Actions	Compliance	Procedures
(4) Only incorporate Cessna Accessory Kits identified in paragraph (d) of this AD that have been inspected and modified in accordance with paragraphs (f)(1), (f)(2), (f)(2)(i), and (f)(2)(ii) of this AD.	As of the effective date of this AD	Follow Cessna Single Engine Service Bulletin SEB86–8, Revision 1, and Cessna Multi-engine Service Bulletin MEB 86–22, Revision 1, both dated July 28, 2003.

(g) If you did the actions of this AD using Cessna Single Engine Service Bulletin SEB86–8 and Cessna Multi-engine Service Bulletin MEB86–22, both dated November 21, 1986, no further action is required as long as you used shoulder harness adjuster, P/N 443030–401.

May I Request an Alternative Method of Compliance?

(h) You may request a different method of compliance or a different compliance time for this AD by following the procedures in 14 CFR 39.19. Unless FAA authorizes otherwise, send your request to your principal inspector. The principal inspector may add comments and will send your request to the Manager, Manager, Wichita Aircraft Certification Office (ACO), FAA. For information on any already approved alternative methods of compliance, contact Gary D. Park, Aerospace Engineer, FAA, Wichita Aircraft Certification Office, 1801 Airport Road, Room 100, Mid-Continent Airport, Wichita, Kansas 67209; telephone: (316) 946–4123; facsimile: (316) 946–4107.

(i) You may get copies of the documents referenced in this AD from Cessna Aircraft Company, Product Support P.O. Box 7706, Wichita, Kansas 67277; telephone: (316) 517–5800; facsimile: (316) 942–9006. You may view these documents at FAA, Central Region, Office of the Regional Counsel, 901 Locust, Room 506, Kansas City, Missouri 64106.

Issued in Kansas City, Missouri, on February 19, 2004.

Dorenda D. Baker,

Manager, Small Airplane Directorate, Aircraft Certification Service.

[FR Doc. 04–4375 Filed 2–26–04; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 483

[CMS–3121–P]

RIN 0938–AM55

Medicare and Medicaid Programs; Requirements for Long Term Care Facilities; Nursing Services; Posting of Nurse Staffing Information

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule would establish a new data collection and recordkeeping requirement for skilled nursing facilities (SNFs) and nursing facilities (NFs). We are proposing that SNFs and NFs complete a CMS-specified form at the end of each shift, on a daily basis, to post the full-time equivalents (FTEs) of registered nurses, licensed practical nurses, licensed vocational nurses, and certified nurse aides who are directly responsible for resident care. We also propose that SNFs and NFs use this form to capture and display daily resident census information. These facilities would also be required to make this information available to the public upon request.

DATES: We will consider comments if we receive them at the appropriate address, as provided below, no later than 5 p.m. on April 27, 2004.

ADDRESSES: In commenting, please refer to file code CMS–3121–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

Submit electronic comments to *http://www.cms.hhs.gov/regulations/ecomments* or to *www.regulations.gov.* Mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–3121–P, P.O. Box 8010, Baltimore, MD 21244–8010.

Please allow sufficient time for mailed comments to be timely received in the event of delivery delays.

If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) to one of the following addresses: Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or Room C5–14–03, 7500 Security Boulevard, Baltimore, MD 21244–1850.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Anita Panicker, (410) 786–5646, or Jeannie Miller, (410) 786–3164.

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on all issues set forth in this rule to assist us in fully considering issues and developing policies. You can assist us by referencing the file code CMS–3121-P and the specific ''issue identifier'' that precedes the section on which you choose to comment.

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and could be considered late.

All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. After the close of the comment period, CMS posts all electronic comments received before the close of the comment period on its public Web site.

Inspection of Public Comments: Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone (410) 786–9994.

I. Background

(If you choose to comment on issues in this section, please include the caption ''BACKGROUND'' at the beginning of your comments.)

Approximately 3 million elderly and disabled Americans receive care in our nation's nearly 16,500 Medicare- and Medicaid-certified nursing homes. The care of nursing home residents is a high priority for this Administration, the Department of Health and Human Services (HHS), and the Centers for Medicare & Medicaid Services (CMS). Medicare- and Medicaid-participating

nursing homes are regulated by sections 1819 and 1919 of the Social Security Act (the Act), added by Title IV, subtitle C of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87) (Pub. L. 100–203, December 22, 1987).

The Congress, CMS (then the Health Care Financing Administration (HCFA)), and the public have been debating the issue of minimum nurse staffing for nursing homes since the passage of OBRA '87. Nursing home resident advocates tend to believe that poor care is directly tied to inadequate staffing. Provider associations are more likely to view staffing problems as a series of complicated interactions involving the short supply of nursing home workers and facility differences in resident acuity and functional limitations.

Section 941 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), effective January 1, 2003, requires SNFs and NFs to post daily, for each shift, the number of licensed and unlicensed nursing staff directly responsible for resident care in the facility. This information must be displayed in a clearly visible place. Additionally, section 941 of BIPA requires the Secretary of Health and Human Services (the Secretary) to specify a "uniform manner'' for display of this information.

In November 2001, the Secretary announced an initiative to highlight efforts addressing quality of care improvement for nursing homes. The Nursing Home Quality Initiative represents a broad-based program that includes our continuing regulatory and enforcement systems, new and improved consumer information, community-based nursing home quality improvement programs, and partnerships, and collaborative efforts to promote quality awareness and improvement. Working with data measurement experts, the National Quality Forum and a diverse group of nursing home industry stakeholders, CMS adopted a set of nursing home quality measures. The initiative combines new information for consumers about the quality of care provided in individual nursing homes with important resources available to nursing homes to improve the quality of care in their facilities.

The main components of the initiative are nursing home quality measures derived from resident assessment data. This information is routinely collected by nursing homes at specified intervals during a resident's stay (the Minimum Data Set or MDS). These measures are additional pieces of available information to help consumers make informed decisions about nursing home care options. The measures are also intended to motivate nursing homes to improve care delivery and encourage discussions about quality between consumers and clinicians.

Although staffing is not an explicit part of this initiative, we believe that our proposed requirement that all SNFs and NFs post nurse staffing information and make the information available to the public is essential to keeping the public informed.

Additional CMS-sponsored quality improvement information may be found in the "Nursing Home Compare'' section of our Web site at *www.medicare.gov.* The primary purpose of Nursing Home Compare is to provide detailed information about the past performance of every Medicare- and Medicaid-certified nursing home in the country. Nursing Home Compare contains the following sections of detailed information:

- *About the Nursing Home:* including the number of beds and type of ownership.
- *Quality Measures:* providing data on quality measures, including the percent of residents with pressure (bed) sores, percent of residents with physical restraints, and more.
- Inspection Result Information: including health deficiencies found during the most recent State nursing home survey and from recent complaint investigations.
- *Nursing Home Staff Information:* including the average number of hours worked by registered nurses, licensed practical or vocational nurses, and certified nursing assistants per resident per day.

Each nursing home is required to report nursing staff totals to its State Survey Agency. CMS then receives this information from State Survey Agencies and converts the nursing staff hours reported into the number of staff hours per resident per day. We report the total nursing staff hours per resident per day, and also the total nursing staff hours per resident per day of registered nurses, licensed practical nurses, licensed vocational nurses, and certified nursing assistants.

Currently, nursing homes are required to have enough staff to give adequate care to all residents. There are no current plans to develop a Federal standard for optimal nursing staff levels. SNFs and NFs must have at least one registered nurse for at least 8 consecutive hours per day, 7 days per week, and either a registered nurse, licensed practical nurse/licensed vocational nurse, and other nursing personnel on duty 24 hours per day, unless a waiver has been granted in accordance with § 483.30(c) or § 483.30(d). Certain States may have more stringent nurse staffing specifications than the Federal requirements.

Section 4801(e)(17)(B) of the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) (Pub. L. 101–508, November 5, 1990) required the Secretary to report to the Congress no later than January 1, 1992 on the appropriateness of establishing minimum caregiver-to-resident and supervisor-to-nurse ratios for Medicare- and Medicaid-certified nursing homes. The purpose of the study was to examine the analytic justification for establishing minimum nurse staffing ratios for nursing homes. The study, "Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes,'' (Report to Congress, July 2000) was conducted in two phases. Phase I of the study (*www.cms.hhs.gov/Medicaid/reports/rp700hmp.asp*) examined whether an association exists between staffing levels in nursing homes and quality of care. Phase II of the study (*www.cms.hhs.gov/medicaid/reports/rp1201home.asp*) examined the cost and benefits associated with establishing staffing minimums and expanding the data used in the multivariate analysis from three States to a more representative national sample. It included an exploration of more refined case mix classification methods and case studies to validate Phase I findings, while examining related issues affecting certified nursing assistant recruitment and retention. In both Phase I and Phase II studies, the phrase "nurse staffing'' referenced all three categories of nurses and nurse aides: registered nurses, licensed practical nurses, and nurse aides/nursing assistants.

Based upon these studies, at this time, we do not believe sufficient evidence exists to warrant minimum nurse staffing ratio requirements. However, we do acknowledge the importance of improving nurse staffing and making accurate information available to the public. Consistent with our November 2001 initiative to disseminate and publish reliable information on nursing home quality for Medicare and Medicaid beneficiaries, our objective is to make staffing information available to the public to assist them in making informed decisions when choosing health care providers. With reliable information, nurse-staffing levels may simply increase due to the market demand created by an informed public.

The Phase I study found data submitted through the only national data source of nursing home staffing for

individual facilities, the Online Survey Certification and Reporting (OSCAR) system, can be less than accurate, and as such, is misleading when used as the sole data source for public reporting. The Phase I study also indicated that nurse staffing could vary considerably during the course of a year. We have concluded that accurately assessing the situation will require a longer reporting period. The proposed BIPA regulation will have the advantage of potentially providing consumers staffing information on a day-to-day basis. On the other hand, we are concerned that this self-reported information may be subject to the same limitations as the current OSCAR system. Hence, the results of the Phase I study as well as the BIPA provision have served as a catalyst for CMS to develop a reliable system of public reporting of nurse staffing.

We believe that additional study is required to develop and test effective audit mechanisms for public and provider reporting. Some assessment of the feasibility of collecting accurate data on the time contributions of volunteers, and facility aides may also be warranted.

Accurate information on facility staffing is necessary but not sufficient for informing the public. It is also essential that information that enables the public to make informed judgments about a facility's reported staffing levels be provided within the context of the facility's case mix.

Although the Phase II analysis did not identify the most efficient levels of staffing to maximize quality of care for various case mix groups, the results did indicate that adverse outcomes were significantly higher with similar staffing levels among facilities with more severe case mix. The investigators concluded that higher staffing levels are warranted for facilities with residents of more profound acuity and functional limitations. Hence, consumers need to have not only accurate staffing information about a nursing home they may be considering, but also need to know how the reported staffing levels compare to facilities of comparable case mix.

Consistent with the above objectives, we have a current contract with Abt Associates to present us with options for: (1) Collecting more accurate staffing data; (2) auditing the data collected; (3) transmitting the data; and (4) configuring the data so that they can be informative to the public when placed on our Web site.

It is important to note that the completion of this project will not result in a self-implementing system of public reporting. On the contrary, the final product will be a report with options for implementing such a system.

To date, we have done the following to implement section 941 of BIPA requirements:

- An October 10, 2002 State Agency Directors letter at *www.cms.hhs.gov/Medicaid/LTCSP/SC0303.pdf.*
- Presentation of information at a national nursing home conference.
- Publication of a notice on an electronic bulletin board used by nursing homes.
- A December 24, 2002 letter to nursing homes at *www.cms.hhs.gov/medicaid/bipa/bipanh.asp.*

II. Provisions of the Proposed Regulations

As discussed in section I of this preamble, we are proposing the following changes:

A. Nursing Services (§ 483.30)

(If you choose to comment on this issue, please include the caption ''NURSING SERVICES'' at the beginning of your comment.)

We are proposing to revise § 483.30 by adding a new paragraph (e) to require nursing homes to post nurse staffing information in accordance with section 941 of BIPA, specified as sections 1819(b)(8) and 1919(b)(8) of the Act. Paragraph (e)(1) would read ''The facility must, on a daily basis, at the end of each shift, calculate the number of FTE(s) for the following licensed and unlicensed nursing staff directly responsible for resident care: registered nurses, licensed practical nurses or licensed vocational nurses (as defined under State law), and certified nurse aides.'' We note that neither section 1819(b)(8) nor section 1919(b)(8) specifies what constitutes ''licensed and unlicensed nursing staff,'' but for the purposes of this proposed rulemaking, we have interpreted licensed and unlicensed nursing staff to mean registered nurses, licensed practical nurses or licensed vocational nurses (as the term(s) are defined under State law), and certified nurse aides.

In this proposed rule, we would require that only nursing staff assigned and directly responsible for resident care be captured on the CMS Daily Nurse Staffing Form. This proposed regulation would not require data collection on other staff, volunteers, or feeding assistants. If, for example, the director of nursing also served as a charge nurse in accordance with § 483.30(b)(3), then he or she would be counted in the information for his or her shift as a charge nurse. Otherwise, he or she would not be included except in situations where the director of nursing performs direct patient care during instances of staff shortages or absence. Additionally, we are proposing that the facility collect and display resident census for that day.

While collection of resident census information is not specifically required under section 941 of BIPA, we believe that collection of this information is authorized under our general supervisory authority as defined in sections 1819(f)(1) and 1919(f)(1) of the Act. These sections require the Secretary to ''assure that requirements which govern the provision of care [in both SNFs and NFs] * * * and the enforcement of such requirements, are adequate to protect the health, safety, welfare, and rights of residents and to promote the effective and efficient use of public moneys.'' Therefore, we believe the addition of census information makes the nurse staffing data more meaningful and useful to the public and is in line with our rulemaking authority. If only nurse staffing data were presented absent resident census information, there would be no way for the public to make inferences regarding the nurse staffing levels in relation to the resident population. We welcome comments on our proposing the addition of resident census information on the form.

We are proposing to add a new § 483.30(e)(1) that would specify the contents and format of the information in accordance with statutory authority provided by BIPA. Section 483.30(e)(1) through § 483.30(e)(3) would require that the nurse staffing and census public must—

- Contain current nurse staffing numbers (FTEs) for each shift;
- Contain the daily resident census;
- Be posted on the CMS Daily Nurse Staffing Form; and
- Be displayed in a prominent place readily accessible to residents and visitors.

A full time equivalent (FTE) equals one person working full time. For example, one person working full time (based upon an 8-hour shift) equals one FTE as does two people each working 4 hours. To determine FTEs, the facility would multiply the number of staff by the number of hours worked, and then divide by the number of hours in that shift. For example, Facility A runs on three 8-hour shifts daily. For the morning shift, Facility A has ten 8-hour employees and two 4-hour employees; $(10 \times 8)+(2 \times 4)= 88$ staff hours; therefore, 88/8=11 FTEs for that shift. Facility B runs two 12-hour shifts on the weekends with eight 12-hour employees and three 4-hour employees on the first

shift; (8 × 12)+(3 × 4)=108 staff hours; therefore, 108/12=9 FTEs for that shift. These instructions would also be included on the CMS Daily Nurse Staffing form as described in Appendix A.

Additionally, we would require the SNF or NF to make the collected information available to the public upon request. We are not proposing to require the facility to transmit the data to CMS or to the State Agency at this time. However, we would expect the facility to retain this information in keeping with standard business practices and be able to produce it if requested by us, the State Agency, or the public. To that end, we would also require that the facility retain the Daily Nurse Staffing Form for a minimum of 3 years, or as required by State law, whichever is greater. We welcome comments on this proposal and any suggestions for other timeframes.

B. Daily Nurse Staffing Form

(If you choose to comment on this issue, please include the caption "DAILY NURSE STAFFING FORM'' at the beginning of your comment.)

We are further proposing a CMS-specific form, the "Daily Nurse Staffing Form'' (found in Appendix A of this proposed rule), to be used by each facility to aid in presenting the nurse staffing information in a uniform manner. We would expect that this form would be completed at the end of each shift with a total FTE count of nursing staff who were actually present and providing direct care to residents. While we would allow the facility to photocopy a blank form or download it from our Web site at *www.cms.hhs.gov* and store them electronically or by paper, we would expect that the actual completion of the FTE count would not commence until after the staff for that shift had actually worked. Although we have not proposed a designated person to fill out the form, we would expect a facility to appoint someone responsible for presenting the information accurately. We welcome any comments on the format, design, and completion of the form.

III. Collection of Information Requirements

(If you choose to comment on this section, please include the caption "COLLECTION OF INFORMATION REQUIREMENTS'' at the beginning of your comments.)

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements:

Section 483.30 Nursing Services

In summary, section 483.30(e)(2) requires that long-term care facilities use the CMS-specified form (Daily Nurse Staffing Form) to enter the information specified in paragraph (e)(1) of this section; and to post the completed Daily Nurse Staffing Form in a prominent place readily accessible to residents and visitors.

The burden associated with this requirement is the time and effort it would take for the facility to complete the form and post it. Currently, there are 16,473 participating nursing homes. We estimate a total of 5 minutes to fill in the information per day. We further estimate that it will require facilities 30.42 hours each on an annual basis to meet these collection requirements.

Section 483.30(e)(3) requires the facility to make the information required in § 483.30(e)(1)–(2) available to the public and to maintain documentation.

The burden associated with this requirement would be the time it would take for the facility to retrieve the documented information being requested. We believe this requirement to be usual and customary business practice; therefore, the burden for this collection requirement is exempt under 5 CFR 1320.3(b)(2)and 5 CFR 1320.3(b)(3).

If you comment on these information collection and recordkeeping requirements, please mail copies directly to the following:

Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Regulations Development and Issuances Group, Attn: Dawn Willinghan, CMS–3121–P, Room C5–14–03, 7500 Security Boulevard, Baltimore, MD 21244–1850; and

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Brenda Aguilar, CMS Desk Officer, *baguilar@omb.eop.gov.* Fax (202) 395–6974.

IV. Response to Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents, we are not able to provide individual responses to comments submitted. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, if we proceed with a subsequent document, our responses to all timely public comments will appear in the preamble of that document.

I. Regulatory Impact Statement

(If you choose to comment on this section, please include the caption "REGULATORY IMPACT ANALYSIS'' at the beginning of your comments.)

We have examined the impact of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 16, 1980, Pub. L. 96–354), section 1102(b) of the Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any one year). This rule does not reach the economic threshold and thus is not considered a major rule.

The RFA requires agencies to analyze options for regulatory relief of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either by virtue of their nonprofit status or by having revenues of $6 million to $29 million in any one year. Individuals and States are not included in the definition of small entities. The only burden associated with this rule is the information collection burden associated with collecting and posting nurse staffing

information. Since this burden is minimal, as we have described in Section III of this preamble, we are not preparing an analysis for the RFA because we have determined that this rule would not have a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. We are not preparing an analysis for section 1102(b) of the Act because we have determined that this proposed rule would not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. The only burden associated with this rule is the information collection burden associated with collecting and posting nurse staffing information. Since this burden is minimal, as we have described in Section III of this preamble, this proposed rule would have no consequential effect on the governments mentioned or on the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. Since this regulation would not impose any costs on State or local governments, the requirements of Executive Order 13132 are not applicable.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects in 42 CFR Part 483

Grant programs-health, Health facilities, Health professions, Health records, Medicaid, Medicare, Nursing homes, Nutrition, Reporting and recordkeeping requirements, Safety.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR part 483 as follows:

PART 483—REQUIREMENTS FOR STATES AND LONG TERM CARE FACILITIES

1. The authority citation for part 483 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

2. Section 483.30 is amended by adding paragraph (e) to read as follows:

§ 483.30 Nursing services.

* * * * *

(e) Posting of nurse staffing information. (1) *Information requirements.* The facility must—

(i) On a daily basis, at the end of each shift, calculate the number of FTE(s) for the following licensed and unlicensed nursing staff directly responsible for resident care:

(A) Registered nurses.

(B) Licensed practical nurses or licensed vocational nurses (as defined under State law); and

(C) Certified nurse aides.

(ii) On a daily basis, determine or verify the resident census.

(2) *Form use and posting requirements.* The facility must on a daily basis—

(i) Use the CMS-specified form (Daily Nurse Staffing Form) to enter the information specified in paragraph (e)(1) of this section; and

(ii) Post the completed Daily Nurse Staffing Form in a prominent place readily accessible to residents and visitors.

(3) *Public access and data retention requirements.* The facility must—

(i) Upon request, make the Daily Nurse Staffing Form(s) available to the public;

(ii) Maintain the Daily Nurse Staffing Form(s) for a minimum of 3 years, or as required by State law, whichever is greater.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance.)

Dated: June 27, 2003.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Approved: October 21, 2003.

Tommy G. Thompson,

Secretary.

The following appendix will not appear in the Code of Federal Regulations.

BILLING CODE 4120–01–P

APPENDIX A

DAILY NURSE STAFFING FORM*

_____

(FACILITY NAME)

Today's Date: _____

Today's Resident Census _____

SHIFT	STAFF	NUMBER
	Registered Nurses:	_____
DAY SHIFT:	**Licensed Practical Nurses/**	
Time:_____ **to** _____	**Licensed Vocational Nurses:**	_____
	Certified Nurse Aides:	_____
	Registered Nurses:	_____
EVENING SHIFT:	**Licensed Practical Nurses/**	
Time:_____ **to** _____	**Licensed Vocational Nurses:**	_____
	Certified Nurse Aides:	_____
	Registered Nurses:	_____
NIGHT SHIFT:	**Licensed Practical Nurses/**	
Time:_____ **to** _____	**Licensed Vocational Nurses:**	_____
	Certified Nurse Aides:	_____

Section 941 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) requires skilled nursing facilities and nursing facilities to post daily for each shift the number of licensed and unlicensed nursing staff directly responsible for resident care in the facility. This information should be displayed in a place where residents and the general public can easily view it.

* Instructions for completion on next page

Instructions to complete the "Daily Nurse Staffing Form:"

1) Add your facility's name above the title "Facility Name."
2) Add today's date above the title "Today's Date" (for example, Tuesday, June 24, 2003).
3) Add your facility's current resident census above the title "Today's Resident Census."
4) Include your shift hours below the name of each shift (see examples below)

Example for three shifts:

DAY: (7:00 a.m. - 3:00 p.m.)
EVENING: (3:00 p.m. - 11:00 p.m.)
NIGHT: (11:00 p.m. - 7:00 a.m.)

Example for two shifts:

DAY: (7:00 a.m. - 7:00 p.m.)
EVENING: n/a
NIGHT: (7:00 p.m. - 7:00 a.m.)

5) Place the number of FTEs in the space marked "Number" next to the appropriate type of Staff" indicator. To calculate FTEs:

MULTIPLY the number of staff by hours worked.

Ex. 3 RNs work 8 hours each, 2 RNs work 4 hours each
(3x8) + (2x4) = 32 staff hours

DIVIDE the number of staff hours by the number of hours for that shift.

Ex. 32 staff hours/8 hrs = 4 RN FTEs

NOTE: FTEs does **NOT** mean number of nursing staff, although in some cases these numbers may be the same. **DO NOT** include other staff, volunteers, or feeding assistants in number of FTEs reported.

[FR Doc. 04–3732 Filed 2–26–04; 8:45 am]
BILLING CODE 4120–01–C

DEPARTMENT OF TRANSPORTATION

National Highway Traffic Safety Administration

49 CFR Part 571

[Docket No. NHTSA–1998–4369; Notice 1]

RIN 2127–AH75

Federal Motor Vehicle Safety Standards; Rear Impact Guards; Notice of Proposed Rulemaking

AGENCY: National Highway Traffic Safety Administration (NHTSA), Department of Transportation (DOT).

ACTION: Notice of proposed rulemaking.

SUMMARY: This document responds to a petition for rulemaking from Thieman Tailgates, Inc., concerning the Federal motor vehicle safety standard requiring trailers and semitrailers to be equipped with rear impact guards. The petitioner asked us to amend the standard so that it expressly excludes trailers with rear-mounted liftgates that reside in or move through any part of the area specified in the standard for the horizontal member of the rear impact guard. Alternatively, the petitioner asked us to exclude rear impact guards on those trailers from the energy absorption requirements of the equipment standard for rear impact guards.