.140 to the adult day health care program. That was partly a mistake. The proposal inadvertently applied nursing home requirements for frequency of meals under § 51.140(f) that would be inapplicable to adult day health care programs. For example, the nursing home bedtime snack requirements have no application to a daytime only program. To correct this error, we have revised the introduction of § 51.440 to exclude application of § 51.140(f), and added the mealtime requirements of current § 52.140(e)(1) and (2) as paragraphs (a) and (b). These requirements are essential to ensure every adult day health care participant receives at least minimal nourishment during each session. Adding these requirements imposes no new burden on the State homes. They merely continue the current timing and nutritional requirements of the adult day health care program without change.

51.445 Physician Services

We are revising the introduction of § 51.445. The proposed language mistakenly refers to a physician's order for enrollment, but physicians don't write orders to enroll participants in the adult day health care program; they write orders to admit participants. We have corrected this error in terminology. We have also revised the next to last sentence to be more readable. As revised, the sentence reads, "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."

VA received comments recommending that VA require all State home adult day health care programs undertake certain practices such as: recording the name of the

participant's primary care physician in his or her medical record; requiring that each participant see a primary care physician annually and when there is a change in condition; providing or arranging for acute care when a resident needs it; and ensuring participants are able to obtain emergency care when necessary. The commenters believed these practices should not be restricted only to adult day health care programs that offer medical supervision.

We agree with the first of these recommendations. As proposed, the provision requiring the State home to record the name of each participant's primary care physician is in paragraph (a) of this section, which applies specifically to programs that offer medical supervision. To apply it to all adult day health care program participants, we have moved the requirement from proposed paragraph (a)(2) to the introductory paragraph of this regulation in the final rule, where it applies to the entire section. We redesignated proposed paragraph (a)(3) as (a)(2).

We decline to require that each participant who is in a program that does not offer medical supervision see a primary care physician annually, because such a requirement is unnecessary for all adult day health care programs. We make no change based on this comment.

We decline to require programs that do not offer medical supervision to provide for acute care. State homes may choose to make acute care available, but those services are not by design the intent of social model programs. We make no change based on this comment.

Regarding the final recommendation, proposed paragraph (d), Availability of physicians for emergency care, does require that the management of all adult day

health care programs “must ensure that participants are able to obtain necessary emergency care,” and the paragraph applies to all adult day health care programs. As with domiciliaries, the State home can meet the requirement by calling 911 emergency services on behalf of the participant. The State home may provide physicians for emergency care, but VA will not require it. We make no change based on this comment.

51.455 Dental Services

For clarity, we have inserted the word “dental” into paragraph § 4.455(a)(1) as proposed to read, “In making dental appointments; and”.

51.470 Physical environment

We have changed § 51.470(a), Life safety from fire, to read, “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.” We determined that the proposed language was confusing regarding which NFPA codes applied to State home adult day health care programs. This change is for clarity only.

VA received comments agreeing with the space requirements proposed in §51.470(b), but only for adult day health care programs with medical supervision. They suggested less space be required for programs that do not provide intensive medical services. Specifically, they suggested at least 70 square feet per participant, including office space for staff, as opposed to the 100 square feet required in the proposed rule; and 40 square feet per participant, excluding office space for staff, as opposed to the 60

square feet required in the proposed rule. They said programs that do not provide intensive medical services do not require the same space as those that do, because they do not provide rehabilitative services or require the same specialized equipment as medical model programs.

The space requirements in proposed § 51.470(b)(3) are the same as the ones in current § 52.200(b)(3). Moreover, they are the same standards VA imposes on VA adult day health care facilities. Likewise, we specify these space allotments in the standards for funding VA construction grants. See 38 CFR part 59. We specify these space allotments because we consider them essential to the health, safety, and well-being of the participants. We make no changes based on this comment.

51.480 Transportation

We received comments requesting that VA provide transportation reimbursement to State homes that provide their residents transportation to a VA medical center for medical care, noting VA reimburses veterans for mileage when traveling to and from a VA medical facility for medical services.

The commenter is correct that VA reimburses veterans for their travel expenses through the Beneficiary Travel program. Veteran residents of a State home may be eligible for Beneficiary Travel depending on the purpose of the travel and other factors. Similarly, VA may make a beneficiary travel payment to a person or organization other than the beneficiary when certain factors are met. 38 CFR 70.2 and 70.20 (defining "claimant" for beneficiary travel payments and explaining the application for payment

process). This is addressed more fully in 38 CFR part 70. We make no change based on this comment.

Other Issues

One commenter commented on VA's definition of "State" in proposed § 51.2. The commenter said that a judicial decision requires the terms "state" and "federal" be interpreted to encompass any medical care a veteran obtains under the Affordable Care Act anywhere in the world. King v. Burwell, 576 U.S. ____ (2015). By this interpretation, the commenter argued, VA must pay per diem to any veteran wherever in the world the veteran resides. The commenter advised VA to allow Congress to draft the per diem regulations to determine VA's logistical, financial, and fiduciary responsibilities.

VA was not a party to King v. Burwell, 576 U.S. ____ (2015), and nothing it decided is binding on VA's payment of per diem to State homes. By law, VA cannot delegate the task of writing regulations for the State home program to Congress. In fact, Congress has directed VA to prescribe regulations which are necessary and appropriate to carry out laws administered by VA which would include the laws governing the payment of state home per diem and standards for State programs receiving such payments. 38 U.S.C. 501. We make no changes in response to this comment.

VA received a comment suggesting we revise the subject heading of this rulemaking to read, "Per Diem for Nursing Home, Domiciliary, or Adult Day Health Care of Veterans in State Homes." The commenter recommended this rulemaking keep the organization and scope of the proposed rule in several respects. Specifically, that

subpart D continues to provide regulations for nursing home care programs and part E for domiciliary care programs.

We decline to change the name of the final rule as the current name adequately describes the content of the rule, and we are keeping the subpart headings and their topics as proposed. We make no change in response to this comment.

The commenter commented that VA should require each State home to employ a regulatory compliance officer who will be a VA employee who resides in the State home to insure the home's compliance with all VA regulations.

VA uses regular surveys of the State homes to ensure compliance with VA regulations governing VA payment of per diem. VA lacks authority to place VA employees on a State home's staff, and adopting this recommendation would blur the line between VA and the State home's independent management. We make no change based on this comment.

In a related comment, another commenter asserted this rulemaking as proposed

> fails to establish a firm and effective system of legal enforcement by the VA of regulatory compliance and legislative oversight by State Veterans Homes (SVH) of VA Domiciliary Care Standards. A firm and effective VA regulatory enforcement mechanism must be established with respect to State Veterans Homes for the new VA regulation on VA-SVH Domiciliary Care Standards to have maximum positive force and effect.

The commenter recommended enforcing a more visible, professional and proactive role for the State Veterans Home [VISN] Liaison or for the SVH VA Medical Facility Representative as those positions were described in VHA Handbook 1145.01, Survey Procedures for State Veterans Homes (SVH) Providing Nursing Home Care and/or Adult Day Health Care (May 17, 2010). The commenter suggested adding

certain duties to those assigned VA officers, including prescribing that VA notify State home residents and resident councils of the existence of these liaison officers, and that those duties be enforced by legislative directives in this rulemaking. The commenter urged that this rulemaking require State Departments of Veterans Affairs to "a) promulgate state legislation that provides regulatory oversight of State Veterans Homes management, administration and operations; and b) promulgate state legislation that provides for the regulatory compliance by State Veterans Homes of VA Program Regulations."

VA cannot require States to legislate. We disagree about whether this rulemaking provides effective means to ensure compliance with these regulations. We believe the processes prescribed in this rulemaking provide an effective means of oversight and enforcement of compliance with these regulations. These include the surveys for recognition and subsequent certification, provisional certification if needed, and potentially denial of certification, together with the multiple standards the State home must meet to obtain recognition and certification under part 51. Further, we decline to revise the duties of the VA officers as any such consideration would be beyond the scope of this rulemaking.

The same commenter sought amendments of §§ 51.70 and 51.100, providing specific language. Specifically, the commenter sought amendments of § 51.70(a)(1), (a)(2), (b)(9)(ii), (f), (j)(1)(iv), (j)(3), and (m) (including extensive suggestions for creation and management of married quarters); § 51.100(c), (d), (f), and (i).

This comment is distinguishable from the others that addressed the proposed rule's application of §§ 51.70 and 51.100 to the domiciliary care program because it

seeks amendment of §§ 51.70 and 51.100. This rulemaking did not propose to amend those sections, and VA declines to make any such amendments in this final rulemaking, without providing an adequate period for notice and comment. We will consider these comments for possible future amendment of §§ 51.70 and 51.100. We make no changes here based on these comments.

VA received a comment saying that as a resident of a State home in a remote location, a requirement to provide accommodations for family members to stay on special occasions would be a great benefit to veterans with families, and even to those without, but who would remember the happiness of family life and enjoy the presence of families. Another commenter urged VA to require State homes to provide private family visitation space, reporting that family has not visited during the resident's 13 years of residence in a State home for lack of a private visitation room or space.

We appreciate the commenters' desire for State homes to facilitate family visits this way and certainly encourage State homes to do what they can to facilitate family visits. However, providing accommodations for visiting family could be a significant expense for State homes. We thus make no change based on this comment.

VA received a comment that State politics and corruption take precedence over State home residents' welfare. The commenter proposed creation of an oversight group to take legal action against misuse of Federal funds, lest the funds that States have earmarked for the care of Veterans disappear into other accounts in each state.

While we understand the commenter has concerns, the solution the commenter seeks is beyond the scope of this rulemaking. Consequently, we make no changes based on this comment.

One commenter asked that VA "coordinate the impact of the semantic differential between terms," i.e., define terms the same in Veterans Health Administration (VHA) regulations in 38 CFR part 51 and Veterans Benefits Administration (VBA) regulations in 38 CFR parts 3 and 4. The commenter asserted differences in the use or definition of the same or similar terms could affect how and to whom VBA awards special monthly compensation benefits or aid and attendance benefits under part 3, or temporary total disability evaluations under part 4. The commenter asserts VA regulations are unclear regarding whether a veteran's residency in a State home can qualify for special monthly compensation or pension rates that use nursing home care as a criterion of entitlement. The commenter also urged VA to apply 38 U.S.C. 1151, Benefits for persons disabled by treatment or vocational rehabilitation, to disability incurred in State homes receiving VA per diem payments. The commenter inquired of the significance of residence in a State home to a veteran's VA disability compensation or pension payments. The commenter asserted VA is creating additional burdens for states and confusion through lack of consistency and clarity throughout its regulations, like that resulting from conflict of laws regarding pensioners getting Medicaid-covered nursing home care.

The commenter raises points worthy of legal review and perhaps of rulemaking. It is beyond the scope of this rulemaking to harmonize definitions among parts 3, 4, and 51 of title 38, Code of Federal Regulations. The application of definitions in this rulemaking to claims for monetary benefits the VBA administers, including benefits under 38 U.S.C. 1151, and the effect of residency in a State home on any veteran's monetary benefits, are appropriately addressed in an individual claim to VBA for those benefits. They too are beyond the scope of this rulemaking. Whereas the commenter

has raised no issue regarding, or requested any change to, the proposed regulations that are within the scope of this rulemaking, we make no changes based on this comment.

Based on the rationale set forth in the supplementary information to the proposed rule and in the preceding discussion, VA is adopting the provisions of the proposed rule as final, with changes as noted.

Effect of Rulemaking

Title 38 of the Code of Federal Regulations, as revised by this final rule, represents VA's implementation of its legal authority on this subject. Other than future amendments to this regulation or governing statutes, no contrary guidance or procedures are authorized. All existing or subsequent VA guidance must be read to conform with this rulemaking if possible. If not possible, this rulemaking supersedes such guidance.

Paperwork Reduction Act

The Paperwork Reduction Act of 1995 (44 U.S.C. 3507) requires that VA consider the impact of paperwork and other information collection burdens imposed on the public. Under 44 U.S.C. 3507(a), an agency may not collect or sponsor the collection of information, nor may it impose an information collection requirement, unless it displays a currently valid Office of Management and Budget (OMB) control number. See also 5 CFR 1320.8(b)(3)(vi).

Although this action contains provisions constituting collections of information at 38 CFR §§ 51.20, 51.30, 51.31, 51.42, 51.210, 51.300, 51.310, 51.320, 51.350, 51.390, 51.400, 51.405, 51.410, 51.415, 51.420, 51.425, 51.430, 51.445, 51.460, and 51.475 under the provisions of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501-3521), no new or proposed revised collections of information are associated with this final rule. The information collection requirements for §§ 51.20, 51.30, 51.31, 51.42, 51.210, 51.300, 51.310, 51.320, 51.350, 51.390, 51.400, 51.405, 51.410, 51.415, 51.420, 51.425, 51.430, 51.445, 51.460, and 51.475 are currently approved by the Office of Management and Budget (OMB) and have been assigned OMB control number 2900-0160.

Section 51.42 also provides for information collection. The OMB currently approves this information collection under control number 2900-0091.

Regulatory Flexibility Act

The Secretary hereby certifies that this final rule will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act, 5 U.S.C. 601-612. This rule affects veterans, State homes, and pharmacies. The State homes that are subject to this rulemaking are State government entities under the control of State governments. All State homes are owned, operated, and managed by State governments or nonprofit organizations created by the State except for a small number that are operated by entities under contract with State governments. These contractors are not small entities. Also, this rulemaking will not have a consequential effect on any pharmacies that could be

considered small entities. Therefore, pursuant to 5 U.S.C. 605(b), this rulemaking is exempt from the final regulatory flexibility analysis requirements of sections 603 and 604.

Executive Orders 12866, 13563, and 13771

Executive Orders 12866 and 13563 direct agencies to assess the costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, and other advantages; distributive impacts; and equity). Executive Order 13563 (Improving Regulation and Regulatory Review) emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. Executive Order 12866 (Regulatory Planning and Review) defines a "significant regulatory action," requiring review by OMB, unless OMB waives such review, as "any regulatory action that is likely to result in a rule that may: (1) Have an annual effect on the economy of $100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities; (2) Create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) Materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) Raise novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in this Executive Order."

OMB has examined the economic, interagency, budgetary, legal, and policy implications of this regulatory action and it has been determined not to be a significant regulatory action under Executive Order 12866. VA's regulatory impact analysis can be found as a supporting document at http://www.regulations.gov, usually within 48 hours after the rulemaking document is published. Additionally, a copy of the rulemaking and its regulatory impact analysis are available on VA's Web site at http://www.va.gov/orpm/, by following the link for "VA Regulations Published From FY 2004 Through FYTD." This rule is not an EO 13771 regulatory action because this rule is not significant under EO 12866.

Unfunded Mandates

The Unfunded Mandates Reform Act of 1995 requires, at 2 U.S.C. 1532, that agencies prepare an assessment of anticipated costs and benefits before issuing any rule that may result in an expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $100 million or more (adjusted annually for inflation) in any one year. This final rule will have no such effect on State, local, and tribal governments, or on the private sector.

Catalog of Federal Domestic Assistance

The Catalog of Federal Domestic Assistance numbers and titles for the programs affected by this document are 64.005, Grants to States for Construction of State Home Facilities; 64.007, Blind Rehabilitation Centers; 64.008, Veterans Domiciliary Care; 64.009, Veterans Medical Care Benefits; 64.010, Veterans Nursing Home Care; 64.011,

Veterans Dental Care; 64.012, Veterans Prescription Service; 64.013, Veterans Prosthetic Appliances; 64.014, Veterans State Domiciliary Care; 64.015, Veterans State Nursing Home Care; 64.016, Veterans State Hospital Care; 64.018, Sharing Specialized Medical Resources; 64.019, Veterans Rehabilitation Alcohol and Drug Dependence; 64.022, Veterans Home Based Primary Care; 64.026, Veterans State Adult Day Health Care; and 64.053, Payments to States for Programs to Promote the Hiring and Retention of Nurses at State Veterans Homes.

List of Subjects in 38 CFR Parts 17, 51, and 52

Administrative practice and procedure, Claims, Day care, Dental health, Government contracts, Grant programs-health, Grant programs-veterans, Health care, Health facilities, Health professions, Health records, Mental health programs, Nursing homes, Reporting and recordkeeping requirements, Travel and transportation expenses, Veterans.

Signing Authority

The Secretary of Veterans Affairs approved this document and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication electronically as an official document of the Department of Veterans Affairs. Robert L. Wilkie, Secretary, Department of Veterans Affairs, approved this document on November 9, 2018, for publication.

Dated: November 13, 2018

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Consuela Benjamin
Regulations Development Coordinator
Office of Regulation Policy & Management
Office of the Secretary
Department of Veterans Affairs

For the reasons stated in the preamble and under the authority of 38 U.S.C. 1741-1743 and 38 U.S.C. 1745, the Department of Veterans Affairs is amending 38 CFR parts 17, 51, and 52 as follows:

PART 17 -- MEDICAL

1. The authority citation for part 17 continues to read as follows:

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

§§ 17.190—17.194 [Removed].

2. Remove the undesignated center heading "Aid to States for Care of Veterans in State Homes" and §§ 17.190 through 17.194.

§§ 17.196—17.200 [Removed]

3. Remove §§ 17.196 through 17.200.

PART 51 – PER DIEM FOR NURSING HOME, DOMICILIARY, OR ADULT DAY HEALTH CARE OF VETERANS IN STATE HOMES

4. The authority citation for part 51 is amended to read as follows:

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)

5. Revise the part heading as set forth above.

6. Revise subpart A, consisting of §§ 51.1 and 51.2, to read as follows:

Subpart A—General

Sec.

51.1 Purpose and scope of this part.
51.2 Definitions.

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.

§ 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.

7. Revise subpart B, consisting of §§ 51.20 and 51.30 through 51.32, to read as follows:

Subpart B—Obtaining Recognition and Certification for Per Diem Payments

Sec.

51.20 Recognition of a State home
51.30 Certification of a State home

51.31 Surveys for recognition and/or certification
51.32 Terminating recognition

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.)

§ 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)

§ 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)

§ 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.

8. Revise the heading for subpart C to read as follows:

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

* * * * *

9. Revise § 51.40 to read as follows:

§ 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.

10. Revise § 51.42 to read as follows:

<u>§ 51.42 Payment procedures</u>.

(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.)

11. Revise § 51.43 to read as follows:

§ 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.)

12. Revise § 51.50 to read as follows:

§ 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.

13. Add § 51.51 to read as follows:

§ 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.

14. Add § 51.52 to read as follows:

<u>§ 51.52 Eligible veterans—adult day health care</u>.

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)

15. Add § 51.58 to read as follows:

<u>§ 51.58 Requirements and Standards applicable for payment of per diem</u>.

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.

16. Revise § 51.59 to read as follows:

§ 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.

17. Revise the heading of subpart D to read as follows:

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

* * * * *

§ 51.120 [Amended]

18. Amend § 51.120 in paragraph (a)(3) by removing "Chief Consultant, Office of Geriatrics and Extended Care (114)" and adding in its place "Office of Geriatrics and Extended Care in VA Central Office".

§ 51.140 [Amended]

19. Amend § 51.140:

a. In paragraph (a)(2), by removing "American Dietetic Association" and adding in its place "Academy of Nutrition and Dietetics"; and

b. In paragraph (d)(4), by removing "who refuse food served".

20. Amend § 51.210:

a. In paragraph (b) introductory text, by removing "Chief Consultant, Office of Geriatrics and Extended Care (114)" and adding in its place "Office of Geriatrics and Extended Care"; and

b. Revising paragraph (b)(2), redesignating paragraph (b)(3) as (b)(4) and revising it, and adding new paragraph (b)(3) and paragraph (h)(3).

The revision and additions read as follows:

§ 51.210 Administration.

* * * * *

(b) * * *

(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.

* * * * *

(h) * * *

(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.

* * * * *

21. Add subpart E, consisting of §§ 51.300 through 51.390, to read as follows:

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

Sec.

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

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.

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.)

§ 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.)

§ 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.)

§ 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.

§ 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.

§ 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.)

§ 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.)

22. Add subpart F, consisting of §§ 51.400 through 51.480, to read as follows:

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

Sec.

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

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

§ 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.)

§ 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)

§ 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)

§ 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.

§ 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.)

§ 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.)

§ 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.)

§ 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.)

<u>§ 51.435 Nursing services</u>.

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.

§ 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.

§ 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)

§ 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.

§ 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.

§ 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)

§ 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.

§ 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 programs 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.

§ 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)

§ 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.

PART 52 – [REMOVED]

23. Remove part 52, consisting of §§ 52.1 through 52.220.

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