Quick Reference Guide for Domiciliary Standards

2025

Standard Reference	Surveyor Discipline
§ 51.40 Basic per diem rates	**Fiscal**
§ 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).	Fiscal
§ 51.43 Drugs and medicines for certain veterans	**Fiscal**
§ 51.43 (a) (1)-(2) Drugs and medicines for certain veterans. 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) Thes 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.	Fiscal
§ 51.43 (b) Drugs and medicines for certain veterans. 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).	Fiscal
§ 51.43 (d) Drugs and medicines for certain veterans. 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.	Fiscal
§ 51.43 (e) Drugs and medicines for certain veterans. 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.	Fiscal
§ 51.300 Resident rights and behavior; State home practices; quality of life.	**Clinical**
§ 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	Clinical

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.	
§ 51.300 (a) (1) Notice of rights and services – notification of changes. 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.	Clinical
§ 51.300 (a) (2) Notice of rights and services – notification of changes. 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).	Clinical
§ 51.300 (a) (3) Notice of rights and services – notification of changes. 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.	Clinical
§ 51.300 (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.	Clinical
§ 51.300 (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.	Clinical
§ 51.300 (d) (1)-(2) 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.	Clinical

(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.	
§ 51.300 (d) (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.	Clinical
§ 51.300 (d) (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.	Clinical
§ 51.300 (d) (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.	Clinical
§ 51.300 (d) (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.	Clinical
§ 51.300 (d) (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.	Clinical

§ 51.300 (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.	Clinical
§ 51.300 (f) (1) Resident activities. 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.	Clinical
§ 51.300 (f) (2) Resident activities. The activities program must be directed by a qualified coordinator.	Clinical
§ 51.300 (g) (1) Social services. 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	Clinical
§ 51.300 (g) (2) Social services. The State home must have a sufficient number of social workers to meet residents' needs.	Clinical
§ 51.300 (g) (3) Social services. 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.	Clinical
§ 51.300 (g) (4) Social services. The facility management must have sufficient support staff to meet patients' social services needs.	Clinical
§ 51.300 (g) (5) Social services. Facilities for social services must ensure privacy for interviews.	Clinical
§ 51.300 (h) (1) 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;	Clinical
§ 51.300 (h) (2) Environment. Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	Clinical
§ 51.300 (h) (3) Environment. Clean bed and bath linens that are in good condition; and	Clinical
§ 51.300 (h) (4) Environment. Private closet space in each resident's room, as specified in §51.200(d)(2)(iv).	Clinical
§51.70 Resident rights.	**Clinical/Fiscal**
§51.70 Resident rights.	Clinical

The resident has the right to a dignified existence, self determination, and communication with and access to persons and services inside and outside the facility. The facility management must protect and promote the rights of each resident, including each of the following rights:	
§ 51.70 (a) (1) – (5) Exercise of rights. (a) Exercise of rights. (1) The resident has a right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. (2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility management in exercising his or her rights. (3) The resident has the right to freedom from chemical or physical restraint. (4) In the case of a resident determined incompetent under the laws of a State by a court of jurisdiction, the rights of the resident are exercised by the person appointed under State law to act on the resident's behalf. (5) In the case of a resident who has not been determined incompetent by the State court, any legal surrogate designated in accordance with State law may exercise the resident's rights to the extent provided by State law.	Clinical
§ 51.70 (b) (1) – (2) Notice of rights and services. (1) The facility management must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. Such notification must be made prior to or upon admission and periodically during the resident's stay. (2) The resident or his or her legal representative has the right: (i) Upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and (ii) After receipt of his or her records for review, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and with 2 working days advance notice to the facility management.	Clinical
§ 51.70 (b) (3) – (6) Notice of rights and services. (3) The resident has the right to be fully informed in language that he or she can understand of his or her total health status; (4) The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (b)(7) of this section; and (5) The facility management must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services to be billed to the resident. (6) The facility management must furnish a written description of legal rights which includes: (i) A description of the manner of protecting personal funds, under paragraph (c) of this section; (ii) A statement that the resident may file a complaint with the State (agency) concerning resident abuse, neglect, misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.	Clinical
§ 51.70 (b) (7) – (8) Notice of rights and services. (7) The facility management must have written policies and procedures regarding advance directives (e.g., living wills) that include provisions to inform and provide written information to all residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. If an individual is incapacitated at the time of admission and is unable to receive information (due to the incapacitating conditions) or	Clinical

articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated individual or to a surrogate or other concerned persons in accordance with State law. The facility management is not relieved of its obligation to provide this information to the individual once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. (8) The facility management must inform each resident of the name and way of contacting the primary physician responsible for his or her care.	
§ 51.70 (c) (1) – (2) Protection of resident funds. (1) The resident has the right to manage his or her financial affairs, and the facility management may not require residents to deposit their personal funds with the facility. (2) Management of personal funds. Upon written authorization of a resident, the facility management must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3) through (c)(6) of this section.	Fiscal
§ 51.70 (c) (3) Deposit of funds. (i) Funds in excess of $100. The facility management must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) (ii) Funds less than $100. The facility management must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund.	Fiscal
§ 51.70 (c) (4) Accounting and records. The facility management must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (i) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (ii) The individual financial record must be available through quarterly statements and on request from the resident or his or her legal representative.	Fiscal
§ 51.70 (c) (5) Conveyance upon death. Upon the death of a resident with a personal fund deposited with the facility, the facility management must convey within 90 calendar days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate; or other appropriate individual or entity, if State law allows.	Fiscal
§ 51.70 (c) (6) Assurance of financial security. The facility management must purchase a surety bond, or otherwise provide assurance satisfactory to the Under Secretary for Health, to assure the security of all personal funds of residents deposited with the facility.	Fiscal
§ 51.70 (d) (1) – (2) Free choice. The resident has the right to— (1) Be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being; and	Clinical

(2) Unless determined incompetent or otherwise determined to be incapacitated under the laws of the State, participate in planning care and treatment or changes in care and treatment.	
§ 51.70 (e) (1) – (3) Privacy and confidentiality. The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. (1) Residents have a right to personal privacy in their accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups. This does not require the facility management to give a private room to each resident. (2) Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility; (3) The resident's right to refuse release of personal and clinical records does not apply when— (i) The resident is transferred to another health care institution; or (ii) Record release is required by law.	Clinical
§ 51.70 (f) (1) – (2) Grievances. A resident has the right to— (1) Voice grievances without discrimination or reprisal. Residents may voice grievances with respect to treatment received and not received; and (2) Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.	Clinical
§ 51.70 (g) (1) – (2) Examination of survey results. A resident has the right to— (1) Examine the results of the most recent VA survey with respect to the facility. The facility management must make the results available for examination in a place readily accessible to residents, and must post a notice of their availability; and (2) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.	Clinical
§ 51.70 (h) (2) Work. The resident has the right to— (2) Perform services for the facility, if he or she chooses, when— (i) The facility has documented the need or desire for work in the plan of care; (ii) The plan specifies the nature of the services performed and whether the services are voluntary or paid; (iii) Compensation for paid services is at or above prevailing rates; and (iv) The resident agrees to the work arrangement described in the plan of care.	Clinical
§ 51.70 (i) Mail. The resident must have the right to privacy in written communications, including the right to— Send and promptly receive mail that is unopened; and (2) Have access to stationery, postage, and writing implements at the resident's own expense.	Clinical
§ 51.70 (j) (1) – (2) Access and visitation rights. (1) The resident has the right and the facility management must provide immediate access to any resident by the following: (i) Any representative of the Under Secretary for Health; (ii) Any representative of the State;	Clinical

(iii) Physicians of the resident's choice (to provide care in the nursing home, physicians must meet the provisions of §51.210(j)); (iv) The State long term care ombudsman; (v) Immediate family or other relatives of the resident subject to the resident's right to deny or withdraw consent at any time; and (vi) Others who are visiting subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time. (2) The facility management must provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.	
§ 51.70 (j) (3) Access and visitation rights. The facility management must allow representatives of the State Ombudsman Program, described in paragraph (j)(1)(iv) of this section, to examine a resident's clinical records with the permission of the resident or the resident's legal representative, subject to State law.	Clinical
§ 51.70 (k) Telephone. The resident has the right to reasonable access to use a telephone where calls can be made without being overheard.	Clinical
§ 51.70 (l) Personal property. The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.	Clinical
§ 51.70 (n) Self-Administration of Drugs. An individual resident may self-administer drugs if the interdisciplinary team, as defined by § 51.110(e)(2)(ii), has determined that this practice is safe.	Clinical
§ 51.80 Admission, transfer and discharge rights.	**Clinical**
§ 51.80 (a) (1) 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.	Clinical
§ 51.80 (a) (3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (a)(2)(vi) of this section, the primary physician must document this in the resident's clinical record.	Clinical
§ 51.80 (a) (5) Timing of notice. (i) The notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged, except when specified in paragraph (a)(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 nursing home; (D) The resident's needs cannot be met in the nursing home;	Clinical
§ 51.80 (a) (6) Contents of the notice.	Clinical

The written notice specified in paragraph (a)(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.	
§ 51.80 (a) (7) Orientation for transfer or discharge. A facility management must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility	Clinical
§ 51.80 (c) Equal access to quality care. The facility management must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services for all individuals regardless of source of payment.	Clinical
§ 51.80 (d) Admissions policy. The facility management must not require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may require an individual who has legal access to a resident's income or resources available to pay for facility care to sign a contract to pay the facility from the resident's income or resources.	Clinical
§51.90 Resident behavior and facility practices.	**Clinical**
§ 51.90 (a) (1) – (4) Restraints. (1) The resident has a right to be free from any chemical or physical restraints imposed for purposes of discipline or convenience. When a restraint is applied or used, the purpose of the restraint is reviewed and is justified as a therapeutic intervention. (i) Chemical restraint is the inappropriate use of a sedating psychotropic drug to manage or control behavior. (ii) Physical restraint is any method of physically restricting a person's freedom of movement, physical activity or normal access to his or her body. Bed rails and vest restraints are examples of physical restraints. (2) The facility management uses a system to achieve a restraint-free environment. (3) The facility management collects data about the use of restraints. (4) When alternatives to the use of restraint are ineffective, a restraint must be safely and appropriately used.	Clinical
§ 51.90 (b) (1) – (5) Abuse. The resident has the right to be free from mental, physical, sexual, and verbal abuse or neglect, corporal punishment, and involuntary seclusion. (1) Mental abuse includes humiliation, harassment, and threats of punishment or deprivation. (2) Physical abuse includes hitting, slapping, pinching, or kicking. Also includes controlling behavior through corporal punishment. (3) Sexual abuse includes sexual harassment, sexual coercion, and sexual assault. (4) Neglect is any impaired quality of life for an individual because of the absence of minimal services or resources to meet basic needs. Includes withholding or inadequately providing food and hydration (without physician, resident, or surrogate approval), clothing, medical care, and good hygiene. May also include placing the individual in unsafe or unsupervised conditions.	Clinical

(5) Involuntary seclusion is a resident's separation from other residents or from the resident's room against his or her will or the will of his or her legal representative.	
§ 51.90 (c) (1) Staff treatment of residents. The facility management must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. (1) The facility management must: (i) Not employ individuals who— (A) Have been found guilty of abusing, neglecting, or mistreating individuals by a court of law; or (B) Have had a finding entered into an applicable State registry or with the applicable licensing authority concerning abuse, neglect, mistreatment of individuals or misappropriation of their property; and (ii) Report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.	Clinical
§ 51.90 (c) (2) Staff treatment of residents. The facility management must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures.	Clinical
§ 51.90 (c) (3) Staff treatment of residents. The facility management must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	Clinical
§ 51.90 (c) (4) Staff treatment of residents. The results of all investigations must be reported to the administrator or the designated representative and to other officials in accordance with State law within 5 working days of the incident, and appropriate corrective action must be taken if the alleged violation is verified.	Clinical
§ 51.100 Quality of life.	**Clinical**
§ 51.100 (a) Dignity. A facility management must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. (a) Dignity. The facility management must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	Clinical
§ 51.100 (b) Self-determination and participation. (b) Self-determination and participation. The resident 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 resident.	Clinical
§ 51.100 (c) Resident Council. The facility management must establish a council of residents that meet at least quarterly. The facility management must document any concerns submitted to the management of the facility by the council.	Clinical
§ 51.100 (d) Participation in resident and family groups. (1) A resident has the right to organize and participate in resident groups in the facility; (2) A resident's family has the right to meet in the facility with the families of other residents in the facility;	Clinical

(3) The facility management must provide the council and any resident or family group that exists with private space; (4) Staff or visitors may attend meetings at the group's invitation; (5) The facility management must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings; (6) The facility management must listen to the views of any resident or family group, including the council established under paragraph (c) of this section, and act upon the concerns of residents, families, and the council regarding policy and operational decisions affecting resident care and life in the facility	
§ 51.100 (e) Participation in other activities. A resident has the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility. The facility management must arrange for religious counseling by clergy of various faith groups.	Clinical
§ 51.100 (f) Accommodation of needs. A resident has the right to— (1) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered; and (2) Receive notice before the resident's room or roommate in the facility is changed.	Clinical
§ 51.100 (g) (1) Patient 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.	Clinical
§ 51.100 (i) (1) 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;	Clinical
§ 51.100 (i) (2) Environment. Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	Clinical
§ 51.100 (i) (3) Environment. Clean bed and bath linens that are in good condition;	Clinical
§ 51.100 (i) (4) Environment. Private closet space in each resident room, as specified in §51.200(d)(2)(iv) of this part;	Clinical
§ 51.310 Resident admission, assessment, care plan, and discharge.	**Clinical**
§ 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	Clinical
§ 51.310 (a) Admission orders and medical assessment.	Clinical

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.	
§ 51.310 (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.	Clinical
§ 51.310 (c) (1) Comprehensive care plans. 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.	Clinical
§ 51.310 (c) (2) Comprehensive care plans. 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 semiannually; and (iv) Revised promptly after a comprehensive assessment reveals a significant change in the resident's condition.	Clinical
§ 51.310 (c) (3) Comprehensive care plans. The services provided by the facility must	Clinical

(i) Meet professional standards of quality; and (ii) Be provided by qualified persons in accordance with each resident's written comprehensive care plan.	
§ 51.310 (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.	Clinical
§ 51.320 Quality of care.	**Clinical**
§ 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.	Clinical
§ 51.320 (a) (1)-(2) 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.	Clinical
§ 51.320 (a) (3) Reporting of sentinel events. 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.	Clinical
§ 51.320 (a) (4) Reporting 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 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.	Clinical
§ 51.320 (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	Clinical

(5) Talk or otherwise communicate.	
§ 51.320 (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.	Clinical
§ 51.320 (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.	Clinical
§ 51.320 (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.	Clinical
§ 51.320 (f) Nutrition. The State home must follow § 51.120(j) regarding nutrition in providing domiciliary care.	Clinical
§ 51.320 (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.	Clinical
§ 51.320 (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.	Clinical
§ 51.320 (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.	Clinical
§ 51.120 Quality of care.	**Clinical**
§ 51.120 (j) Nutrition. Based on a resident's comprehensive assessment, the facility management must ensure that a resident— (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when a nutritional deficiency is identified	Clinical
§ 51.120 (m) (1) Unnecessary drugs - (1) General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: (i) In excessive dose (including duplicate drug therapy); or	Clinical

(ii) For excessive duration; or (iii) Without adequate monitoring; or (iv) Without adequate indications for its use; or (v) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (vi) Any combinations of the reasons above.	
§ 51.120 (m) (2) Antipsychotic Drugs. Based on a comprehensive assessment of a resident, the facility management must ensure that— (i) Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and (ii) Residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	Clinical
§ 51.120 (n) Medication Errors The facility management must ensure that— (1) Medication errors are identified and reviewed on a timely basis; and (2) strategies for preventing medication errors and adverse reactions are implemented.	Clinical
§ 51.330 Nursing care	**Clinical**
§ 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.	Clinical
§ 51.340 Physician and other licensed medical practitioner services.	**Clinical**
§ 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:	Clinical
§ 51.340 (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.	Clinical
§ 51.340 (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.	Clinical
§ 51.340 (c) Visits. The primary care physician or other licensed medical practitioner, for each visit required by paragraph (d) of this section,	Clinical

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.	
§ 51.340 (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.	Clinical
§ 51.340 (e) Availability of emergency care. The State home must assist residents in obtaining emergency care.	Clinical
§ 51.350 Provision of certain specialized services and environmental requirements.	**Clinical/Life Safety**
§ 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.	Clinical and LSC
§ 51.350 (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.	Clinical
§ 51.350 (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.	Clinical
§ 51.350 (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.	LSC
§ 51.350 (d) Privacy. The facility must provide the means for visual privacy for each resident.	Clinical
§ 51.140 Dietary services.	**Clinical**
§ 51.140 Dietary services. The facility management must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.	Clinical
§ 51.140 (a) Staffing. (a) Staffing. The facility management must employ a qualified dietitian either full-time, part-time, or on a consultant basis. (1) If a dietitian is not employed, the facility management must designate a person to serve as the director of food service who receives at least a monthly scheduled consultation from a qualified dietitian.	Clinical

(2) A qualified dietitian is one who is qualified based upon registration by the Commission on Dietetic Registration of the Academy of Nutrition and Dietetics.	
§ 51.140 (b) Sufficient staff. The facility management must employ sufficient support personnel competent to carry out the functions of the dietary service.	Clinical
§ 51.140 (c) Menus and nutritional adequacy. Menus must— (1) Meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; (2) Be prepared in advance; and (3) Be followed.	Clinical
§ 51.140 (d) Food. Each resident receives and the facility provides— (1) Food prepared by methods that conserve nutritive value, flavor, and appearance; (2) Food that is palatable, attractive, and at the proper temperature; (3) Food prepared in a form designed to meet individual needs; and (4) Substitutes offered of similar nutritive value to residents.	Clinical
§ 51.140 (e) Therapeutic diets. Therapeutic diets must be prescribed by the primary care physician.	Clinical
§ 51.140 (f) Frequency of meals. (1) Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.	
§ 51.140 (g) Assistive devices. The facility management must provide special eating equipment and utensils for residents who need them.	Clinical
§ 51.140 (h) Sanitary conditions. The facility must: (1) Procure food from sources approved or considered satisfactory by Federal, State, or local authorities; (2) Store, prepare, distribute, and serve food under sanitary conditions; and (3) Dispose of garbage and refuse properly.	Clinical
§ 51.170 Dental services.	**Clinical**
§ 51.170 (a)-(c) Dental services. A facility must provide or obtain from an outside resource, in accordance with §51.210(h) of this part, routine and emergency dental services to meet the needs of each resident; (b) A facility may charge a resident an additional amount for routine and emergency dental services; and (c) A facility must, if necessary, assist the resident— (1) In making appointments; (2) By arranging for transportation to and from the dental services; and (3) Promptly refer residents with lost or damaged dentures to a dentist.	Clinical
§ 51.180 Pharmacy services.	**Clinical**

§ 51.180 (a) Procedures. The facility management must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §51.210(h) of this part. The facility management must have a system for disseminating drug information to medical and nursing staff. (a) Procedures. The facility management must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	Clinical
§ 51.180 (b) Service consultation. The facility management must employ or obtain the services of a pharmacist licensed in a State in which the facility is located or a VA pharmacist under VA contract who— (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	Clinical
§ 51.180 (d) Labeling of drugs and biologicals. Drugs and biologicals used in the facility management must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	Clinical
§ 51.180 (e) (1) Storage of drugs and biologicals. (1) In accordance with State and Federal laws, the facility management must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	Clinical
§ 51.180 (e) (2) Storage of drugs and biologicals. The facility management must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse.	Clinical
§ 51.190 Infection control.	**Clinical**
§ 51.190 (a) Infection control program. The facility management must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection control program. The facility management must establish an infection control program under which it— (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	Clinical
§ 51.190 (b) Preventing spread of infection. (1) When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility management must isolate the resident. (2) The facility management must prohibit employees with a communicable disease or infected skin lesions from engaging in any contact with residents or their environment that would transmit the disease. (3) The facility management must require staff to wash their hands after each direct resident contact for which hand	Clinical

washing is indicated by accepted professional practice.	
§ 51.190 (c) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	Clinical
§ 51.200 Physical environment.	**Life Safety**
§ 51.200 (c) (1) Space and equipment. Facility management must— (1) Provide sufficient space and equipment in dining, health services, recreation, and program areas to enable staff to provide residents with needed services as required by these standards and as identified in each resident's plan of care; and	LSC
§ 51.200 (c) (2) Space and equipment. (2) Maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.	LSC
§ 51.200 (d) (1) Resident rooms. Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents: (1) Bedrooms must— (i) Accommodate no more than four residents;	LSC
§ 51.200 (d) (2) Resident rooms. The facility management must provide each resident with— (i) A separate bed of proper size and height for the safety of the resident; (ii) A clean, comfortable mattress; (iii) Bedding appropriate to the weather and climate; and (iv) Functional furniture appropriate to the resident's needs, and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident.	LSC
§ 51.200 (e) Toilet facilities. Each resident room must be equipped with or located near toilet and bathing facilities. It is recommended that public toilet facilities be also located near the resident's dining and recreational areas.	LSC
§ 51.200 (g) Dining and resident activities. The facility management must provide one or more rooms designated for resident dining and activities. These rooms must— (1) Be well lighted; (2) Be well ventilated; (3) Be adequately furnished; and (4) Have sufficient space to accommodate all activities.	LSC
§ 51.200 (h) (1) Other environmental conditions. The facility management must provide a safe, functional, sanitary, and comfortable environment for the residents, staff and the public. The facility must— (1) Establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply;	LSC
§ 51.200 (h) (2) Other environmental conditions. Have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two;	LSC
§ 51.200 (h) (4) Other environmental conditions. Maintain an effective pest control program so that the facility is free of pests and rodents	LSC

§ 51.390 Administration.	Administrative
§ 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.	Admin
§ 51.210 Administration.	**Administrative**
§ 51.210 (a) Governing body. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident. (a) Governing body. (1) The State must have a governing body, or designated person functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and (2) The governing body or State official with oversight for the facility appoints the administrator who is— (i) Licensed by the State where licensing is required; and (ii) Responsible for operation and management of the facility.	Admin
§ 51.210 (b) Disclosure of State agency and individual responsible for oversight of facility. Disclosure of State agency and individual responsible for oversight of facility. The State must give written notice to the Office of Geriatrics and Extended Care, VA Headquarters, 810 Vermont Avenue, NW, Washington, DC 20420, at the time of the change, if any of the following change: (1) The State agency and individual responsible for oversight of a State home facility; (2) The State home administrator; (3) The director of nursing services (or other individual in charge of nursing services); and (4) The State employee responsible for oversight of the State home if a contractor operates the State home	Admin
§ 51.210 (c) (1) – (6) Required Information. The facility management must submit the following to the director of the VA medical center of jurisdiction as part of the application for recognition and thereafter as often as necessary to be current or as specified: (1) The copy of legal and administrative action establishing the State-operated facility (e.g., State laws); (2) Site plan of facility and surroundings; (3) Legal title, lease, or other document establishing right to occupy facility; (4) Organizational charts and the operational plan of the facility; (5) The number of the staff by category indicating full-time, part-time and minority designation (annual at time of survey); (6) The number of nursing home patients who are veterans and non-veterans, the number of veterans who are minorities and the number of non-veterans who are minorities (annual at time of survey);	Admin
§ 51.210 (c) (7) Required Information. Annual State Fire Marshall's report;	Admin or LSC
§ 51.210 (c) (8)-(11) Required Information. (8) Annual certification from the responsible State Agency showing compliance with Section 504 of the Rehabilitation Act of 1973 (Public Law 93-112) (VA Form 10-0143A, which is available at any VA medical center and at http://www.va.gov/vaforms); (9) Annual certification for Drug-Free Workplace Act of 1988 (VA Form 10-0143, which is available at any VA medical center	Admin

and at http://www.va.gov/vaforms); (10) Annual certification regarding lobbying in compliance with Public Law 101-121 (VA Form 10-0144, which is available at any VA medical center and at http://www.va.gov/vaforms); and (11) Annual certification of compliance with Title VI of the Civil Rights Act of 1964 as incorporated in Title 38 CFR 18.1-18.3 (VA Form 10-0144A, which is available at any VA medical center and at http://www.va.gov/vaforms).	
§ 51.210 (d) Percentage of Veterans. The percent of the facility residents eligible for VA nursing home care must be at least 75 percent veterans except that the veteran percentage need only be more than 50 percent if the facility was constructed or renovated solely with State funds. All non-veteran residents must be spouses of veterans, or parents any of whose children died while serving in the Armed Forces.	Admin
§ 51.210 (e) Management Contract Facility. If a facility is operated by an entity contracting with the State, the State must assign a State employee to monitor the operations of the facility on a full-time onsite basis.	Admin
§ 51.210 (f) Licensure. The facility and facility management must comply with applicable State and local licensure laws.	Admin
§ 51.210 (g) Staff qualifications. (1) The facility management must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. (2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws.	Admin
§ 51.210 (h) Use of outside resources. (1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility management must have that service furnished to residents by a person or agency outside the facility under a written agreement described in paragraph (h)(2) of this section. (2) Agreements pertaining to services furnished by outside resources must specify in writing that the facility management assumes responsibility for— (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and (ii) The timeliness of the services. (3) If a veteran requires health care that the State home is not required to provide under this part, the State home may assist the veteran in obtaining that care from sources outside the State home, including the Veterans Health Administration. If VA is contacted about providing such care, VA will determine the best option for obtaining the needed services and will notify the veteran or the authorized representative of the veteran.	Admin
§ 51.210 (i) Medical director. (1) The facility management must designate a primary care physician to serve as medical director. (2) The medical director is responsible for— (i) Participating in establishing policies, procedures, and guidelines to ensure adequate, comprehensive services; (ii) Directing and coordinating medical care in the facility; (iii) Helping to arrange for continuous physician coverage to handle medical emergencies; (iv) Reviewing the credentialing and privileging process;	Admin

(v) Participating in managing the environment by reviewing and evaluating incident reports or summaries of incident reports, identifying hazards to health and safety, and making recommendations to the administrator; and (vi) Monitoring employees' health status and advising the administrator on employee-health policies.	
§ 51.210 (j) Credentialing and Privileging. Credentialing is the process of obtaining, verifying, and assessing the qualifications of a health care practitioner, which may include physicians, podiatrists, dentists, psychologists, physician assistants, nurse practitioners, licensed nurses to provide patient care services in or for a health care organization. Privileging is the process whereby a specific scope and content of patient care services are authorized for a health care practitioner by the facility management, based on evaluation of the individual's credentials and performance. (1) The facility management must uniformly apply credentialing criteria to licensed practitioners applying to provide resident care or treatment under the facility's care. (2) The facility management must verify and uniformly apply the following core criteria: current licensure; current certification, if applicable, relevant education, training, and experience; current competence; and a statement that the individual is able to perform the services he or she is applying to provide. (3) The facility management must decide whether to authorize the independent practitioner to provide resident care or treatment, and each credentials file must indicate that these criteria are uniformly and individually applied. (4) The facility management must maintain documentation of current credentials for each licensed independent practitioner practicing within the facility. (5) When reappointing a licensed independent practitioner, the facility management must review the individual's record of experience. (6) The facility management systematically must assess whether individuals with clinical privileges act within the scope of privileges granted.	Admin
§ 51.210 (k) (1) – (2) Required training of nursing aides. (1) Nurse aide means any individual providing nursing or nursing-related services to residents in a facility who is not a licensed health professional, a registered dietitian, or a volunteer who provide such services without pay. (2) The facility management must not use any individual working in the facility as a nurse aide whether permanent or not unless: (i) That individual is competent to provide nursing and nursing related services; and (ii) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State.	Admin
§ 51.210 (k) (3) Registry verification. (3) Before allowing an individual to serve as a nurse aide, facility management must receive registry verification that the individual has met competency evaluation requirements unless the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.	Admin
§ 51.210 (k) (4) Multi-State registry verification.	Admin

(4) Multi-State registry verification. Before allowing an individual to serve as a nurse aide, facility management must seek information from every State registry established under HHS regulations at 42 CFR 483.156 which the facility believes will include information on the individual.	
§ 51.210 (k) (5) Required retraining. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.	Admin
§ 51.210 (k) (6) Regular in-service education. (6) Regular in-service education. The facility management must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must— (i) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; (ii) Address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and (iii) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired	Admin
§ 51.210 (l) Proficiency of Nurse aides. The facility management must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.	Admin
§ 51.210 (m) (1) Level B Requirement Laboratory services. (1) The facility management must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet all applicable certification standards, statutes, and regulations for laboratory services. (ii) If the facility provides blood bank and transfusion services, it must meet all applicable certification standards, statutes, and regulations. (iii) If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of services and meet certification standards, statutes, and regulations. (iv) The laboratory performing the testing must have a current, valid CLIA number (Clinical Laboratory Improvement Amendments of 1988). The facility management must provide VA surveyors with the CLIA number and a copy of the results of the last CLIA inspection. (v) Such services must be available to the resident seven days a week, 24 hours a day.	Admin
§ 51.210 (m) (2) Level B Requirement Laboratory services. The facility management must— (i) Provide or obtain laboratory services only when ordered by the primary physician; (ii) Promptly notify the primary physician of the findings; (iii) Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance; and	Admin

(iv) File in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory.	
§ 51.210 (n) (1) Radiology and other diagnostic services. (1) The facility management must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own diagnostic services, the services must meet all applicable certification standards, statutes, and regulations. (ii) If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services. The services must meet all applicable certification standards, statutes, and regulations. (iii) Radiologic and other diagnostic services must be available 24 hours a day, seven days a week.	Admin
§ 51.210 (n) (2) Radiology and other Diagnostic services The facility must— (i) Provide or obtain radiology and other diagnostic services when ordered by the primary physician; (ii) Promptly notify the primary physician of the findings; (iii) Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance; and (iv) File in the resident's clinical record signed and dated reports of x-ray and other diagnostic services.	Admin
§ 51.210 (o) (1) Clinical records. (1) The facility management must maintain clinical records on each resident in accordance with accepted professional standards and practices that are— (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized.	Admin
§ 51.210 (o) (2) Clinical records. Clinical records must be retained for— (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law.	Admin
§ 51.210 (o) (3) Clinical records. The facility management must safeguard clinical record information against loss, destruction, or unauthorized use;	Admin
§ 51.210 (o) (4) Clinical records. The facility management must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is required by— (i) Transfer to another health care institution; (ii) Law; (iii) Third party payment contract; (iv) The resident or; (v) The resident's authorized agent or representative.	Admin
§ 51.210 (o) (5) Clinical records.	Admin

The clinical record must contain— (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The plan of care and services provided; (iv) The results of any pre-admission screening conducted by the State; and (v) Progress notes.	
§ 51.210 (p) (1) Quality assessment and assurance. (1) Facility management must maintain a quality assessment and assurance committee consisting of— (i) The director of nursing services; (ii) A primary physician designated by the facility; and (iii) At least 3 other members of the facility's staff.	Admin
§ 51.210 (p) (2) Quality assessment and assurance. The quality assessment and assurance committee— (i) Meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develops and implements appropriate plans of action to correct identified quality deficiencies; and	Admin
§ 51.210 (p) (3) Quality assessment and assurance. Identified quality deficiencies are corrected within an established time period. (4) The VA Under Secretary for Health may not require disclosure of the records of such committee unless such disclosure is related to the compliance with requirements of this section.	Admin
§ 51.210 (q) (1) Disaster and emergency preparedness. (1) The facility management must have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents.	Admin or LSC
§ 51.210 (q) (2) Disaster and emergency preparedness. The facility management must train all employees in emergency procedures when they begin to work in the facility, periodically review the procedures with existing staff, and carry out unannounced staff drills using those procedures.	Admin or LSC
§ 51.210 (r) Transfer agreement. (1) The facility management must have in effect a written transfer agreement with one or more hospitals that reasonably assures that— (i) Residents will be transferred from the nursing home to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the primary physician; and (ii) Medical and other information needed for care and treatment of residents, and, when the transferring facility deems it appropriate, for determining whether such residents can be adequately cared for in a less expensive setting than either the nursing home or the hospital, will be exchanged between the institutions. (2) The facility is considered to have a transfer agreement in effect if the facility has an agreement with a hospital sufficiently close to the facility to make transfer feasible.	Admin
§ 51.210 (s) Compliance with Federal, State, and local laws and professional standards. The facility management must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing	Admin

services in such a facility. This includes the Single Audit Act of 1984 (Title 31, Section 7501 et seq.) and the Cash Management Improvement Acts of 1990 and 1992 (Public Laws 101-453 and 102-589, see 31 USC 3335, 3718, 3720A, 6501, 6503).	
§ 51.210 (t) Relationship to other Federal regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other Federal laws and regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, national origin, handicap, or age (38 CFR part 18); protection of human subjects of research (45 CFR part 46), section 504 of the Rehabilitation Act of 1993, Public Law 93-112; Drug-Free Workplace Act of 1988, 38 CFR part 48; section 319 of Public Law 101-121; Title VI of the Civil Rights Act of 1964, 38 CFR 18.1-18.3. Although these regulations are not in themselves considered requirements under this part, their violation may result in the termination or suspension of, or the refusal to grant or continue payment with Federal funds.	Admin
§ 51.210 (u) Intermingling. A building housing a facility recognized as a State home for providing nursing home care may only provide nursing home care in the areas of the building recognized as a State home for providing nursing home care.	Admin
§ 51.210 (v) VA Management of State Veterans Homes. Except as specifically provided by statute or regulations, VA employees have no authority regarding the management or control of State homes providing nursing home care.	Admin