



Guidance for Providers, Designers, and Authorities Having Jurisdiction on CMS Reform of Requirements for Long-Term Care Facilities

A Position Paper Responding to the October 2016 CMS Final Ruling

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March 27, 2018

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Purposes of This Document

On October 4, 2016, the Centers for Medicare & Medicaid Services (CMS) final rule on the “Reform of Requirements for Long-Term Care Facilities,” CMS-3260-F, was published in the *Federal Register*. This updated rule revises the requirements that long-term care (LTC) facilities must meet to participate in the Medicare and Medicaid reimbursement programs. Progressive phases for implementation were scheduled. Relevant effective dates for topics discussed in this paper have been cited; the three phases are as follows:

- Phase 1 regulations (became effective on 11/28/16)
- Phase 2 regulations (became effective on 11/28/17)
- Phase 3 regulations (will be effective 11/28/19)

Many of these revised regulations will significantly affect providers offering LTC residential care, presenting new challenges both financially and operationally. Of specific concern are the effects on renovation costs for existing spaces, permissible configurations of resident rooms based on the new requirements, and possible reductions in resident census caused by changes in the rules.

The primary purpose of this position paper is to provide guidance that can help LTC residential facility owners and operators, design professionals, and authorities having jurisdiction (AHJs) comply with the new rules for licensed nursing home settings. As well, the information provided can help designers understand how the CMS ruling will affect the physical environment and help AHJs understand why care providers must comply with the CMS ruling and how AHJs may be able to assist by providing waivers that make compliance possible.

Background

The Facility Guidelines Institute (FGI) is an independent, not-for-profit organization dedicated to developing guidance for the planning, design, and construction of hospitals, outpatient facilities, and residential health, care, and support facilities. FGI oversees regular four-year revisions of its *Guidelines for Design and Construction* documents, funds research, and offers other resources that can help facilitate the development of safe, effective built environments for residential health, care, and support facilities. FGI partners with numerous organizations and subject matter experts to help develop the *Guidelines* and other practical, evidence-informed publications.

The 2018 FGI *Guidelines for Design and Construction of Residential Health, Care, and Support Facilities* contains minimum requirements for program, space, risk assessment, physical environment, architectural detail, surface, built-in furnishing, and building system needs for the following facility types:

- Nursing homes
- Hospice facilities
- Assisted living facilities
- Independent living settings
- Settings for individuals with intellectual and/or developmental disabilities
- Long-term residential substance abuse treatment facilities
- Wellness centers
- Adult day care facilities
- Outpatient rehabilitation centers

CMS's Revised Rules and FGI *Guidelines* Affecting Long-Term Care Facilities

Since the FGI *Guidelines* includes minimum standards for long-term care nursing homes affected by the new rules promulgated by CMS, experts from the 2018 FGI Residential Document Group reviewed and analyzed the final rules for their effect on the *Guidelines* content and on compliance by LTC owners and care providers. The topics cited in the following pages are excerpts from the CMS ruling; included are a description of the challenge each requirement presents, a discussion of relevant FGI requirements, and proposed solutions to meeting the new CMS requirements.

Topic 1: New Annual Facility Assessment (§483.70(e))

Effective in Phase 2, 11/29/17

Challenge: Providing a consistent process for completing assessments for new and existing facilities

FGI Position: The FGI *Guidelines* requires completion of a physical space assessment prior to undertaking a renovation or new construction project. The Residential *Guidelines* defines relevant minimum requirements in sections 1.2-2 (Functional Program) and 1.2-3 (Resident Safety Risk Assessment). Use of the *Guidelines* to develop an annual facility assessment, where needed, is recommended.

Topic 2: We are requiring facilities that are constructed, re-constructed, or newly certified after the effective date of this regulation to accommodate no more than two residents in a bedroom. We are also requiring facilities that are constructed or newly certified after the effective date of this regulation to have a bathroom equipped with at least a commode and sink in each room. From Executive Summary of the CMS Ruling: Physical environment (§483.90)

Effective in Phase 1, 11/28/16

Challenges: (a) For comprehensive renovation of existing settings, a shared bathroom between a pair of single- or double-occupancy resident rooms is **no** longer compliant with CMS requirements for reimbursement.

(b) Definition of a single-occupancy room is one resident living in one room with a single entry. A single-occupancy room requires, at minimum, a bathroom with a commode and sink.

(c) Definition of a double-occupancy room is two residents living in one room with a single entry. A double-occupancy room requires, at minimum, a bathroom with a commode and sink.

FGI Position: The FGI Residential *Guidelines* specifies performance criteria for the design of both single- and double-occupancy resident rooms for new construction and major renovation. The following examples illustrate room layouts that are allowed by the CMS ruling and comply with the performance criteria in both the 2014 and 2018 FGI Residential *Guidelines*.

Based on the existing nursing home building stock, FGI and the Mayer-Rothschild Foundation asked CMS to clarify the definition of a single- versus a double-occupancy room. This request was made primarily because of a common existing layout in which two double-occupancy or single-occupancy resident rooms share a bathroom, as shown in Figure 1.

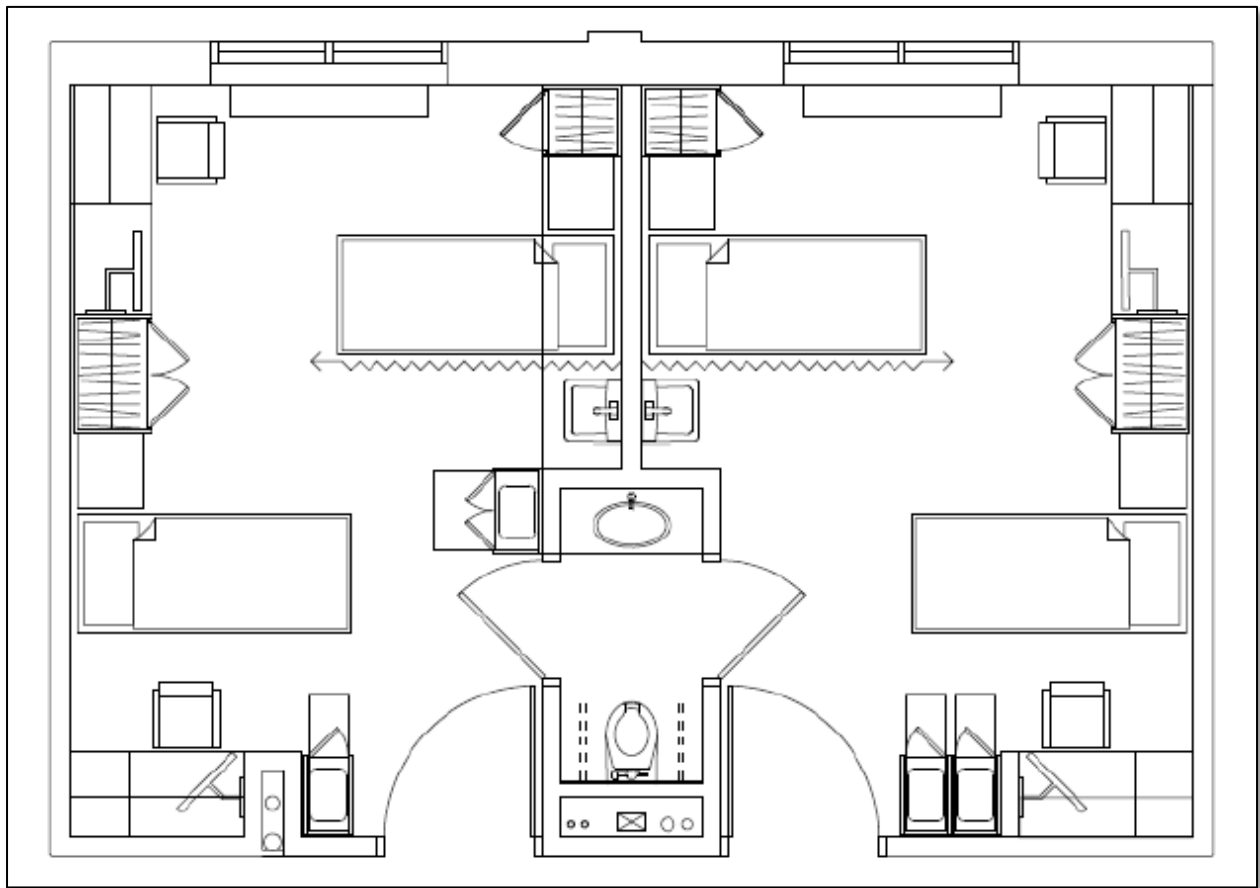


Figure 1: Example of a common existing room configuration with shared bathroom between two double-occupancy rooms **that is not compliant with CMS and not compliant with 2014 Guidelines requirements for new construction or with 2018 FGI Guidelines requirements.**

According to CMS, each room that has an entry door from a corridor is either a single-occupancy or double-occupancy room. Therefore, rooms located side by side with a door from the corridor into each room are considered separate rooms, and each room would require a minimum of a half bathroom with a commode and sink.

The configuration in Figure 1 also would not meet the 2014 or 2018 FGI *Guidelines* for new construction. Although FGI permits shared bathrooms between resident rooms, the *Guidelines*' performance requirements state that a double-occupancy room must provide access to a window, wardrobe, and bathroom without the resident needing to ambulate through another resident's living space.

If an existing pair of resident rooms had one entry with a shared bathroom, this configuration would comply with both the CMS ruling and the 2018 FGI *Guidelines*. For this layout to be acceptable, however, these adjacent rooms would have to be single-occupancy rather than double-occupancy, as shown in figures 2 and 3. Also, if this configuration were used for a renovation or new construction project, the bathroom would have to meet accessibility requirements. Because CMS permits a maximum of just two residents per room, an existing facility that previously included four beds per room would no longer be allowed to do so. As a result, census for the facilities in figures 2 and 3 would be decreased from four residents to two residents per room in the same square footage and building footprint.

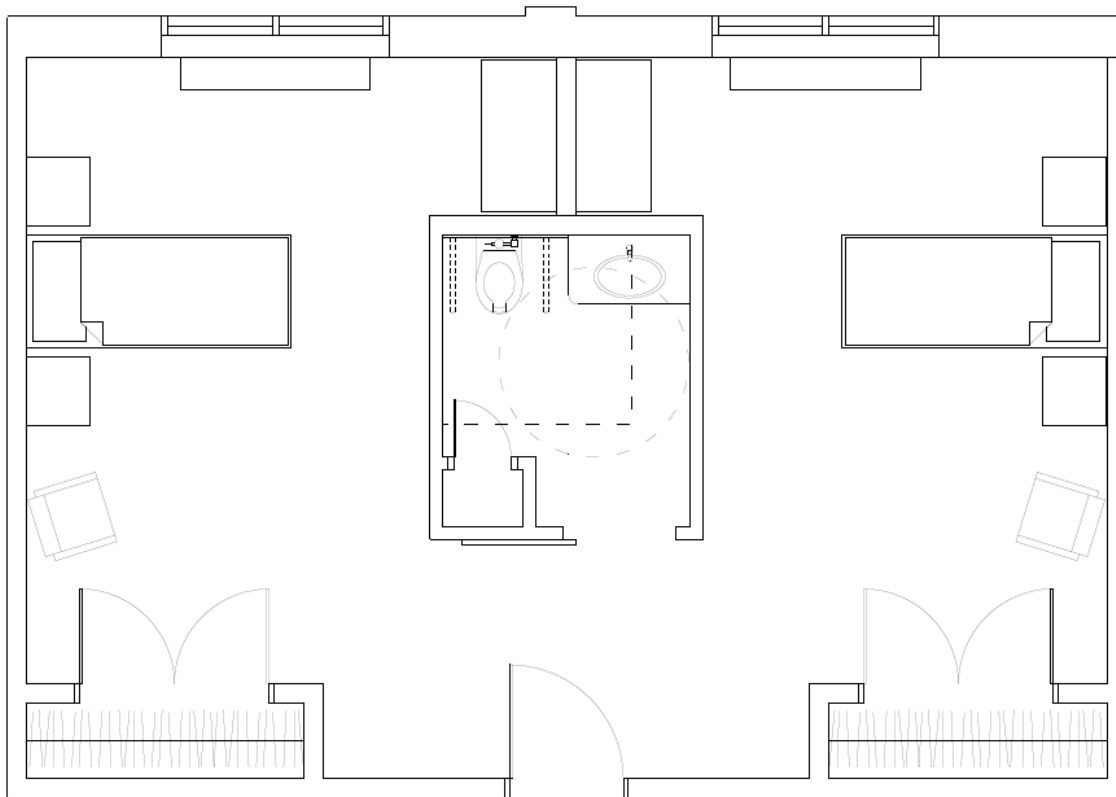


Figure 2: Two existing double-occupancy rooms are shown as a redesign with a shared half bathroom. Compliance with CMS would require a single-door entry and accommodate only two residents. Renovation would require an accessible half bathroom. This layout reflects a reduction from four residents to two residents in an existing footprint, reducing census by half from the existing plan shown in Figure 1.

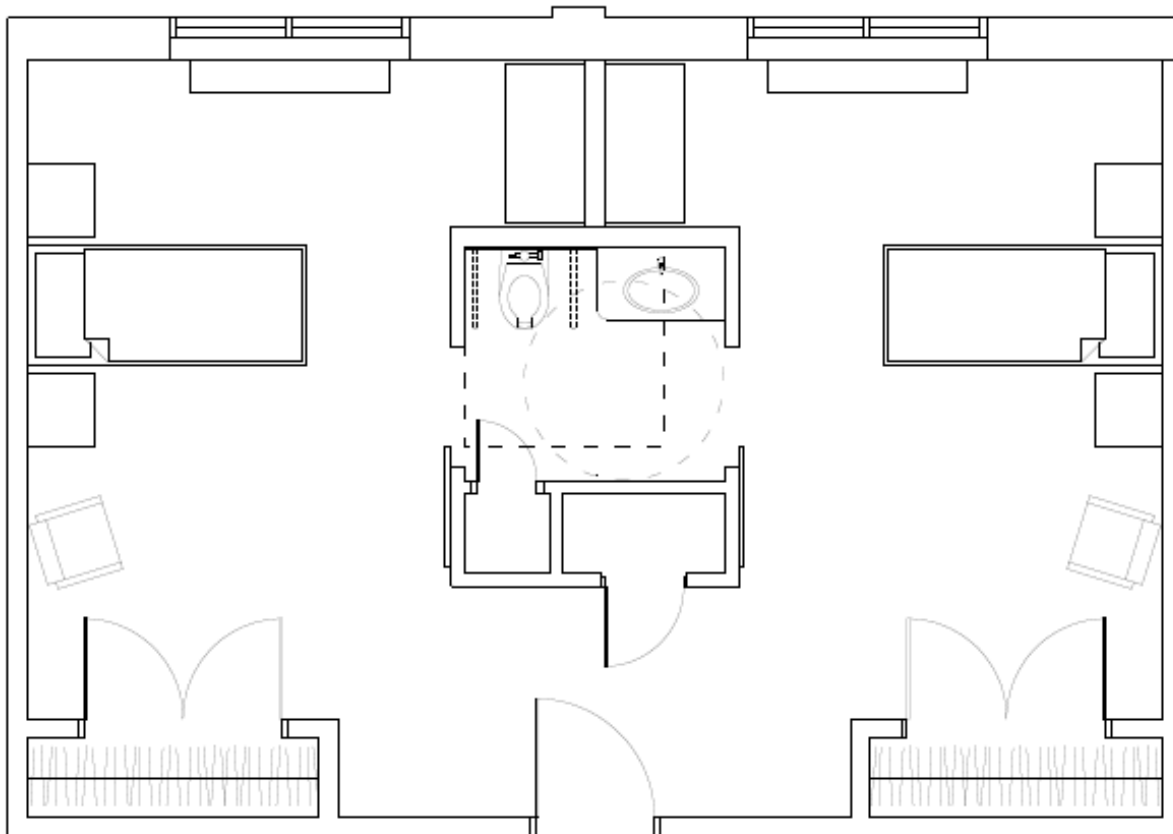


Figure 3: Two existing double-occupancy rooms are shown as a redesign with a shared half bath with dual access between sleeping areas. Compliance with CMS would require a single-door entry and accommodation for only two residents. Renovation would require an accessible half bathroom. This layout reflects a reduction from four residents to two residents in the existing footprint, reducing census by half from the existing plan shown in Figure 1.

Often, a renovation provides an opportunity to convert existing double-occupancy rooms into single-occupancy rooms because the available square footage is usually sufficient to fit a shower in the accessible bathroom redesign. Both a half bath and a full bath require substantial plumbing changes; however, a full bath with a shower would provide a person-centered solution and increase residents' bathing privacy.

Where an existing pair of resident rooms has an individual entry from the corridor into each room, the new CMS minimum requirement is a half bathroom for each room, as shown in Figure 4. For renovation of an existing nursing home, the CMS ruling would allow two residents in each of the rooms, but only if adequate square footage per resident can be met after a new accessible bathroom has been provided for each room. In this situation, the square footage requirements for a second bed typically cannot be met, resulting in a renovation with single rooms with half baths that accommodate one rather than two residents, reducing the facility's overall census by half.

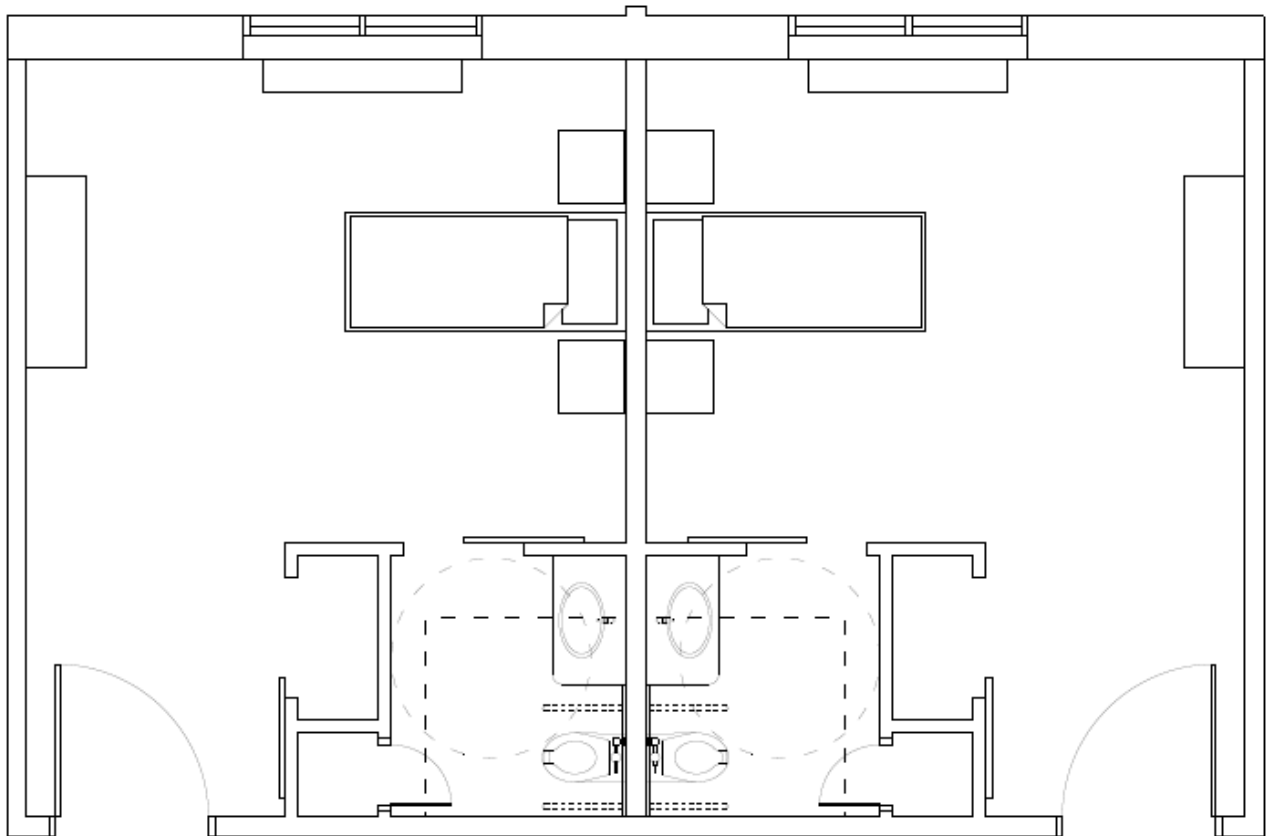


Figure 4: Here, an existing double-occupancy room with shared bathroom between two rooms has been renovated into two single-occupancy rooms each with its own entry and an accessible half bath. This layout reduces the overall square footage of the room, resulting in two single-occupancy rooms with private half bathrooms rather than two double-occupancy rooms with a shared half bath.

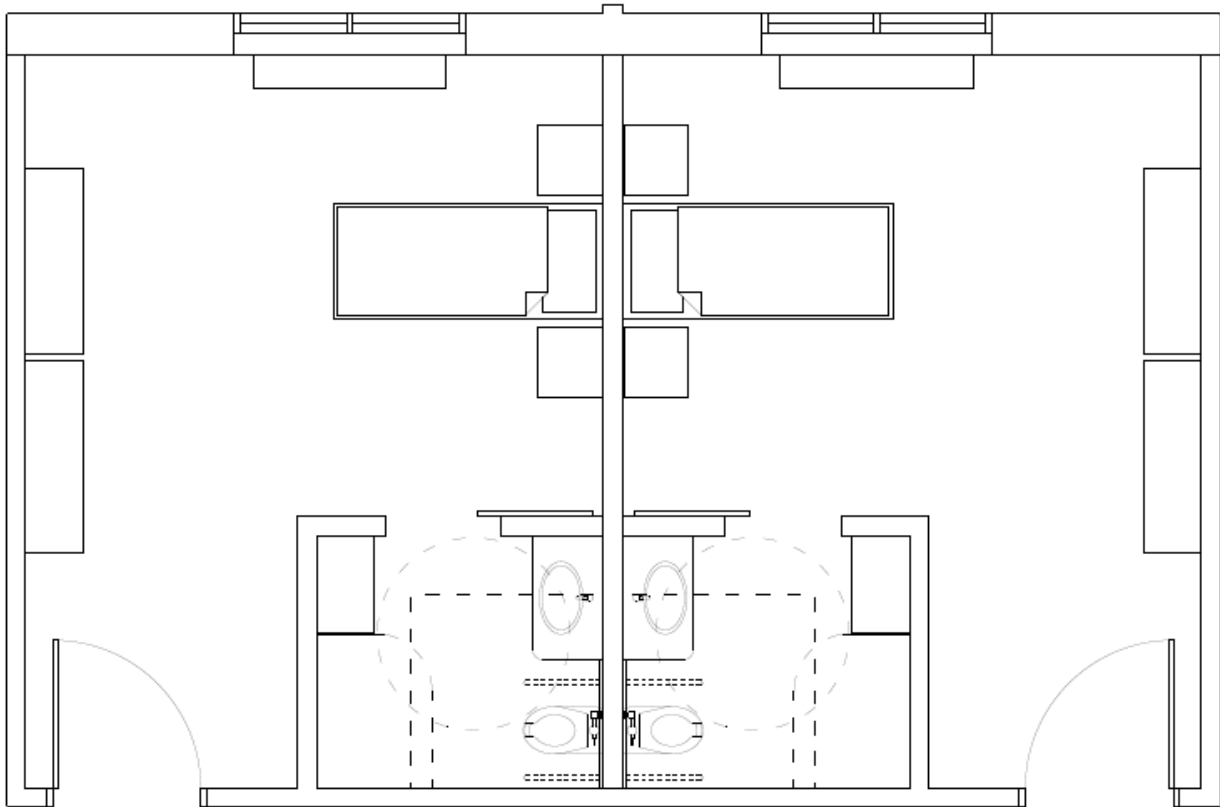


Figure 5: Shown is an existing double-occupancy room with shared bathroom between two rooms that has been redesigned into two single-occupancy rooms each with its own entry and an accessible full bath. The sleeping area of these rooms does not have enough square footage to accommodate two residents, but the bathroom redesign could include a full bathroom with shower and adequate storage.

Unfortunately, the CMS ruling supports the institutional layout of side-by-side resident beds with a shared bathroom shown in Figure 6. This is not considered a person-centered solution to design of double-occupancy rooms because it affords little privacy and discourages visits by family members. Initially developed for acute care, this layout has no merit in a nursing home where people are living and receiving care.

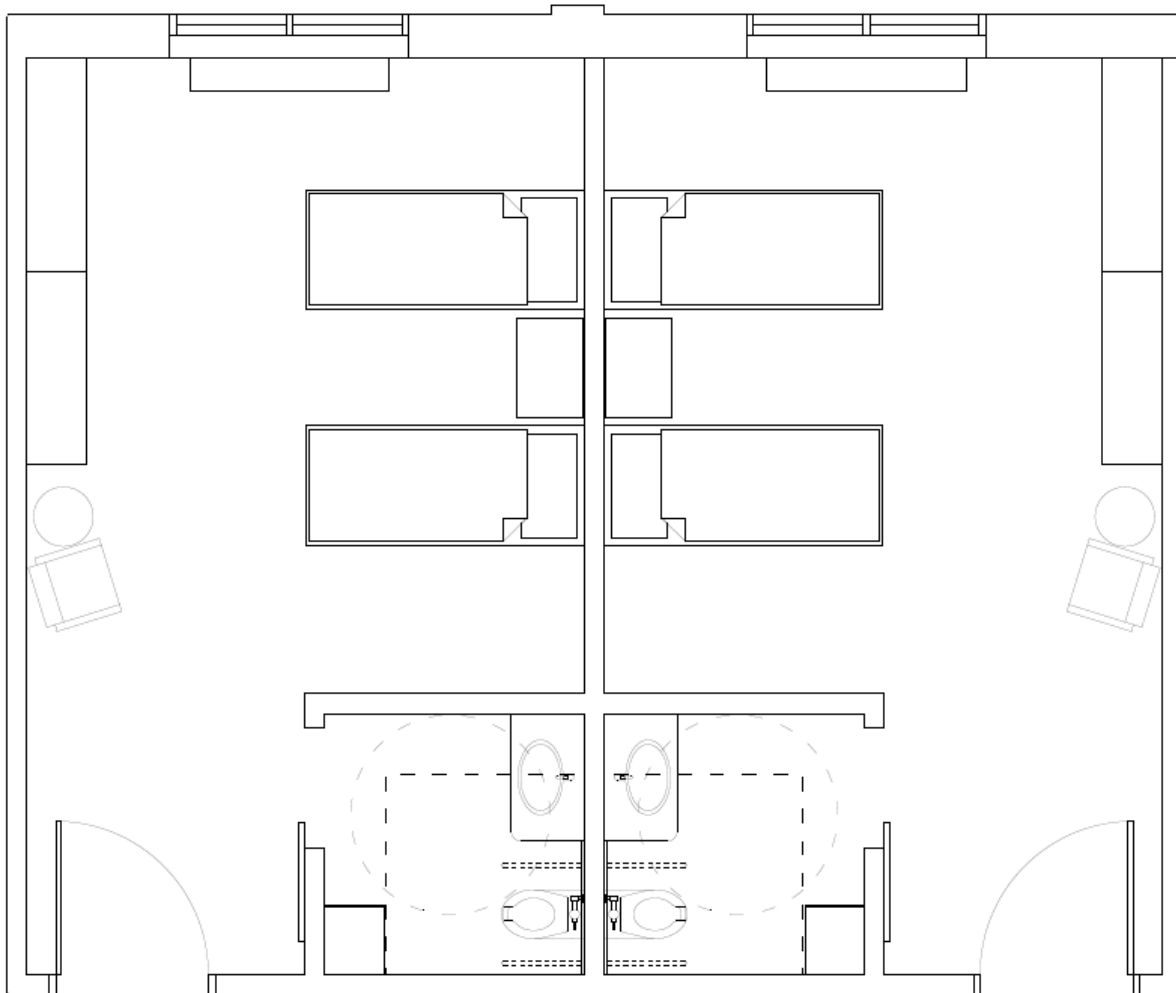


Figure 6: The CMS ruling allows side-by-side beds as shown here, but the FGI Guidelines does not permit this layout in new construction. For renovation, the CMS ruling requires a minimum of a half bath for this double-occupancy room with one entry door.

For the reasons cited above, the FGI Residential *Guidelines* does not allow side-by-side bed layouts in new construction. Instead, the *Guidelines*' performance requirements include individual resident access to a window, wardrobe, and bathroom without ambulating through another resident's living space. See figures 7 and 8 for options that meet the *Guidelines* using an "alcove" solution that addresses the performance requirements and supports enhanced privacy. These plans include full bathrooms, which provide additional privacy for residents so are considered a positive design intervention supporting person-center care. However, the *Guidelines* also permits a half bathroom in this layout.

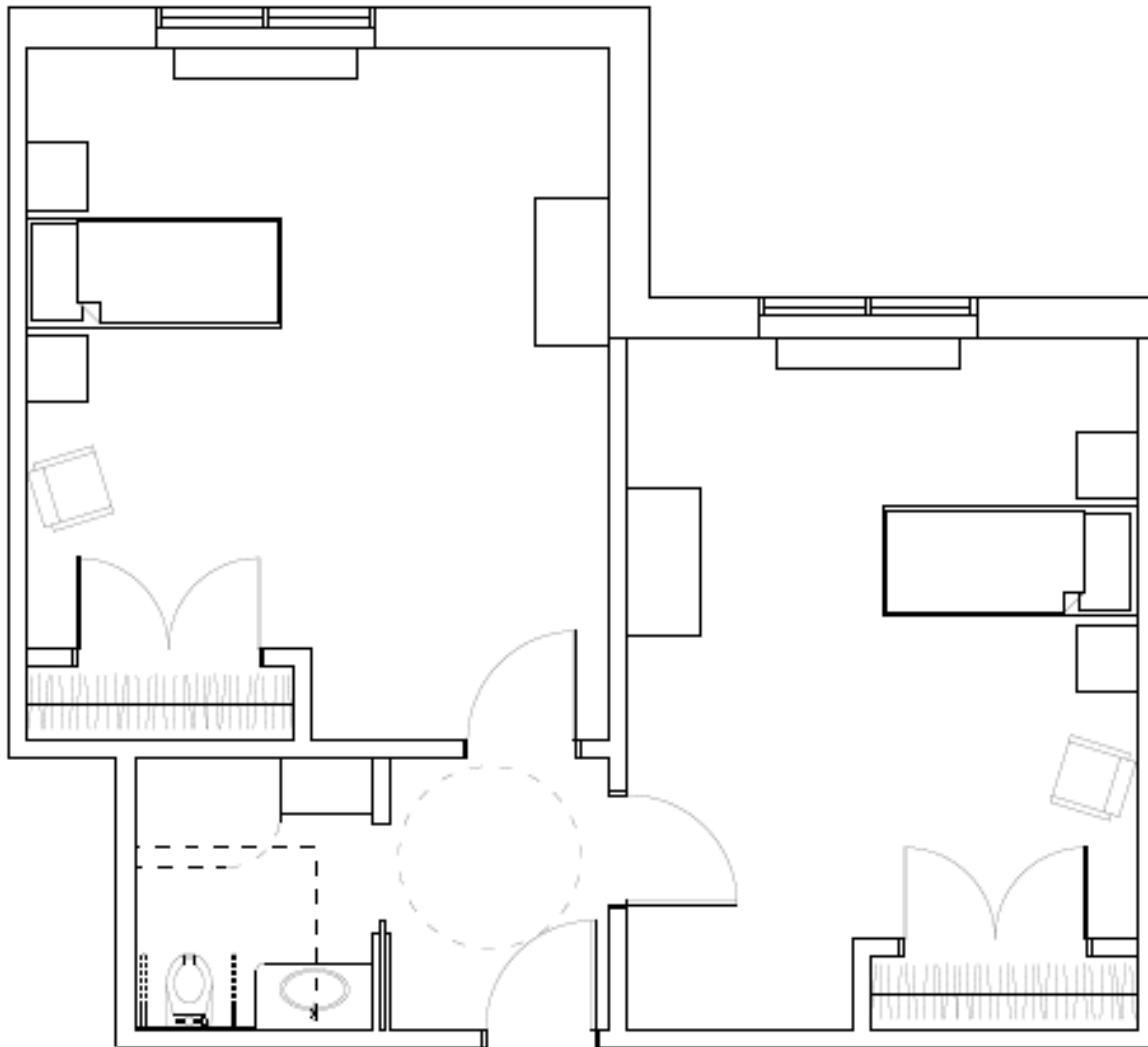


Figure 7: This alcove-style double-occupancy room with full bath and single corridor entry meets the FGI Guidelines requirements but would have to be confirmed with CMS for acceptance because of the vestibule and second set of doors into each sleeping area. These types of layouts are also referred to as “enhanced privacy” rooms. Provision of a full or half bath would meet the Guidelines performance requirements.

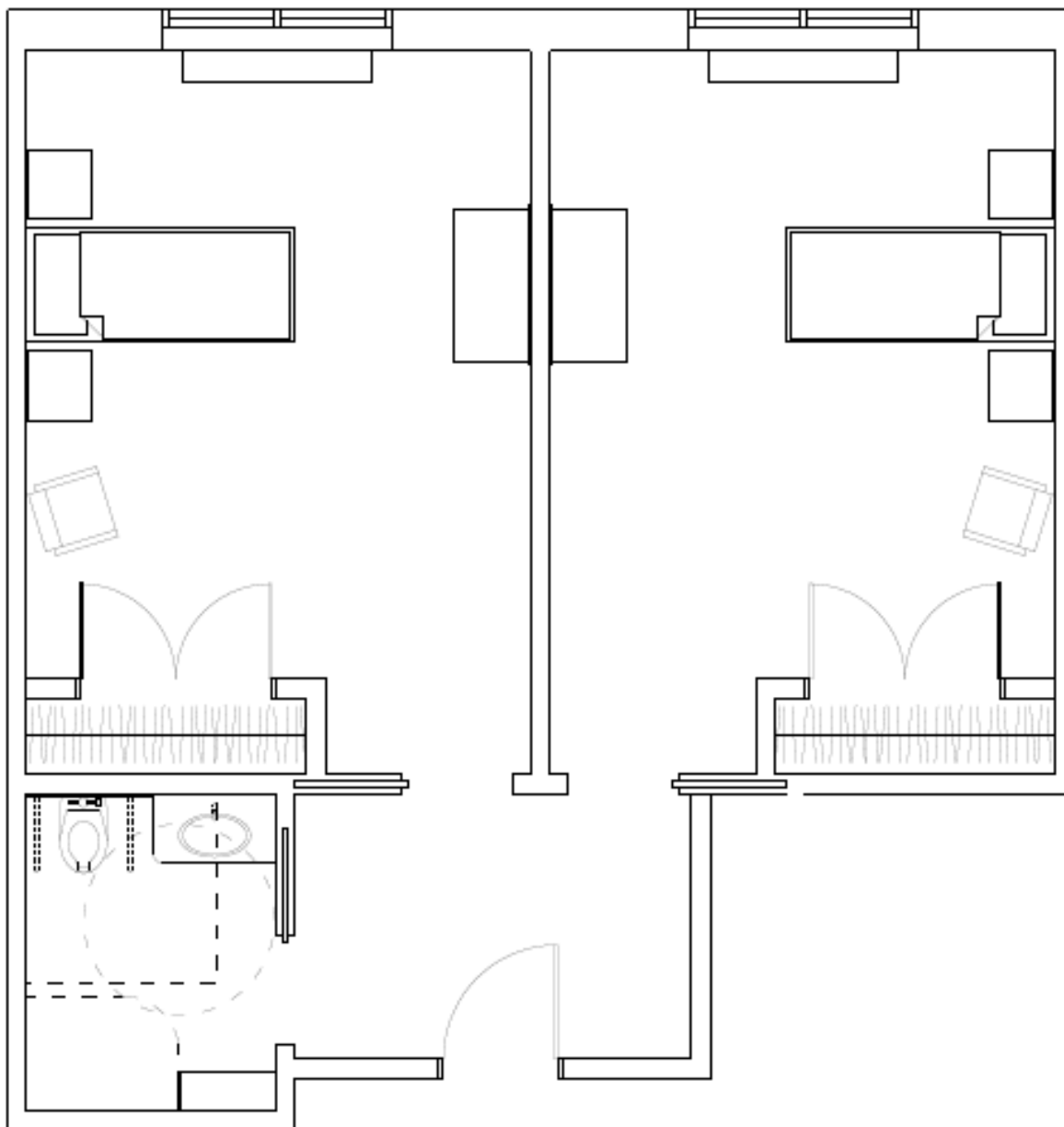


Figure 8: This alcove-style double-occupancy room with full bath and single corridor entry meets FGI Guidelines requirements but would have to be confirmed with CMS for acceptance because of the vestibule and second set of doors into each sleeping area. These types of layouts also are referred to as “enhanced privacy” rooms. Provision of a full or half bath would meet the Guidelines performance requirements.

The sample layouts in figures 7 and 8 were submitted to CMS by the Mayer-Rothschild Foundation and the Facility Guidelines Institute for further review to verify compliance with the ruling. **No response from CMS has been received as of March 27, 2018, the publication date of this position paper.** Therefore, CMS would have to verify and confirm that use of these types of “alcove” layouts would meet the intent of the CMS ruling and be approved for reimbursement. Note that in figures 7 and 8, if no secondary doors were provided on the alcove sleeping spaces, the layout would meet the CMS ruling and FGI *Guidelines* performance requirements.

A private room solution with private full bath is often optimal for person-centered care. Figure 9 shows an example of a single room with full bath—commode, sink, and shower. This single-room example would comply with both the CMS ruling and the FGI *Guidelines* as shown with a full bathroom or with a half bathroom with only a commode and sink.

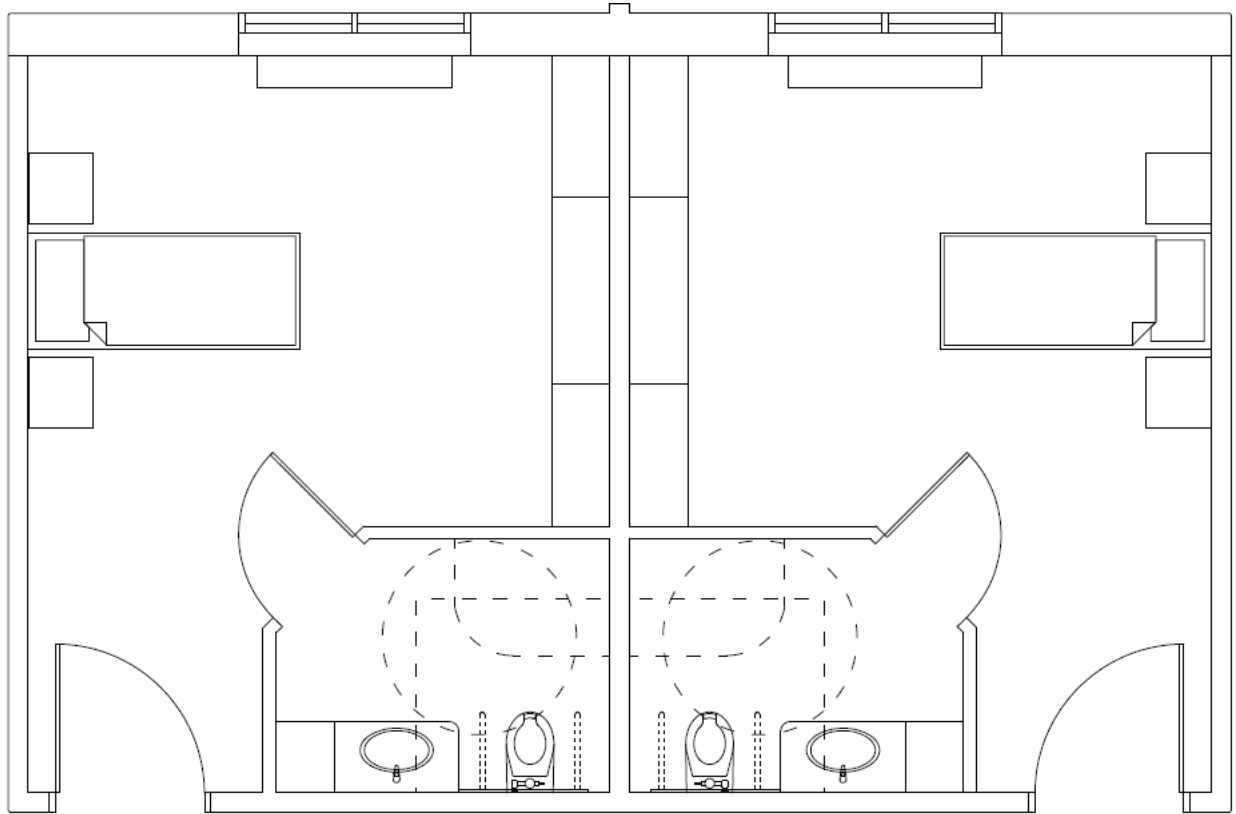


Figure 9: This sample single room layout with full bathroom is compliant with both the CMS ruling and the FGI Guidelines.

Topic 3: Organizations must establish policies in accordance with applicable federal, state, and local laws and regulations regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. (CMS § 483.90(h)(5))
Effective in Phase 2, 11/28/17

Challenge: With the advent of sustainability measures in the physical environment, smoking typically is not allowed in health, care, and support buildings. However, specific operational information is required to accommodate residents who smoke as well as those who are non-smoking.

FGI Position: The *Guidelines* provides requirements and recommendations for indoor environmental quality. Appendix section A2.2-2.4.1 (b) (Tobacco smoke-free environment) states:

- a. Signage indicating that smoking is not allowed in buildings should be posted within 10 feet (3 meters) of each building entrance.
- b. Where designated smoking areas are provided, they should be located a minimum of 25 feet (7.6 meters) from building entrances, outdoor air intakes, and operable windows.

Topic 4: **Bed rails §483.25(d) Proposed paragraph (2) sets out several requirements to be met before the bed or side rail is installed. We believe these requirements are important for resident safety before installation can create an expectation of use. We have re-designated this as paragraph (n) and, based on a combination of commenter suggestions, revised it to require that the facility must attempt to use appropriate alternatives prior to installing a side or bed rail, then to require that if a side or bed rail is used, such use must meet specific requirements.**

We have re-designated proposed §483.25(d)(2) Bed rails as paragraph §483.25(n), added an appropriateness qualifier to the regulatory text and reworded the provision about the bed's dimension for clarity.

Effective in Phase 1, 11/28/16

Challenge: Bed rail safety

FGI Position: The 2018 *Guidelines* defines minimum requirements and provides appendix guidance in Section **1.2-3.3.2.10 (4) (Bed safety)** and accompanying appendix section **A1.2-3.3.2.10 (4)**.

1.2-3.3.2.10 Coordination between mobility and transfer equipment and other aspects of the physical environment

***(4) Bed safety.** The configuration of beds being used shall be evaluated based on the care population to reduce the risk of injury related to bed rails, mattresses, and bed configurations.

A1.2-3.3.2.10 (4) Bed safety

a. *Bed rail safety.* Depending on the care population and individual resident needs, the same device may act as a restraint or a supportive aid. For example, someone cognitively intact may use bed rails to safely enter and exit a bed. However, someone who is confused or unsteady may slide between the rails or between the mattress and bed, creating a risk for entrapment, entanglement, or falling. For more information, see “Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities, and Home Care Settings,” published by the Food and Drug Administration.

b. *Other bed safety options.* The following environmental adjustments should be considered depending on an individual resident's assessment:

- Use of low beds with adjacent mat on the floor
- Use of electrically adjustable low beds
- Placement of resident's nurse call device within easy reach and visual and verbal cues for use of the device
- Inclusion of bed exiting alarms in the call system
- Use of body pillow/cushions or raised mattress edges to define the edges or borders of the mattress
- Potential use of a trapeze affixed to bed to increase a resident's bed mobility
- Placement of cues for interdisciplinary care team recommendations regarding each resident's unique needs

Topic 5: Call system from each resident's bedside (CMS §483.90(f)(1))

Effective in Phase 3, 11/28/19

Challenge: Providing guidance for wireless nurse call systems.

FGI Position: The *Guidelines* defines minimum requirements for how the call system would be provisioned with more detail in appendix guidance. The following paragraphs are excerpted from 3.1-6.5.2 Call System for nursing home specific requirements.

3.1-6.5.2 Call System

A nurse/staff call system shall be provided.

3.1-6.5.2.1 General

- (1) Use of alternative technologies, including wireless systems, shall be permitted for emergency or nurse call systems.
 - (a) Where wireless systems are used, consideration shall be given to electromagnetic compatibility between internal and external sources.
 - (b) Wireless systems shall comply with UL Standard 1069: *Hospital Signaling and Nurse Call Equipment*.
- (2) Nurse and emergency call systems shall be listed by a nationally recognized testing laboratory (NRTL).

3.1-6.5.2.2 Resident room call stations

- (1) Where a hardwired system is used, each bed location shall be provided with a call device that is accessible to the resident.
 - (a) One call station shall be permitted to serve two call devices.
 - (b) Wireless call stations are permitted.

- (2) A call initiated by a resident activating either a call device attached to a resident's call station or a portable device that sends a call signal shall register at the staff call station or device and shall either:
 - (a) Activate a visual signal in the corridor at the resident's door. In multi-corridor or cluster resident units, additional visual signals shall be installed at corridor intersections; or
 - (b) Activate a handheld mobile device carried by a staff member, identifying the specific resident and location from which the call was placed.

***3.1-6.5.2.3 Emergency call system.** An emergency call device shall be accessible from each toilet, bathtub, and shower used by residents.

A3.1-6.5.2.3 Hair salons, resident lounges, and all common resident areas should be evaluated for incorporation of emergency call system stations. This evaluation should consider the care model, care population, scale of the facility, and staff sight lines for observing residents.

- (1) The device shall be accessible to a resident in any position in the room, including lying on the floor. Inclusion of a pull cord or portable wireless device shall satisfy this requirement.
- (2) The emergency call system shall be designed so that a call activated will initiate a signal that is distinct from the resident room call device and can be turned off only at the activated emergency call device.
- (3) The signal shall activate at the staff work area and/or signal a handheld mobile device carried by staff.

How the *Guidelines* Complements Other Standards Used for Long-Term Care Facilities

The FGI *Guidelines* is used by care providers, designers, and AHJs in a variety of ways. In some states, the *Guidelines* is adopted as licensing code. Some states automatically update to the current edition of the *Guidelines* (such as Delaware), while others adopt a specific edition of the *Guidelines* through legislation (such as Florida, which recently adopted the 2014 *Guidelines for Design and Construction of Residential Health, Care, and Support Facilities*).

When used as a licensing code, the *Guidelines* is applied in addition to the applicable building code requirements and permit process, which may be regulated differently depending on the state and/or local jurisdiction (county, city, town, etc.). NFPA 101: *Life Safety Code*® is referenced in both the building code and the licensing code. Building codes are usually based on the International Code Council's [I-Codes](#), which are developed through a consensus process. Examples include the *International Building Code* (IBC), *International Mechanical Code* (IMC), *International Energy Conservation Code* (IECC), and *International Plumbing Code* (IPC). Similar to the licensing codes, the I-Codes are often modified by the jurisdiction referencing the code. This could be additive or deductive for portions of the I-Code.

The adoption and enforcement of building codes is undertaken by the local jurisdiction and its permit office. For the licensing code, the AHJ for nursing homes is usually the state department of health; however, it could also be the Department of Health and Mental Hygiene, the Department of Social Services, or another enforcement agency designated as the licensor. This varies from state to state.

The accompanying table lists states that have adopted an edition of the FGI *Guidelines* for nursing homes and other residential health, care, and support facilities as of March 27, 2018:

Adoption of FGI Residential *Guidelines* by Facility Type and State

Facility Type	State Adopted		
Adult day care facility	Delaware* New Hampshire**	New York	Vermont*
Assisted living facility	Colorado (intellectually/developmentally disabled) Delaware* Florida**	Louisiana New Hampshire** Tennessee Utah (dementia unit)	Vermont* Washington State** West Virginia
Hospice facility	Alaska Colorado Connecticut Delaware	New Hampshire Rhode Island Tennessee Utah	Vermont* Virginia* Washington State** West Virginia*
Nursing home	Alaska Arizona Colorado Connecticut Delaware* D.C.* Florida** Georgia	Iowa Louisiana Nebraska Nevada New Hampshire New Jersey* New York North Dakota**	Rhode Island Tennessee Utah Vermont* Virginia* Washington State** West Virginia* Wyoming
Other	North Dakota ("basic care" facility)		

*Regulations say "current" or "latest" edition

**Adopted 2014

No asterisk indicates a previous version was adopted.

How the *Guidelines* Benefits Long-Term Care Providers

The FGI *Guidelines* is used in most U.S. states either to regulate residential health, care, or support facilities or as a reference document. Some advantages of adopting the *Guidelines* as licensing code include:

- The *Guidelines* documents keep pace with evolving health, care, and support facility requirements; changing models of care; and new technologies. State adoption of the *Guidelines* not only addresses federal requirements and provides consistency between states, but also provides a framework for AHJs to evaluate and approve facilities that support alternative or innovative care models.

- Adopting the latest edition helps new U.S. residential health, care, and support facilities meet important evidence-based minimum requirements.
- AHJs have clear minimum requirements against which to evaluate a facility's compliance.
- Residential health, care, and support facility design teams and/or providers may have projects in multiple states and efficiencies are gained when consistent minimum requirements are applied across state lines.
- The *Guidelines* keeps pace with and seeks to remain aligned with other codes and standards such as NFPA 101: *Life Safety Code*®, the ICC codes, and ASTM standards.
- Public proposals and comments submitted during the *Guidelines* revision cycle to update the text are reviewed by a multidisciplinary group of 100+ industry experts.
- Costs to implement minimum requirements are carefully considered by the Health Guidelines Revision Committee, including consideration of benefits to the provider, staff, and resident quality of life.
- Members of LeadingAge®, the National Center for Assisted Living, ASHRAE, and many other organizations support and participate in the development of *Guidelines* content.
- The *Guidelines* requirements can be amended at the state level.
- Consistent application of minimum requirements across the nation helps reduce design and construction costs.
- FGI provides additional electronic resources to support application of the *Guidelines* requirements.
- The *Guidelines* requirements allow for design creativity based on the resident care population and the development of a functional program.

Resources

Facility Guidelines Institute. *Residential Care Guidelines: A Provider, Designer, and Regulator Perspective*. (www.fgiguilines.org/resource/video-series-residential-care-facilities)

Reform of Requirements for Long-Term Care Facilities, A Rule by the Centers for Medicare & Medicaid Services, 81 Fed. Reg. 68688 (October 4, 2016) (codified at 42 C.F.R. 483 pt. 483). (<https://www.federalregister.gov/documents/2016/10/04/2016-23503/medicare-and-medicaid-programs-reform-of-requirements-for-long-term-care-facilities>)

Rohde, Jane, and Residential Health Care Workgroup. "Issue Briefs: Residential Healthcare Facilities." (The Center for Health Design, July 2012.) (https://www.healthdesign.org/system/files/issue_briefs_-_residential_healthcare_facilities.pdf)

Senior Living Sustainability Guide®. (www.withseniorsinmind.org)

Wrublowsky, Robert. *Design Guide for Long Term Care Homes*, 2018 ed. (MMP Architects, 2017.) (www.fgiguilines.org/resources and www.withseniorsinmind.org/references-and-resources)

About the Health Guidelines Revision Committee (HGRC)

The HGRC is a select multidisciplinary consensus body of more than 100 providers, clinicians, administrators, architects, engineers, gerontologists, specialty consultants, and representatives from authorities having jurisdiction that is convened to revise and update the FGI *Guidelines* documents. As a group, HGRC members are experts on the many issues addressed in the *Guidelines*. The Residential Document Group is responsible for revisions to the *Guidelines for Design and Construction of Residential Health, Care, and Support Facilities*. Two additional *Guidelines* available for reference and adoption are the *Guidelines for Design and Construction of Hospitals* and *Guidelines for Design and Construction of Outpatient Facilities*.