AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

(F) Hospice medication information specific to each patient.

(G) Hospice physician and attending physician (if any) orders specific to each patient.

(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.

(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at § 483.25.

(p) *Social worker*. Any facility with more than 120 beds must employ a qualified social worker on a full-time basis. A qualified social worker is:

(1) An individual with a minimum of a bachelor's degree in social work or a bachelor's degree in a human services field including, but not limited to, sociology, gerontology, special education, rehabilitation counseling, and psychology; and

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

(q) *Mandatory submission of staffing information based on payroll data in a uniform format*. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS.

(1) *Direct Care Staff*. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping).

(2) *Submission requirements*. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following:

(i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS);

(ii) Resident census data; and

(iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual).

(3) *Distinguishing employee from agency and contract staff*. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.

(4) *Data format*. The facility must submit direct care staffing information in the uniform format specified by CMS.

(5) *Submission schedule*. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly.

[56 FR 48877, Sept. 26, 1991, as amended at 56 FR 48918, Sept. 26, 1991; 57 FR 7136, Feb. 28, 1992; 57 FR 43925, Sept. 23, 1992; 59 FR 56237, Nov. 10, 1994; 63 FR 26311, May 12, 1998; 68 FR 55539, Sept. 26, 2003; 74 FR 40363, Aug. 11, 2009; 76 FR 9511, Feb. 18, 2011; 78 FR 16805, Mar. 19, 2013; 78 FR 38605, June 27, 2013; 80 FR 46477, Aug. 4, 2015; 81 FR 64032, Sept. 16, 2016. Redesignated and amended at 81 FR 68861, 68865, Oct. 4, 2016; 82 FR 32259, July 13, 2017; 84 FR 34735, July 18, 2019]

§ 483.73 Emergency preparedness.

The LTC facility must comply with all applicable Federal, State and local emergency preparedness requirements. The LTC facility must establish and maintain an emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:

(a) *Emergency plan.* The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following:

(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.

(2) Include strategies for addressing emergency events identified by the risk assessment.

(3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.

(4) Include a process for cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation.

(b) *Policies and procedures.* The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:

(1) The provision of subsistence needs for staff and residents, whether they evacuate or shelter in place, include, but are not limited to the following:

(i) Food, water, medical, and pharmaceutical supplies.

(ii) Alternate sources of energy to maintain—

(A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions;

(B) Emergency lighting;

(C) Fire detection, extinguishing, and alarm systems; and

(D) Sewage and waste disposal.

(2) A system to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the LTC facility must document the specific name and location of the receiving facility or other location.

(3) Safe evacuation from the LTC facility, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.

(4) A means to shelter in place for residents, staff, and volunteers who remain in the LTC facility.

(5) A system of medical documentation that preserves resident information, protects confidentiality of resident information, and secures and maintains the availability of records.

(6) The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency.

(7) The development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to LTC residents.

(8) The role of the LTC facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.

(c) *Communication plan.* The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:

(1) Names and contact information for the following:

(i) Staff.

(ii) Entities providing services under arrangement.

(iii) Residents' physicians.

(iv) Other LTC facilities.

(v) Volunteers.

(2) Contact information for the following:

(i) Federal, State, tribal, regional, or local emergency preparedness staff.

(ii) The State Licensing and Certification Agency.

(iii) The Office of the State Long-Term Care Ombudsman.

(iv) Other sources of assistance.

(3) Primary and alternate means for communicating with the following:

(i) LTC facility's staff.

(ii) Federal, State, tribal, regional, or local emergency management agencies.

(4) A method for sharing information and medical documentation for residents under the LTC facility's care, as necessary, with other health care providers to maintain the continuity of care.

(5) A means, in the event of an evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii).

(6) A means of providing information about the general condition and location of residents under the facility's care as permitted under 45 CFR 164.510(b)(4).

(7) A means of providing information about the LTC facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee.

(8) A method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives.

(d) *Training and testing.* The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.

(1) *Training program.* The LTC facility must do all of the following:

(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.

(ii) Provide emergency preparedness training at least annually.

(iii) Maintain documentation of the training.

(iv) Demonstrate staff knowledge of emergency procedures.

(2) *Testing.* The LTC facility must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following:

(i) Participate in an annual full-scale exercise that is community-based; or

(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.

(B) If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an additional annual exercise that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed.

(e) *Emergency and standby power systems.* The LTC facility must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.

(1) *Emergency generator location.* The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim

Amendments TIA 12–2, TIA 12–3, TIA 12–4, TIA 12–5, and TIA 12–6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12–1, TIA 12–2, TIA 12–3, and TIA 12–4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.

(2) *Emergency generator inspection and testing.* The LTC facility must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.

(3) *Emergency generator fuel.* LTC facilities that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.

(f) *Integrated healthcare systems.* If a LTC facility is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated emergency preparedness program, the LTC facility may choose to participate in the healthcare system's coordinated emergency preparedness program. If elected, the unified and integrated emergency preparedness program must do all of the following:

(1) Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program.

(2) Be developed and maintained in a manner that takes into account each separately certified facility's unique circumstances, patient populations, and services offered.

(3) Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance with the program.

(4) Include a unified and integrated emergency plan that meets the requirements of paragraphs (a)(2), (3), and (4) of this section. The unified and integrated emergency plan must also be based on and include—

(i) A documented community-based risk assessment, utilizing an all-hazards approach.

(ii) A documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach.

(5) Include integrated policies and procedures that meet the requirements set forth in paragraph (b) of this section, a coordinated communication plan and training and testing programs that meet the requirements of paragraphs (c) and (d) of this section, respectively.

(g) The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: *http://www.archives.gov/federal__register/code__of__federal__regulations/ibr__locations.html.* If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the FEDERAL REGISTER to announce the changes.

(1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, *www.nfpa.org*, 1.617.770.3000.

(i) NFPA 99, Health Care Facilities Code 2012 edition, issued August 11, 2011.

(ii) Technical interim amendment (TIA) 12–2 to NFPA 99, issued August 11, 2011.

(iii) TIA 12–3 to NFPA 99, issued August 9, 2012.

(iv) TIA 12–4 to NFPA 99, issued March 7, 2013.

(v) TIA 12–5 to NFPA 99, issued August 1, 2013.

(vi) TIA 12–6 to NFPA 99, issued March 3, 2014.

(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.

(viii) TIA 12–1 to NFPA 101, issued August 11, 2011.

(ix) TIA 12–2 to NFPA 101, issued October 30, 2012.

(x) TIA 12–3 to NFPA 101, issued October 22, 2013.

(xi) TIA 12–4 to NFPA 101, issued October 22, 2013.

(xii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.

(2) [Reserved]

[81 FR 64030, Sept. 16, 2016; 81 FR 80594, Nov. 16, 2016; 84 FR 51824, Sept. 30, 2019]

§ 483.75 Quality assurance and performance improvement.

(a) *Quality assurance and performance improvement (QAPI) program.* Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must—

(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities;

(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation;

(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and

(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request.

(b) *Program design and scope.* A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must:

(1) Address all systems of care and management practices;

(2) Include clinical care, quality of life, and resident choice;

(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF.

(4) Reflect the complexities, unique care, and services that the facility provides.

(c) *Program feedback, data systems and monitoring.* A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:

(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at § 483.70(e) and including how such information will be used to develop and monitor performance indicators.

(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

(d) *Program systematic analysis and systemic action.* (1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

(2) The facility will develop and implement policies addressing: