

should consider how the device or practice affects the patient. For example, if a patient were in a wheelchair with a belt, the belt would not be considered a restraint if the patient can independently unsnap the belt. The key is to assess each patient and each situation to determine how a device or practice will affect the patient. If the belt described above were snapped in the back so that the patient could not reach it to release it, it would be considered a restraint. (See previous discussion in the preamble of the interim final at 64 FR 67032.)

Current professional standards of practice and guidelines advocate for minimal use of physical restraints, in limited medical circumstances. The Medicare and Medicaid programs have very strict criteria for the use of physical restraints in other provider types, such as hospitals and nursing homes, that require both medical supervision and intensive "medical \* \* \* examination, diagnosis, prognosis [and] treatment" of the patient in order to assure that the minimum appropriate restraint is used. While it would seem that rare occasions could arise where (physical) restraints could be used to protect the safety of a patient or staff, we believe that this restraint use, without medical review poses too great a hazard. Since the RNHCI statute expressly prohibits these facilities from engaging in "medical \* \* \* examination, diagnosis, prognosis [and] treatment," the use of restraints is not within their purview.

We disagree that the utilization review committees in the RNHCI could provide an adequate oversight function for the use of physical restraints. While the UR committees are the body responsible for ascertaining the appropriateness of Medicare (or Medicaid) covered services for an individual, they do not have the medical expertise necessary to assure that physical restraints could be provided to Medicare or Medicaid beneficiaries safely.

#### Condition of Participation: Food Service § 403.734(b)

*Comment:* The commenter requested that we add the language to our standard regarding requirements for the meal served to the patient in the RNHCI at § 403.734(b). The commenter believes we should add that the RNHCI should be required to ensure that the meals served to beneficiaries meet the recommended daily allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences, "except insofar as compliance with such dietary allowances would be contrary to the

religious beliefs observed by the institution or its personnel." The commenter considered the recommended dietary allowances of the National Academy of Sciences to be a medical model that involved learning the chemistry of food and determining the patient's body weight and height. As the basis for their objection, the commenter cited section 1861(ss)(3)(B)(i) of the Act, which states that the Secretary shall not subject a religious nonmedical health care institution or its personnel to any medical supervision, regulations, or control, insofar as such supervision, regulation, or control would be contrary to the religious beliefs observed by the institution or those personnel.

*Response:* Our first priority is to patient health and safety. We appreciate the commenter's suggestion, but we disagree with the suggested provision. We do not believe that this requirement violates section 1861(ss)(3)(B)(i) of the Act because the requirement is designed to meet general physical health needs unrelated to medical treatment for any illness, injury, or condition. Because therapeutic diets or parenteral nutrition are not expected to be ordered for the population of patients in these facilities, we are not suggesting that nurses perform duties outside the scope of their religious beliefs. The requirements in the rule are not medical in nature, but rather guidance for the maintenance of health within the general population.

#### Condition of Participation: Discharge Planning § 403.736(a)(1)

*Comment:* One commenter requested that, following the first sentence of the discharge planning evaluation standard at § 403.736(a) that states the RNHCI must assess the need for a discharge plan for patients likely to suffer adverse consequences if there is no plan and for patients upon request or at the request of their legal representative, we add the following language, "provided that this planning process shall not require actions which would be contrary to the religious beliefs observed by the institution or its personnel." The commenter believes that the requirement to initiate discharge planning on admission requires the nurse to make a prognosis. Again, the commenter cited section 1861(ss)(3)(B)(i) of the Act as the basis for the objection.

*Response:* Again, we appreciate the commenter's suggestion for additional language, but we do not agree that the requirement violates section 1861(ss)(3)(B)(i) of the Act. The requirement for discharge planning is for the safety of the patient and does not

mean that a medical prognosis is being made. The requirement is not that a prognosis be made but rather that the discharge process be started early on during a stay, and not only when discharge is imminent. The RNHCI is also responsible for identifying the qualified and experienced person for developing or supervising a discharge plan. If a patient may need additional services after discharge from the RNHCI, a plan must be in place to ensure that those services will be available in the community or another facility.

#### Condition of Participation: Utilization Review (UR) § 403.746(a)&(b)

*Comment:* The commenter objected to the requirement of having a UR plan that must contain written procedures for evaluating the duration of care and the need for continuing care of an extended duration. The commenter believes that the requirement leads to speculation about the duration of a patient's illness and requires nurses to make a prognosis, which is contrary to the nursing practice of the religious group. The commenter requested that we revise the standard under § 403.746(a) to include a disclaimer in favor of their beliefs.

*Response:* We are not suggesting that RNHCI nurses practice outside of their scope of practice or religious beliefs. We are requiring, however, that the RNHCI provide, through procedures written in their UR plan, the patient's initial need and appropriateness of an RNHCI stay and justifications for extending that stay. The UR condition of coverage and condition of participation are statutory, and we do not believe we have authority to alter those conditions.

*Comment:* The commenter requested that we remove the requirement that the governing body be included on the UR committee. The commenter stated that the governing bodies of most Christian Science facilities are made up of Christian Scientists from the large geographical area served by the facility and are not involved in the daily administration of the facility. Many do not live close enough to the facility to permit review of admissions or decisions on a daily basis. Additionally, they do not possess the skills or experience required to make appropriate UR decisions. The commenter suggested that the UR committee be composed of the administrator, superintendent of nursing, the assistant superintendent of nursing or another Christian Science nurse, and a nonvoting secretary/recorder.

*Response:* We appreciate the commenter's concerns; however, we do not agree with these suggestions. The purpose of this requirement is to afford