The National CONSUMER VOICE for Quality Long-Term Care formerly NCCNHR

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Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Ave., S.W.
Washington, D.C. 20201

Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities
CMS-3260-P

Submitted electronically: http://www.regulations.gov

Dear Acting Administrator Slavitt:

The National Consumer Voice for Quality Long-Term Care (Consumer Voice) is a national non-profit organization that advocates on behalf of long-term care consumers across care settings. Our membership consists primarily of consumers of long-term care and services, their families, long-term care ombudsmen, individual advocates, and citizen advocacy groups. Consumer Voice has 40 years' experience advocating for quality nursing home care.

The proposed Requirements of Participation for Long-Term Care Facilities will impact the lives of thousands of nursing home residents. We thank CMS for the opportunity to submit these comments, which are endorsed by the many local, state and national organizations and individuals listed at the end of this letter.

Consumer Voice appreciates the time and effort that CMS has spent in revising the Requirements of Participation. We support the overall focus on person-centered care that is found throughout the proposed regulations. The rule would require that facilities learn more about who the resident is as a person, provide greater support for resident preferences and give residents increased control and choice This focus on person-centered care and culture change would improve both the resident's quality of life and quality of care.

There are other aspects of the proposed requirements for long-term care facilities that we support as well, including ensuring that any representative of the resident is only exercising those rights specifically delegated by the resident or determined by a court; more robust protections against abuse and neglect; and enhancements to the care planning process, such as a greater emphasis on resident participation. We are also pleased that residents' rights have been strengthened in certain provisions.

Nevertheless, CMS has failed to address the greatest problem in nursing homes today — staffing. Good staffing practices are necessary for facilities to deliver preventive, quality person-centered care and start with adequate numbers of nurses and nurse aides.

The lack of enough nursing staff is the number one complaint about nursing homes that Consumer Voice hears from residents, families, and advocates. The absence of a minimum staffing standard and a registered nurse 24 hours a day can and does harm nursing home residents. The proposed language of "sufficient staffing" and a "competency based approach" based on a facility assessment does not adequately protect residents when nursing homes owned by corporations or private equity firms are incentivized to reduce staffing to dangerously low levels. The proposed regulation must establish a level below which staffing cannot be cut. Without detailed, explicit staffing standards, nursing homes cannot meet the ever increasing needs of the frail elders and individuals with disabilities who reside there, nor can they comply with many of the proposed regulations.

In addition to numbers, good staffing practices include systems that promote individualized care, consistency, communication, and continuity. The proposed regulations should include provisions related specifically to staffing practice in order to prevent adverse events and provide person-centered care.

Our detailed comments and recommendations are outlined below. New proposed language is indicated in bold, italicized font.

**DEFINITIONS**

Consumer Voice is pleased to see the clarification under "Composite distinct part" that prohibits segregation of residents by payment source or on a basis other than care needs. We also appreciate the definition of "misappropriation of resident property" and "neglect," which moves what was in the interpretive guidelines into the regulation, as well as the more inclusive definition of "neglect" that encompasses not only the facility, but also its employees or service providers.

**Adverse event**

Consumer Voice recommends an expanded definition of adverse events to encompass the events referred to in the 2014 OIG report on adverse events, including *preventable harm due to substandard treatment, inadequate resident monitoring,* and *failure or delay of necessary care*. These comments focus the facility's systematic analysis and systemic action on preventable avoidable harm, rather than only on one-time events. A significant

diminution of a resident's highest practicable well-being, when that decline that is not a natural progression of a resident's condition, should be an adverse event

**Recommendation:**
An adverse event is an ~~untoward,~~ undesirable, **avoidable, iatrogenic** ~~and usually unanticipated~~ event ***or cascading series of events, resulting in preventable harm including*** ~~***that causes***~~ death or serious injury, or the risk thereof~~.~~ ***or significant diminution in physical, mental, or psychosocial well-being.***

**Person-centered care**
We suggest that person-centered care could be further enhanced in the rule by revising the definition so it means to empower the resident as the locus of control, not merely focus on the resident as the locus of control.

***Portable Order for Scope of Treatment***
***A Portable Order for Scope of Treatment" means a set of medical orders in standardized format (such as physician orders for life-sustaining treatment or similar portable medical orders) that address key medical decisions consistent with the patient's goals of care and results from a clinical process designed to facilitate shared, informed medical decision making and communication between health care professionals and patients with serious, progressive illness or frailty.***

**Resident representative**
We support the comments submitted by the American Bar Association (ABA) about the proposed term "resident representative" and agree that a new term and definition are necessary. However, Consumer Voice suggests changing the term suggested by the ABA - "resident enabler" - to "resident supporter" since "enabler" can have a negative connotation.

**Recommendation:**
***Resident supporter means an individual or individuals chosen by the resident to participate in healthcare discussions and assist the resident in making decisions or a personal representative with legal standing, such as a power of attorney, legal guardian, or health care surrogate appointed or designated in accordance with state law.***

**Sexual abuse**
We suggest that CMS keep the current definition of sexual abuse which states "Sexual abuse" includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault. This definition seems more inclusive than the one in the proposed rule. We agree with the National Association of State Long-Term Care Ombudsman Programs (NASOP) that there should be some additional reference of the use of technology in sexually abusing a resident, e.g., ***the definition of sexual abuse also includes the use of technology such as a smartphone or webcam to record or take images of a resident that are used for sexual gratification or exploitative purposes.***

***Staffing practices***
***Staffing practices include number and types of staff, staffing assignments (such as rotating or consistent assignment), schedules, and systems that affect communication, teamwork, and participation.***

**483.10 RESIDENT RIGHTS**
**Restructuring**
Consumer Voice is very concerned about the way in which CMS is proposing to restructure the section on Resident Rights. There are many important resident rights that have been moved from the current residents' rights rules, §483.10, and relocated in Facility Responsibilities, proposed §483.11, without a counterpart in the new Residents' Rights. At the same time many rights now found under Facility Responsibilities are not listed at all under Resident Rights. Since residents, their families and advocates look at the residents' rights language to know what residents' rights are (and they may be given copies of the federal rights), it is important that the statement of residents' rights be thorough, comprehensive, and accurate.

**Recommendation:**
Add rights currently found under Facility Responsibilities but not under Resident Rights to the Resident Rights section. This include but are not limited to:

Rights related to:
- Visitation policies **§**483.11(d)(2)
- Resident and family groups **§**483.11(d)(3)
- Resident personal funds **§**483.11(d)(5) & (6)
- Notice of Rights and Services §483.11(e)(9)
- Notification of changes. §483.11(e)(7)
- Grievances §483.11(h)(3)

**Specific Provisions**
**§483.10(a) Exercise of rights**
One of the most fundamental rights of U.S. citizens is the right to vote, yet in its written comments, the American Bar Association (ABA) states, "residence in a nursing home poses enormous obstacles to exercising this right, including isolation, mobility limitations, and impaired capacity." The ABA further notes, "Evidence suggests gate-keeping by facility staff, and summary judgments being made about residents' ability to vote. Current procedures in many facilities fail to protect voting rights and fail to protect against voting irregularities."

**Recommendation**
To better support nursing home residents' right to vote, Consumer Voice endorses the ABA's recommendations to include the right to vote as one of the rights specified under **§**483.10 and to require facilities to develop policies and procedures to support voting.

**§483.10 (a)(3)-(5) Retaining right to exercise right and resident representative**
Although we use the term "resident representative" in our comments, we recommend in the definitions section above that the term "resident representative" be changed to "resident supporter."

Consumer Voice strongly supports the proposed requirements in this section which uphold resident self-determination and autonomy. We are pleased that the proposed regulation explicitly states that a resident's representative, including a court appointed representative, can only exercise the rights delegated to them by the resident or a court, and that the resident retains the right to exercise all other rights. Far too often, nursing homes give a representative or guardian more authority than they actually have, which robs residents of their rights. We also agree that a resident representative would have to consider the resident's wishes and preferences and that even residents who have been adjudicated incompetent would have a right to participate in their care planning. Simply because a resident has a representative does not mean that he or she cannot communicate what he or she wants.

**§483.10(b) Planning and implementing care**
We commend CMS for strengthening resident rights related to care planning and support the proposed changes. The new rule would give more control to residents and permit residents to play a greater role in directing their own care.

However, we believe the proposed rule does not go far enough in creating a truly person centered planning. This language can and should be further improved by drawing from CMS's own 2014 Medicaid HCBS rule. Although CMS states in the preamble that "These requirements support the standards set forth by the Secretary in the 'Guidance for Implementing Standards for Person-Centered Planning and Self-Direction in Home and Community Based Services Programs' (p. 42182), the proposed regulations do not include a number of important provisions from the HCBS rule, including giving the person receiving services the right to lead the planning process. We see no reason why the person-centered planning process in nursing facilities should not be more consistent with the process mandated for Medicaid-funded home and community-based services.

**Recommendation:**
**§483.10(b)** The resident has the right to ~~be informed of~~ ***give or withhold informed consent***, and participate in, his or her treatment, including:
(5) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:

- ***(i) The right to lead the person-centered planning process where possible. The resident's representative may have a participatory role, as needed and as defined by the resident. In instances where state law confers decision-making authority to the representative, the individual will lead the care planning process to the extent possible.***
- ***(ii) The right to necessary information and support so that the resident directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.***

~~(i)~~***(iii)***The right to participate in the planning process, including the right to identify individuals ~~or~~ ***and*** roles to be included in the planning process, the right to request meetings, the right to have meetings ***at times and locations of their choice within the facility***; and the right to request revisions to the person-centered plan of care.
~~(ii)~~ ***(iv)*** The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.
~~(iii)~~ ***(v)***The right to be informed, in advance, of changes to the plan of care.
~~(iv)~~***(vi)*** The right to receive the services and/or items included in the plan of care.

***(vii) The right to have the care plan written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient***.
~~(v)~~ ***(vii)*** The right to ~~see~~ ***review*** the care plan~~, including the right to sign after changes to the plan of care~~ ***before it is implemented, to indicate informed consent by signing the care plan and to receive a copy of the finalized care plan at no cost to the resident.***

**§483.10(c) Choice of attending physician**

**§483.10(c)(2) Credentialing**
The rule proposes to limit a resident's right to choose his or her attending physician by requiring that the resident's physician meet the credentialing requirements of the facility. CMS does not provide any reasons why such credentialing is necessary, nor does it propose any restrictions on what those credentialing requirements could be. Consequently, facilities could choose to write these in arbitrary ways that restrict a resident's choice of physician.

If the intent of the requirement is to improve the care provided by attending physicians, CMS should pull stakeholders together to determine how that could best be done and assess whether credentialing would accomplish that goal. If the intent is to remove a physician of the resident's choosing who is failing to fulfill a given requirement (e.g. frequency of physician visits, unnecessary drugs), the current interpretive guidelines that outline such a process could be retained ("the facility will have the right, after informing the resident, to seek alternate physician participation to assure provision of appropriate and adequate care and treatment").

The proposed new limits on a resident's right to choose a physician clash are contrary to federal law at 42 USC Section 1395i-3(c)(1)(A)(i), which gives residents an unfettered right to choose their physician. Consumer Voice opposes the proposed requirement as it is currently writing and recommends it be deleted.

**Recommendation:**
**§483.10(c)** Choice of attending physician. The resident has the right to choose his or her attending physician.

~~(1) The physician must be licensed to practice, and~~
~~(2) The physician must meet the professional credentialing requirements of the facility.~~
~~(3) If the physician chosen by the resident refuses to or does not meet requirements specified in this part, the facility may seek alternate physician participation as specified in § 483.11(c) to assure provision of appropriate and adequate care and treatment~~

**§483.10(d) Respect and dignity**

**§483.10(d)(2) Personal possessions**
We are pleased to see that "some" related to furnishings and "appropriate" related to clothing have been eliminated. These limitations unnecessarily reduced the rights of a resident. Personal possessions are an important component of quality of life and who the resident is as a person.

Nevertheless, the proposed regulations fail to require facilities to take steps to protect resident property, which is a serious problem. Loss and theft of resident personal items such as clothing, dentures, eyeglasses, jewelry, radios, and televisions are two of the most common problems experienced by residents. These losses can have a devastating effect on the psychosocial well-being of residents, who already have experienced many losses. However, little is done to protect resident possessions or to respond when an item is reported missing. As one resident told us, filing a complaint in the facility about lost or stolen property is like throwing something into a black hole.

**Recommendation:**
**§483.10(d)(2)** The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.
***(i) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.***
***(ii) The administrator or the administrator's designee is responsible for investigating reports of lost or stolen residents' property.***
***(iii) The facility will have written policies and procedures outlining the steps to be taken in the event an item is reported lost or stolen.***
***(iv) The policies will include a mechanism to report the results of the investigation to the resident or his or her legal representative in the event the lost or stolen item is not recovered.***
***(v) If the resident's clothing is laundered by the facility, the facility shall identify the clothing in a suitable manner. The facility is only responsible for marking those items that are recorded on the resident's inventory sheet.***
***(vi) The facility must:***

- ***A. Inventory, upon admission and discharge, the personal effects, money, and valuables declared by the resident;***
- ***B. Review the resident's inventory at each care plan meeting to determine its accuracy and whether it needs to be updates; and***
- ***C. Remind the resident and representative annually in writing of the need to update inventory records.***

**§483.10(d)((5) Sharing a room**
We commend CMS for seeking to broaden a resident's right to choose with whom he or she lives. CMS rightly notes in the preamble that such choice is an important aspect of respect, dignity and self-determination. This right would further enhance the person-centered focus CMS intends.

**§483.10(6) Notice before change in room or roommate**
The impact of moving residents against their will is well documented. A resident's room is their home and forced relocation, even when it is within the same facility, can lead to both psychosocial and physical harm. Resident, family and ombudsman experience has been that residents are moved with little, if any, advance notice and for reasons that are often for staff convenience. Given the potential risk of any move that is not the resident's choice, such moves should only be permitted for certain reasons and written notice should be provided within a set timeframe. We are aware of several states, including Connecticut, Colorado, Texas and Indiana that require written notice when the facility is proposing to move a resident. The time frame we propose is based on Colorado and Texas regulations.

Furthermore, it is critical that the facility prepare a resident for such a move. This preparation can help in orienting and preparing a resident for an upcoming move. The current and proposed regulations require such preparation when a resident is to be transferred or discharged from the facility, but it is no less important when the move is within the facility.

**Recommendation:**

**§483.10(d)(6)** The right to receive ***written*** notice before the resident's room or roommate in the facility is changed.
***(i) An involuntary change in room can be made only if:***
***(A) The transfer is necessary for medical reasons as determined by the attending physician; or***
***(B) The transfer is necessary for the welfare of the resident or other residents.***
***(ii) The resident must be given notice at least five business days before relocation. The notice must include:***
***(A) The name, address, and telephone number of the local and state long term care ombudsman.***
***(B) For facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy services under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.), and for individuals with mental illness, the agency responsible for protection and advocacy services under the Protection and Advocacy for Mentally Ill Individuals Act of 2000 (42 U.S.C. 10802***)
***(iii) The facility must develop a relocation plan to orient and prepare the resident for the move. The plan must include but is not limited to taking the resident to see his or her new room and unit and meeting staff who will be assigned to him or her.***

**§483.10(e) Self-determination**

**§483.10(e) (1) Choice**
Consumer Voice is pleased to see that the proposed regulations specifically state that the resident's right to choose schedules includes sleeping and waking times. Because many residents are still forced to wake up and go to sleep according to the facility's schedule, this specificity would better ensure that residents truly have choice in their schedules. However, to ensure residents' choices are actually honored, these choices need to be communicated to staff, and staffing practices that promote consistency and continuity must be implemented.

There must also be a range of activities that residents are interested in or their "choice" is not meaningful.

**Recommendation:**
**§483.10( e) (1)** Choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care, ***and to have these choices be known to staff who are assigned using staffing practices that maximize staff's ability to fulfill the resident's choices. Residents must be able to choose from a range of activities correspond to their interests.***

**483.10( e) (10)** Make choices about aspects of his or her life in the facility that are significant to the resident***, and communicated to staff who are assigned using staffing practices that promote implementation of the resident's choices.***

**§483.10( e) (2) Going outside- the facility**
We are aware of numerous instances when residents have not been allowed to go outside, and families have not been permitted to take them outside. While other rights can be interpreted as giving residents the right to go outside, explicitly stating this removes any doubt. Residents should be able to go outside of the facility when they choose and the outside should be easily accessible to them.

**Recommendation:**
(2) Interact with members of the community and participate in community activities both inside and outside the facility~~,~~. ***This includes the right to go outside and move freely within and outside the facility as he or she chooses with easy access to the outside. Outside spaces must be physically accessible.***

**483.10(e)(3) Visitors**
We strongly support this provision and agree with CMS that being able to receive visitors of the resident's choosing, at the time of the resident's choosing, is an essential element of self-determination. Since the facility is the resident's home, residents should have the same 24 hour access to visitors as those of us who live in the community.

However, we believe that the language at 483.11(d)(1)(iii) and 483.10(d)(2) erodes these resident visitation rights by placing restrictions on visits that go beyond what is permitted under the Nursing Home Reform Law. We provide comments on these restrictions in the next section.

**§483.10(5) Resident participation in family groups**

Consumer Voice has always supported resident engagement and participation in activities within the facility, but our experience has shown that the concerns of residents and families can differ. Both residents and families need to be able to freely raise and discuss issues in their respective groups. The presence of one or more residents at a family group would likely prevent at least some family members from speaking out candidly or at all. This undermines the purpose of such a group.

However, we think that communication between the two groups is important and that the rules should facilitate that communication.

**Recommendation:**

**§483.10(5)** Participate ~~in family groups~~ ***The resident group and the family group may invite a representative from the family group and resident group respectively to attend their meetings for a pre-arranged amount of time and provide an update and information***.

**§483.10(f) Access to information**

**§483.10(f)(2) Notices**

We applaud CMS for proposing that notices be given in a format and a language the resident understands. The right to information is meaningless if the resident does not comprehend it. CMS rightly notes that effective communication for some residents requires the use of auxiliary aids and services.

**§483.10(f)(2)(vi) Information for filing grievances or complaints**

We note that this proposed language does not state that the resident can file grievances with the state survey and certification agency. This provision also limits the scope of grievances/complaints that can be filed by a resident to those solely relating to abuse, neglect, misappropriation of resident property in the facility and non-compliance with 489.102, whereas the statement required at §483.11(e)(12)(iv) regarding written information to be given to residents states that residents may file a complaint concerning <u>any</u> suspected violation of state or federal nursing facility regulations. There are other important differences between the language under Resident Rights and Facility Responsibilities. Residents should be provided with the broadest range of information possible.

**Recommendation:**
**§**483.10(f)(2)(ii) – (vi)
(ii) Information and contact information for ***all pertinent*** State and local ***agencies*** and advocacy organizations, including but not limited to the ***State survey and certification agency,*** State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2006 (42 U.S.C. 3001 et seq)***;*** ~~and~~ the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.); ***and adult protective services where state law provides for jurisdiction in long-term care facilities;***
(iii) Information regarding Medicare and Medicaid eligibility and coverage;
(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act) or other No Wrong Door Program***; home and community based service programs; and the local contact agency for information about returning to the community***
(v) Contact information for the Medicaid fraud control unit; and
(vi) Information and contact information for filing grievances or complaints about ***any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.***

**§483.10(f)(3) Access to medical records**
The proposed regulations would weaken residents' rights to access their records. Current requirements give residents access to **all** their records. According to the interpretive guidelines, "In addition to clinical records, the term "records" includes all records pertaining to the resident, such as trust fund ledgers pertinent to the resident and contracts between the resident and the facility."

The proposed rule changes "all records" to "medical records," giving residents access to less information than before. This is a step in the wrong direction. Moreover, the "cost-based fee" for the provision of copies that includes labor could easily become prohibitively expensive, further limiting a resident's right to their records. We recommend that CMS retain the current language that allows facilities to charge no more than the community standards and that it add language from the interpretive guidelines that defines the community standard. We also agree with the National Association of State Long-Term Care Ombudsman Program (NASOP) that an annual copy of their records should be provided to residents at no charge.
Two additional and long-standing concerns with resident access to records have been the requirements that 1) the 24-hour time frame for accessing current records excludes weekends and holidays; and 2) the resident must inspect the record before purchasing it. Because the facility is the resident's home, access to his or her records should be 24/7 and not contingent upon weekday staffing. Furthermore, the resident may wish to review his/her records with family members, whose visits may occur more frequently on the weekend and holidays. Additionally, we can see no valid reason for making residents inspect their records prior to purchasing copies except to delay resident access. There is

no such requirement for individuals who wish to obtain copies of their records in settings outside of nursing homes.

Finally, many facilities refuse to give families a copy of the resident's records after death or delay for months before releasing them, even with assistance from an attorney. The right of families to obtain these records within a reasonable amount of time should be made explicit.

**Recommendation:**

**§483.10(f)(3)** The resident has the right to access ***all*** ~~medical~~ records pertaining to him or herself,—

(i) Upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such ~~medical~~ records are maintained electronically); or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, including current medical records, within 24 hours ~~(excluding weekends and holidays)~~; and

(ii) ***Upon request and 2 working days advance notice to the facility***, ~~receipt of his or her medical records for inspection, to purchase,~~ a copy of the ~~medical~~ records or any portions thereof (including in an electronic form or format when such ~~medica~~l records are maintained electronically) ~~upon request and 2 working days advance notice to the facility.~~ The facility may charge:

(A) ~~Labor for copying the medical records requested by the individual, whether in paper or electronic form;~~ A fee not to exceed the community standard for photocopies of the records or any portions of the records.

~~(B) Supplies for creating the paper copy or electronic media if the individual requests that the electronic copy be provided on portable media; and~~

~~(C)~~ ***(B)*** Postage, when the individual has requested the copy be mailed.

***(iii) The facility must provide each resident with a copy of their records annually at no charge.***

***(iv) The resident's representative has the right to receive a copy of the resident's records upon the resident's death upon request and 2 working days advance notice to the facility.***

**§483.10(f)(4)(i) Survey results**

This language does not reflect the requirements of the Nursing Home Transparency and Improvement Act which gives residents, families and the public access to three years of survey information.

Moreover, Consumer Voice frequently hears that residents, families and members of the public cannot review the survey results without asking staff to provide the results to them. When staff are not available or too busy, consumers cannot examine the survey results as required by the Nursing Home Reform Act. The Interpretive Guidelines make it

clear that making the survey report available for examination means not having to ask a staff person.

**Recommendation:**
**§483.10(f)(4)** The resident has the right to— (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors, ***surveys from the past three years***, and any plan of correction in effect with respect to the facility~~;~~***. The results must be available in a place readily accessible to residents, families and the public without having to ask a staff person.***

**§483.10(g) Privacy and confidentiality**
We support CMS's changes to the current regulation to include both verbal and electronic privacy, which are just as important in today's nursing homes as privacy in written communications. We also agree that residents should have the right to send and receive unopened other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal services.

**§483.10(h) Communication**
The clarification that the use of a telephone including TTY and TDD services is helpful, but the limits placed on resident access to electronic communications are problematic. Given that facilities must electronically convey their MDS data, there can be no nursing home that does not have internet access. We therefore believe the language in (i) and (ii) is not needed and could be used as a way to deny resident electronic access.

**Recommendation:**
**§483.10(h(2)** The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research.
~~(i) If the access is available to the facility.~~
~~(ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident~~
**§483.10(j) Grievances**

**§483.10(j) (1)**
Consumer Voice is pleased to see that this right has been expanded to give residents the right to voice grievances without fear of discrimination or reprisal. As CMS notes, this clarifies that even when no actual reprisal or discrimination occurs, intimidation and threats of reprisal or discrimination are not permissible.

While complaints about care and treatment that has or has not been furnished are important, so are concerns about the behavior of other residents (in current Requirements of Participation). Additionally, our experience has been that residents may feel uncomfortable voicing concerns about staff and may believe that such concerns would not be addressed or taken as seriously. Adding "and staff" would indicate to both residents and the facility that all grievances, including those about staff, must be resolved. Finally, we are concerned that the way in which this right is phrased may send a message

to residents that these are the only grievances that can be voiced. This language should be revised to explicitly state that all other concerns can be expressed as well.

We also believe that "prompt" is too vague and that as a result, resolution of resident complaints may be delayed so long that resident quality of care and/or quality of life may be negatively impacted. A specific time frame should be set.

Consumer Voice is pleased to see in the Facility Responsibilities section, 483.11(h) that CMS is proposing that grievances be investigated and written decisions issued to residents. We urge CMS to include this information about grievances in the Resident's Rights section as well. Residents need to know the totality of their rights and should not be forced to read facility responsibilities in order to learn what they are.

**Recommendation:**
**§483.10(j)** Grievances. (1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished***; the behavior of other residents and staff; and any other concerns regarding their nursing home stay.***
(2) The resident has the right to ~~prompt~~ efforts by the facility to resolve grievances ***within 10 business days*** in accordance with §483.11(h).
***(3)*** The resident has the right to:

- Written and oral information on how to file a grievance or complaint;
- Receive a written copy of the facility grievance policy upon admission and whenever it is revised; and
- Obtain a written decision regarding his or her grievance that includes:
    - a summary of the pertinent findings or conclusions regarding the resident's concerns;
    - a statement as to whether he grievance was confirmed or not confirmed;
    - any corrective action taken or to be taken;
    - the date the decision was issued; and
- Contact information of independent entities with whom grievances may be filed.

**§483.11 FACILITY RESPONSIBILITIES**
It is impossible to achieve quality of life without staffing practices that promote consistency, communication, and continuity.

**Recommendation:**
**§483.11** A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment ***and using staffing practices*** that promote~~s~~ maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident as specified in 483.10, including, but not limited to the following obligations:

**§483.11(a)(2) Equal access to quality care**
Consumer Voice is pleased to see that the proposed rule would require facilities to provide equal access to care regardless of diagnosis and severity of condition, as well as payment source.

We strongly support the proposed requirement as consistent with the Medicaid Act. This provision guards against possible discrimination in caring for residents with diagnoses/conditions such as HIV, antibiotic resistant infections or severe mental illness. The proposed rule also furthers national policy as expressed by the Americans with Disabilities Act and the Rehabilitation Act of 1973.

However, there is a very important omission from the regulation. The proposed rule should explicitly prohibit discrimination in admission, which remains a problem. Even though one meaning of the word "access" is "to enter," and in the Thesaurus, "admission" is given as a synonym for "access," CMS has not considered admission to be part of "access." The result has been discrimination on the basis of race since African-Americans and other minorities are disproportionately poor and are therefore disproportionately dependent upon Medicaid for their coverage.[1] Over a quarter of African-Americans have Medicaid coverage and African-Americans are nearly 2.5 times more likely to be covered by Medicaid than non-Hispanic white Americans.[2] *See, e.g.*, Linton v. Carney, 779 F. Supp. 925 (M.D. Tenn. 1990), *aff'd on other grounds* Linton by Arnold v. Comm'r of Health & Env't, State of Tenn., 65 F.3d 508 (6th Cir. 1995), *cert. denied*, St. Peter Villa, Inc. v. Linton, 517 U.S 1155 (1996). Such discrimination is a violation of Title VI of the Civil Rights Act of 1964, which prohibits discrimination on the basis of race in federally funded programs, including Medicare and Medicaid. Consumer Voice urges CMS to explicitly state that equal access includes policies and practices regarding admission.

**Recommendation:**
**§483.11(a)(2)** The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding ***admission,*** transfer, discharge, and the provision of services under the State plan ***or waiver*** for ***all applicants and*** residents regardless of payment source.

**§483.11(a)(3) –(5) Resident representative**
See earlier comments in 483.10 (a)(3)-(5): Retaining right to exercise rights and resident representative

**§483.11(b) Planning and implementing care**
Consumer Voice supports the language in this section which promotes person-centered care by identifying what is important to the resident, incorporates the resident's preferences, and engages residents. We are pleased that the regulation would require nursing homes to facilitate the inclusion of the resident in the planning process.

[1] Kaiser Commission on Medicaid and the Uninsured. 2001. Medicaid's role for Black Americans.
[2] Ibid.

However, we urge CMS to require facilities to provide information and education to residents and representatives about care planning and how to participate in the process. Residents and representatives do not have the same knowledge and understanding of care planning as staff do, and it can be overwhelming and intimidating to attend a meeting where you are surrounded by health care professionals.

Furthermore, to implement a care plan in a person-centered way, the plan must identify what staffing practices will be utilized to ensure care is delivered in the manner that best supports the individuality of the resident.

**Recommendation:**
**§483.11(b)** *Planning and implementing care.* (1) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right, consistent with 483.10(b). The planning process must:
(i) Facilitate the inclusion of the resident or resident representative.
(ii) Include an assessment of the resident's strengths and needs.
(iii) Incorporate the resident's personal and cultural preferences in developing and implementing individualized goals of care.
***(iv) Identify staffing practices that maximize caregiving staff's delivery of person-centered care and prevention of adverse events.***

**§483.11(c) Attending physician**

**§483.11(c)(1)** We agree that residents should be provided with the name and contact information for the other primary care professionals responsible for their care. This is basic health care information that should be available to all consumers regardless of where they reside.

**§483.11(c)(2)** We strongly oppose the requirement that a physician must be credentialed by the facility and that the facility can force a resident to switch doctors if the resident's doctor does not meet the credentialing requirements. Please see our comments regarding 483.10(c) above.

**§483.11(d) Self determination**

**§483.11(d)(1) Visitation**
Consumer Voice objects to the proposed language at **§**483.11(d)(1)(iii) and **§**483.11(d)(2) which would make visits from other visitors subject to reasonable "clinical and safety restrictions" and allow the facility to create written policies and procedures restricting resident access to visitors for clinical or safety reasons. These requirements would gut resident visitation rights by giving facilities complete latitude to create whatever policies they want. We hear directly from residents, families and advocates that far too many facilities already prohibit residents from seeing visitors, often family and friends, for baseless reasons.

The proposed restrictions are not consistent with federal law, 42 U.S.C. §§1395i-3(c)(3), 1396r(c)(3), Medicare and Medicaid, respectively. They undermine the right of residents to choose their visitors and the timing of visits that are proposed in §483.10(e)(3) and CMS's stated position that visitation is an important part of self-determination and resident choice.

A number of issues have been raised by the provider community. One concern is that the outbreak of an infectious disease would be a clinical reason for restricting visits. We realize that there may be times when visits might need to be curtailed or constrained in some way. In those cases, the facility should follow CDC guidelines, which are evidence-based, and not make its own decisions about visitation. A second concern is about permitting 24 hour visitation. However, 24-hour visitation is already allowed, as underscored by a Survey and Certification letter dated June 18, 2013: "Facilities must provide 24-hour access to all individuals visiting with the consent of the resident.[3]" Since questions about 24-hour visitation still arise and many facilities still post signs indicating only specific hours for visitation, we recommend that the regulations clarify this point.

**Recommendation:**
**§483.11(d((1)** The facility must:
(i) Provide immediate access to any resident by:
(A) Any representative of the Secretary,
(B) Any representative of the State,
(C) Any representative of the Office of the State long term care ombudsman, (established under section 712 of the Older Americans Act of 1965, as amended 2006 (42 U.S.C. 3001 et seq.);
(D) The resident's individual physician,
E) Any representative of the protection and advocacy systems, as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.),
(F) Any representative of the agency responsible for the protection and advocacy system for individuals with mental illness (established under the Protection and Advocacy for Mentally Ill Individuals Act of 2000 (42 U.S.C. 10802); and
(G) The resident representative.
(ii) Provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time;
(iii) Provide immediate access to a resident by others who are visiting with the consent of the resident, subject to ~~reasonable clinical and safety restrictions and~~ the resident's right to deny or withdraw consent at any time;
(iv) Provide reasonable access to a 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; and
(2) The facility must have written policies and procedures regarding the visitation rights of residents, ~~including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation that the facility may need to~~

[3] https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-13-42.pdf

~~place on such rights and the reasons for the clinical or safety restriction or limitation.~~ ***That include a statement that residents have the right to 24 hour visitation.*** A facility must meet the following requirements:
(i) Inform each resident (or resident representative, where appropriate) of his or her visitation rights, ~~including any clinical or safety restriction or limitation on such rights, when he or she is informed of his or her other rights under this section.~~

**§483.11(d)(3) Resident and family groups**
We are pleased to see a number of proposed additions to the current Requirements of Participation regarding resident and family groups. These revisions, such as requiring staff and visitors to attend meetings only if invited and mandating that the designated staff person be approved by the resident or family group, would enhance the autonomy of resident and family groups. We also support the proposed requirement that facilities demonstrate their response and rationale to group requests. This would help make nursing homes more responsive to the concerns of residents and families and hopefully less likely to dismiss or discount their requests.

At the same time, Consumer Voice believes there are important ways in which the regulations should be further strengthened.

Families face significant barriers in forming and maintaining a family council. Family councils may encounter resistance from administration. Resistance can take many forms, including not helping families to promote the council, scheduling other events at times that conflict with the family council meeting, not allowing families to meet at a convenient time in the facility and more. One of the major problems is difficulty informing new family members about the council and publicizing its meetings. Families interested in starting a council or participating in an existing council must rely heavily on the facility administration and staff to advertise and promote the council. However, there are nursing homes that will not distribute family council information or allow families to post notices. Regulations requiring such activities are necessary in order to support family council development.

There are also facilities that refuse to allow family members whose loved ones have died or friends of residents to participate in the council. Expanding the definition of "family" would address this issue and allow these individuals to contribute to the council in important ways.

Finally, resident groups, and particularly family groups, report that they must wait weeks to receive a response to a grievance or recommendation they have submitted to the facility - if they get a response at all. Requiring a response within a set amount of time would help resolve this problem.

**Recommendation:**
**§483.11(d)(3)** The facility must provide a resident or family group, if one exists, with private space; and
(i) Staff or visitors may attend meetings only at the group's invitation;

(ii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings;
(iii) The facility must consider the views of a resident or family group and act upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. ***The facility must provide a written response to a resident or family group's views, grievances or recommendations within 10 days and state what the facility will do to address these views, grievances or recommendations.***
(A) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.
(B) The facility must be able to demonstrate their response and rationale for such response.
***(iv) A facility shall not prohibit the formation of a resident or family group or willfully interfere with the formation, maintenance, or promotion of a resident or family group. Willful interference includes, but is not be limited to, discrimination or retaliation in any way against an individual as a result of his or her participation in a resident or family group, or the willful scheduling of facility events in conflict t with a previously scheduled resident or family group meeting.***
***(v) The facility must inform each new resident and family member of each new resident of their right to form a resident or family group.***
***(vi) The facility must provide each new resident and the family member of each new resident with information about any resident or family group. Information shall include the time, place and date of meeting and the person to contact regarding involvement in the resident/family group, as well as the resident/family group's brochure or other introductory materials. The facility must indicate whether the group is family-run or facility-run in any of its materials or advertising about the family group.***
***(vii) The facility must provide a resident or family group adequate space on a prominent bulletin board or other posting area for the display of notices, newsletters, or other information pertaining to the operation or interest of the council.***
***(viii) The facility must post notices of the resident or family group's meetings upon request.***
***(ix) The facility must keep a record of whether or not it provided written notice of the right to form a resident/family group, and when a resident/family group exists, the resident/family group meeting and contact information. These records must be maintained in the facility and may be requested by state surveyors during the survey or complaint process.***
***(x) For the purposes of this section, the term" family" includes a current, or former, resident representative or interested family members.***

**§483.11(d)(5) Resident Funds**

In 2013, the issue of inadequate protection of resident personal funds received national attention. *USA Today* documented scores of cases in which nursing home employees stole money for everything from shopping and gambling sprees to routine household expenses. In many cases, the problems could have been caught far sooner or avoided altogether if audits and background checks were routine practice.

**Recommendation:**
Require that: 1) all facility employees handling resident money or accounts be subject to a criminal background check prior to employment and annually thereafter; 2) resident fund accounts be audited by an outside entity with no affiliations with the facility at least biannually; and 3) nursing home administrators be responsible for reviewing the accounts for irregularities annually.

**§483.11(d)(5)(v) Conveyance upon discharge**
Consumer Voice appreciates the expansion of this requirement to include upon discharge and eviction since residents and their representatives have reported problems with receiving their funds in a timely fashion upon leaving the facility. We encourage CMS to clarify the difference between "discharge" and "eviction" and to define "eviction" if the term will be used since it is not referred to anywhere else in the proposed regulations.

**§483.11(d)(6) Charges against resident personal funds**

**§483.11(d)(6)(i)**
Since the facility is not permitted to charge residents for the services listed in this provision we recommend changing "may" to "must." This will better ensure that residents will not end up paying for these services and items.

**Recommendation:**
**§483.11(d)(6)(i)** Services included in Medicare or Medicaid payment. During the course of a covered Medicare or Medicaid stay, facilities ~~may~~ ***must*** not charge a resident for the following categories of items and services:

**§483.11(d)(6)(ii)**
We welcome the new language that states that residents may not be charged for items/services if they are required to achieve the goals stated in the resident's care plan. This supports person-centered care practices and will make achieving those goals more likely.

**§483.11(d)(6)(ii)(L)(2)**
We thank CMS for proposing that facilities must take residents' needs and preferences and the overall cultural and religious make-up of the facility's population into consideration when preparing foods and meals. This will promote person-centered care since residents should not have to pay for meals/food that reflect their needs, preferences and cultural and/or religious backgrounds.

**§483.11(e) Information and communication**

**§483.11(e) Information and communication**
Consumer Voice is pleased that CMS would require facilities to ensure that information is provided to each resident in a form and manner the resident can access and understand.

We agree with CMS that it is essential for residents to have the opportunity to understand all information that is provided.

**§483.11(e)(2) Access to records**
Please see our comments regarding records at 483.10(f)(3).

**§483.11(e)(3) Survey report**
We object to the addition of "upon request" in the proposed rule. This requirement would make residents and others have to ask to see survey reports. This is not the case in the current regulations and is contrary to the Interpretive Guidelines which state:

> "Made available for examination" means that survey results and approved plan of correction, if applicable, are available in a readable form, such as a binder, large print, or are provided with a magnifying glass, have not been altered by the facility unless authorized by the State agency, and are available to residents without having to ask a staff person.
>
> "Upon request" restricts residents' access to survey reports by making it more difficult to view them. Residents may not want staff to know that they are reviewing the survey and such a requirement might inhibit them from obtaining this information. In addition, staff may be busy and not able to provide the surveys to residents or others who wish to see them. This is also a problem for prospective residents and their families touring the facility who should have ready access to these reports at the time of their visit.

**Recommendation:**
**§483.11(e)(3)** The facility must make reports with respect to any surveys, certifications, and complaint investigations conducted by Federal or State surveyors during the 3 preceding years available for any individual to review ~~upon request~~ and any plan of correction in effect with respect to the facility available for examination in a place readily accessible to and in a form understandable by residents, ***without having to ask a staff person,*** and must post a notice of its availability.

**§483.11(e)(4) Posting information**
The term "support person" is not defined and appears nowhere else in the proposed regulations. This posting should be available not just to residents and resident representatives, but also to visitors, volunteers and others in the facility.

**Recommendation:**
**§483.11(e)(4)** The facility must post, in a form and manner accessible and understandable to residents, resident representatives and ~~support person~~ ***any individual in the facility, including visitors and volunteers***:

**§483.11(e)(4)(i) List of names, addresses and telephone numbers**
As noted in our comments for **§**483.10(f)(2), we are pleased to see the addition of adult protective services and home and community based services programs to the list of

names and contact information to be posted. However, information about the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act or other No Wrong Door Program) and the local contact agency for residents who might wish to transition back to the community should also be posted since this is the agency that will actually assist with the transition.

**Recommendation:**
**§483.11(e )(4)(i)** A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State survey and certification agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, ***the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act) or other No Wrong Door Program), the local contact agency for residents who might wish to transition back to the community***, and the Medicaid fraud control unit;

**§483.11(e)(4)(ii) Statement about filing a complaint**
The information the facility would be required to post under this proposed requirement and the information it would be mandated to give residents in writing at §483.11(e)(12)(iv) differ regarding filing a grievance or complaint with the state survey and certification agency. The posting states that residents may file a complaint only "concerning resident abuse, neglect, misappropriation of resident property in the facility, and non-compliance with the requirements specified in 42 CFR part 489, subpart I," while the written information called for is much broader and includes complaints concerning any suspected violation of state or federal nursing facility regulations and requests for information regarding returning to the community. The posted and written information should both provide as much information to the resident as possible.

**Recommendation:**
**§483.11(e)(4)(ii)** A statement that the resident may file a complaint with the State survey and certification agency concerning ***any suspected violation of state or federal nursing facility regulations, including but not limited to*** resident abuse, neglect, misappropriation of resident property in the facility, non-compliance with the requirements specified in 42 CFR part 489 subpart I (Advance Directives)~~.~~, ***and requests for information regarding returning to the community***.

**§483.11(e)(7 )(D)(iii)(A) Notification of changes - room or roommate**
Please refer to our comments under 483.10(6) Notice before change in room or roommate

**§483.11(e)(11)(v) Admission contract provisions**
We support the addition of this proposed requirement. We have reviewed admission contracts and found many of them to include provisions that violate the regulations and often the Nursing Home Reform Law itself. However, residents and families who do not know the law and regulations believe they must follow what the contracts says. We join Justice in Aging in requesting one revision. The regulation's current language applies

only when the facility "requires" execution of an admission contract. The language should be changed to refer to all admission contracts, whether or not "required." Nursing facilities often attempt to avoid contract-related laws by claiming that a resident or resident representative was not required to agree to a contract or provision, but purportedly "volunteered" to do so.

**Recommendation:**
**§483.11(e)(11)(v)** ~~Where the facility requires the execution of an admission contract by or on behalf of an individual seeking admission to the facility~~, the terms of ~~the~~ ***an admission*** contract must not conflict with the requirements of these regulations.

**§483.11(h) Grievances**
Consumer Voice commends CMS for significantly enhancing residents' rights to voice grievances. This emphasizes the importance and seriousness of resident concerns. We are pleased to see that facilities must create a grievance policy and appoint a Grievance Official. This will better ensure that complaints are processed and responded to appropriately, and that residents know how to file a complaint. We recommend that every resident be given a copy of the written grievance policy upon admission and not just upon request. Every resident should know what the policy is from the beginning of their stay.

We agree with many aspects of the grievance process CMS proposes. It is very helpful to have a person specifically tasked with handling grievances from beginning to end and who is required to take immediate action to prevent further potential violations, although this should include any violations of state and federal requirements, not just resident rights as noted in (iii). We also believe the grievance official should be responsible for protecting the complainant from retaliation since many residents will not speak up because they fear reprisal.

We are also pleased that CMS is proposing that the Official issue written grievance decisions, and we support the proposed content of the decisions. Additionally, we recommend that residents be given the room number in the facility if the Official is housed within the facility and a toll free number if not, and be provided with information about where they can turn within the facility organization if they are not satisfied with the decision. This could be a regional manager or a member of a board of directors. Furthermore, since it is important that the resident understand the decision, CMS should require that it be provided to each resident in a form and manner the resident can access and understand. Finally, it is unlikely that one person can take corrective action. We suggest that the Grievance Official do this in conjunction with the administrator and other appropriate staff.

Additionally, Consumer Voice suggests that the grievance policy include the establishment of a grievance committee that would consist, at a minimum, of the administrator of the facility or his/her designee, a resident selected by the resident population of the facility, the facility social worker, and the Grievance Official. The work of the Grievance Official would be reviewed by the full committee so he or she is not operating in a vacuum and there would be resident involvement in the process.

Our recommendation below reflects these comments and those regarding §483.10(j).

**Recommendation:**
**483.11(h) (2)** The facility must make ~~prompt~~ efforts to resolve ***within 10 business days*** grievances the resident may have, including those with respect to ***care and treatment which has been furnished as well as that which has not been furnished; the behavior of other residents and staff; and any other concerns regarding their nursing home stay***. ***If more than 10 days is needed, the facility shall inform the resident in writing and include the reason more time is necessary and when the efforts will be completed.***

(3) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in §483.10. ~~Upon request, t~~The ***facility*** ~~provider~~ must give a copy of the grievance policy to the resident ***upon admission***. The grievance policy must include:

(i) Notifying resident individually ~~or~~ ***and*** through postings in prominent locations throughout the facility of the right to file grievances verbally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email), ***room number if the official is located within the facility;*** and business phone number ***or toll free number if the official is located outside the facility; the right to expect the review to be completed within 10 business days;*** ~~a reasonable expected time frame for completing the review of the grievance;~~ the right to obtain a written decision regarding his or her grievance ***in a format or language the resident can understand***; ***the contact information for someone within the facility organization whom the resident can contact if he or she is not satisfied with the decision findings***; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long Term Care Ombudsman program or protection and advocacy system;

(ii) ***Establishing a Grievance Committee consisting of at least the administrator or his/her designee, a resident selected by the resident population, the facility social worker and a Grievance Official. The committee will oversee the work of the Grievance Official and ensure the effectiveness of the grievance policy and process.***

***(A)*** ~~**Identifying a**~~ ***The*** Grievance Official ~~who~~ is responsible for overseeing the grievance process, receiving and tracking grievances through their conclusion; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously; issuing written grievance decisions to the resident; and coordinating with State and Federal agencies as necessary in light of specific allegations;

(iii) As necessary, taking immediate action to ***protect the resident from retaliation and*** prevent further potential violations of ***any state or federal requirement*** ~~resident right~~ while the alleged violation is being investigated;

**§483.12 FREEDOM FROM ABUSE, NEGLECT, AND EXPLOITATION**

Consumer Voice supports the creation of this new section, which brings more attention and focus to abuse, neglect and exploitation. We also support the new provisions that would provide greater protections for residents. In particular, we are pleased to see that exploitation would be included and that facilities would be required to:

- Not employ or otherwise engaging individuals with certain findings or disciplinary actions against them.
- Not employ licensed individuals with a disciplinary action against their license
- Develop policies and procedures related to prohibit, prevent and investigate abuse, neglect, exploitation or misappropriation of resident property
- Report alleged violations of abuse, neglect, exploitation, misappropriation of resident property to adult protective services where state law provides for jurisdiction in long-term care facilities
- Provide training
- Report suspicion of a crime to law enforcement and the state survey and certification agency

We have two recommendations.

1. We believe that giving covered individuals up to two hours to report to law enforcement and the state agency in cases of serious bodily injury is unacceptable. Outside a nursing home, societal expectation is that any citizen who suspects a crime resulting in serious harm to another person would immediately contact law enforcement. Waiting can place the person in increased danger or put others at risk. Nursing homes, where extremely vulnerable and dependent individuals reside, should be held to the same standard.

2. Those of us who live in the community would immediately call the police if we had reason to believe items had been stolen from our home. There should be the same expectation in a nursing home, where theft of resident personal possessions continues to be a serious problem. Reporting suspected theft as a crime could serve as a deterrent and send a message that stealing will not be tolerated. To this end, Consumer Voice recommends that CMS clarify in guidelines that suspicion of theft of resident property is considered a reportable crime.

**Recommendation:**

**§483.12(b)(5)(i)(B)** Each covered individual shall report ***immediately*** ~~not later than 2 hours~~ after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury.

**§483.15 TRANSITIONS OF CARE**
Consumer Voice supports the detailed comments and proposed changes submitted by Justice in Aging for this section.

In addition, we want to indicate our position on a few key provisions:

**§483.15 Resident rights described as provisions relating to "transitions"**
Proposed section §483.15 uses the title "Transitions of Care," although it contains many provisions that are denominated as "Admission, transfer and discharge rights" in current 42 C.F.R. §483.12. The proposed loss of the term "rights" is troubling for two reasons. First, the term "rights" emphasizes the fact that a nursing facility is home to its residents, and they should not be deprived of that home except in rare circumstances. The term "transitions," by contrast, suggests that a resident's place of residence is of relatively little import as the resident "transitions" through levels of care.

Second, state nursing facility laws often incorporate the federal resident's rights. If the federal rights in section §483.15 are no longer denominated as rights, they may not be incorporated by these state law provisions, which would lessen the protection extended to nursing facility residents.

**§483.15(a)(2), (3) "Requesting" improper contractual provisions**
We strongly support the addition of the word "request" in subsections (2)(i), (ii), (iii), and (3). Sometimes facilities attempt to evade current law by using contracts that "request" but purportedly do not "require" residents to take on certain unfair obligations. From a consumer's perspective, these provisions are objectionable whether the provision is phrased as a request or requirement. In either case, the facility is drafting the contract, and the resident (or resident representative) is signing the contract with little understanding of its contents, and little or no ability to negotiate terms.

**§483.15(a)(2)(iii) Waivers of liability**
We support the proposed provision that prohibits waivers of a facility's liability for loss of personal property, but do not understand why this provision should be limited to personal property. All waivers of liability should be prohibited, whether they relate to (for example) the loss of a resident's clothing, or negligent care by facility staff.

**§483.15(a)(3) Suing a resident's family member or friend for a resident's unpaid facility bills**
Federal law prohibits a nursing facility from requiring a resident's family member or friend to sign a financial guarantee to become financially responsible for the resident's nursing facility expenses. Many facilities today are evading the no-financial-guarantee rule by using contracts that commit a resident representative to pay facility charges from the resident's income or resources, and to take all necessary steps to submit a Medicaid application on the resident's behalf. If the resident's bill is unpaid, the facility then sues the representative on the contract, arguing that the representative has breached his or her contractual duties, and also arguing that this contractual obligation does not violate the no-financial-guarantee rule.

We ask CMS to revise the regulation to prohibit this evasion of current law. A resident's family member should not face potentially enormous financial liability because a resident's bill is (allegedly) not paid in full, or a Medicaid application is denied due to insufficient information. Such contractual provisions are just as unfair and coercive as the financial guarantees that explicitly are prohibited by current federal law.

We note that existing law has other tools for a nursing facility to use if a resident representative has misappropriated a resident's money, rather than paying a facility. For example, courts have found family members liable to nursing facilities for fraudulent conveyance when they have used the resident's money for themselves, rather than paying nursing facility bills.

**§483.15(a)(6) Disclosure of "special characteristics or service limitations"**
We urge complete deletion of proposed section §483.15(a)(6), which obligates a nursing facility at admission to give "notice of special characteristics or service limitations." The proposed subsection implies that a facility could use this notice to diminish the standard of care otherwise established by federal and state law, and to justify involuntary transfers and discharges for a purported inability to meet a resident's needs.

The preamble discussion refers to a "more predictable" transfer if "the need for specific types of care or services later become necessary," and gives the example of notice that a facility could not care for residents needing "psychiatric care." In fact, many persons, both inside and outside of nursing facilities, have psychiatric diagnoses, and the nursing facility regulations explicitly establish a nursing facility's duty to provide specialized services for residents with mental illness. Under the proposed subsection, a facility might well attempt to engineer the involuntary transfer or discharge of a "heavy care" resident with mental health issues, rather than providing the care otherwise required under the federal nursing facility law.

The preamble discussion also suggests that a facility's "religious affiliation" might lead to a facility giving notice of "any special characteristics, requirements, or limitations." This is a slippery slope, threatening a situation where a facility might cite its religious affiliation to justify various limitations on care.

For all these reasons, we urge the deletion of subsection (a)(6). If it were to go into effect, its primary effect would be to encourage facility discrimination against residents with higher care needs.

**§483.15(b)(1)(iii) Appeal of an involuntary transfer/discharge**
We support CMS's common-sense protection to prohibit an involuntary transfer or discharge while the resident's appeal is pending.

**§483.15(b)(3)(i)) Copies of notices of proposed transfer/discharge to ombudsman program**

We support the proposed provision requiring copies of transfer/discharge notices be sent to the Long-Term Care Ombudsman Program. We ask CMS to delete language requiring resident consent, since that would give facilities an opportunity to find justifications for not notifying ombudsman programs. Ombudsman programs are "health oversight agencies" under HIPAA, so the resident's consent is not required prior to release of information. *See* Information Memorandum AOA-IM-03-01 (Feb. 4, 2003). We also suggest that the language be revised to specify that notice be sent to the local ombudsman program (rather than to the state ombudsman office).

**§483.15(b)(4)(ii) Reduced notice**

Current law says that under certain circumstances a facility "may" give reduced notice of proposed transfer/discharge. In the proposed regulations, however, "may" has been changed to "must."

We strongly recommend that the relevant language be changed back to "may." Otherwise, a facility would feel an obligation to always give the most limited notice period possible, which would greatly disadvantage residents.

**§ 483.15(c)(3)(i) Readmission to the same room**

We support the proposed requirement that, in readmitting a hospitalized resident to the next available nursing facility bed, the resident should be readmitted to the previous room, if that room is available.

**§483.15(c)(3)(ii) Right to appeal when bed hold or readmission request is denied**

We are both encouraged and troubled by subsection (c)(3)(ii) which appears to authorize an administrative hearing for residents who have been denied readmission. The troubling aspects of the subsection are its limited scope and vague language. The subsection relates only to readmissions, but should also include instances when a facility refuses to honor a bed hold. Our biggest concern is the subsection's failure to clearly state that a resident has an appeal right when he or she is not allowed to return to a facility after a hospitalization or other therapeutic leave. Given the importance of appeal rights, and the many instances in which nursing facilities essentially dump residents in hospitals, the final regulations should be much more explicit in stating that a resident has a right to appeal when denied his or her rights under a bed hold or under the provision that provides readmission to the next available room.

We also recommend that the regulation be revised to specify that a facility can only refuse a bed hold or a readmission right if 1) the resident's needs cannot be met in the facility, or the resident's presence in the facility would endanger others' safety or health, and 2) the resident's condition does not allow for the facility to follow the standard notice procedures for involuntary transfers and discharges. In general, a hospitalization should not be a means for a facility to evade the normal procedural requirements applicable to involuntary transfers and discharges.

## §483.20 RESIDENT ASSESSMENT

### §483.20(b)(1) Assessment

Consumer Voice strongly supports the proposed requirement that a facility must assess not just a resident's needs, but their strengths, goals, life history and preferences. In order to help residents attain or maintain their highest level of well-being, a facility must know about the resident as a person. Gathering this additional information will promote person-centered care.

### §483.20(b)(xviii) Documentation of participation

We are pleased to see the inclusion of direct access staff members in the assessment process. These individuals, who include housekeeping and maintenance staff, have contact and interaction with residents and often know a great deal about the resident, how he or she is doing, and his or her needs and preferences. Their input is valuable and important.

We would recommend that direct access staff be defined in order to provide more clarity.

### §483.21(a) Baseline care plans

We strongly support requiring the facility to develop a baseline care plan. Staff need to have relevant information about the resident and instructions for care as quickly as possible in order to support the resident and prevent decline and injury. However, requiring that this baseline care plan be created within 48 hours means that the plan might not be ready until 48 hours have passed. This is too late since staff need to know from the time of admission how to support and care for a resident in an individualized and person-centered manner. For instance, staff need to know from the beginning - starting with the very first night - that a resident always gets up in the middle of the night to go to the bathroom.

Moreover, to better ensure that staff have the most important information right from the start, CMS should require the facility to obtain medication orders and information about the resident's customary routines and preferences. We also support the recommendation by the American Bar Association that the baseline care plan should include, if applicable and with the resident's consent, Portable Orders for Scope of Treatment.

Once the information is obtained, it must be communicated to staff. This may sound obvious, but we frequently hear from residents and their families that staff caring for them during the first few days did not have key details about their needs. It is also critical that the plan be carried out using staffing practices that help staff get to know the resident. It is of little use if the information about a resident is communicated to staff who are then not assigned to the resident.

### Recommendation:

**§483.21(a)** 483.21 Comprehensive person-centered care planning.

(a) *Baseline care plans.* (1) The facility must develop a baseline care plan for each resident that includes the instructions needed to provide effective and

person-centered care of the resident that meet professional standards of quality care. The baseline care plan must –
(i) Be developed ~~within~~ **starting** ***upon a resident's admission*** and over the first 48 hours ~~of a resident's admission~~ ***of his or her stay***. ***The information must be sufficient to allow staff to deliver person-centered care immediately.***
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to—
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable. (A) Initial goals based on admission orders.
***(G) Medication orders.***
***(H) Resident customary routines and preferences.***
***(H) Portable Orders for Scope of Treatment, if applicable and with resident consent.***
***(iii) Be implemented through staffing practices that maximize staff's ability to get to know each new resident.***

**§483.21(b)(2)(ii) Members of interdisciplinary team**
We are very pleased to see that the interdisciplinary team would include a nurse aide with responsibility for the resident, a member of the food and nutrition services staff, and a social worker. Since nurse aides provide approximately 90% of the direct care to residents, they are the ones most likely to know the resident and know how the resident is doing. The involvement of a member of the food and nutrition services staff and a social worker is also extremely important in order to ensure that the totality of a resident's needs are met.

However, we ask CMS to clarify how it envisions social workers being part of each resident's IDT when facilities with 120 or fewer beds are not mandated to have a social worker and those with more than 120 are only required to have one social worker. We cannot see how the proposed requirement of IDT participation can be met without changes to the regulations.

Furthermore, Consumer Voice supports the comments of the Center for Medicare Advocacy that if a resident is prescribed psychotropic drugs, the appropriate health care professional is a pharmacist, who has the professional background to advise the IDT about drug interactions and the inappropriateness of antipsychotic drugs for individuals who do not have a diagnosis of psychosis, among other issues. The rules should mandate participation of this professional, as appropriate.

**§483.21(b)(2)(ii)(F) Involvement of resident and resident representative**
Consumer Voice strongly supports the participation of the resident and the resident's representative(s) in the IDT and the proposed requirement that the facility would have to

provide an explanation if such participation is found not practicable. This would better ensure resident involvement in decision making. However, we believe that CMS has not gone far enough and that the facility should actively facilitate and promote involvement of the resident, the resident representative and anyone else the resident wishes to attend. Facilitation would entail advance written notice of the date and time of the care plan meeting and reasonable accommodation of the schedules of the resident, resident representative and/or others invited at the resident's request. Additionally, the facility should also arrange for conference calls or electronic tools for video conferencing if necessary to permit participation.

Care plan meeting

Consumer Voice strongly supports requiring that the care plan be developed at a care plan meeting and that all members of the IDT must participate to the extent practicable. Residents and their representatives need to be able to ask questions, raise concerns and discuss their care directly with representatives from the disciplines involved in that care. Far too often, there may be only one nurse present at the meeting. We would suggest that if the presence of an IDT member is not possible, that the member provide a written explanation for their absence in the resident's record (similar to that proposed when the participation of the resident and their resident representative is determined to be not practicable).

**Recommendation:**

**§483.21(b)(2)(ii)** Prepared by an interdisciplinary team ***at a care plan meeting,*** that includes but is not limited to—

(A) The attending physician.

(B) A registered nurse with responsibility for the resident.

(C) A nurse aide with responsibility for the resident.

D) A member of food and nutrition services staff.

(E) A social worker.

(F) ***A pharmacist, if the resident is prescribed any psychotropic medication.***

~~(F)~~ (***G)To the extent practicable, members of the interdisciplinary team must attend the care plan meeting in person or participate by phone or video conference. An explanation must be included in the resident's medical record if the participation of a member is not practicable.***

***(H)*** To the extent practicable, the participation of the resident***,*** ~~and~~ the resident's representative(s)~~.~~***, and anyone else the resident would like to have present. The facility must facilitate the involvement of these individuals by providing advance written notice of the date and time of the care plan meeting; reasonable accommodation of the schedules of the resident, resident representative or others invited at the resident's request, and alternate means of participating in the meeting, such as conference calls or electronic tools for video conferencing.*** An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.

~~(G)~~ ***(I)*** Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.

**§483.21(b)(2)(iii) Revision of care plan after assessment**
We urge CMS to require that a copy of the care plan be given to the resident and with resident consent to the resident representative whenever the care plan is revised. However, the resident must be able to understand the care plan, which is often written in medical jargon, using medical abbreviations. To promote resident understanding of his or her own plan, we recommend that a revised version of the language proposed in 483.11(e) be added.

**Recommendation:**
**§483.21(b)(2)( (iii)** Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
***(iv)The facility must ensure that the information in the care plan is provided to each resident in a form and manner the resident can access and understand, including in an alternative format or in a language that the resident can understand.***

**§483.21(b)(3)( (iii) Culturally competent and trauma-informed**
We agree that services must be culturally competent and trauma-informed. This supports person-centered care.

**§483.21(c)(1) Discharge planning process**
We commend CMS for putting forth comprehensive and meaningful requirements for discharge planning. For too long, residents have returned to their homes in the community or been transferred or discharged to other health care settings with inadequate preparation and too little information for the receiving providers. Equally problematic is the fact that residents and their representatives have often had little to no involvement in the discharge planning process and have instead been told where they are going, not given a choice. For this reason we are pleased to see that there would be a discharge planning process that would include them.

**§483.21 (c)(1) Discharge planning process**
We support the ABA recommendation that the POLST be included as part of the discharge planning process.

**Recommendation:**
**§483.21 (c)(1)** Discharge planning—
(1) Discharge planning process. The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals and preparing residents to be active partners in post-discharge care, effective transition of the resident from SNF to post-SNF care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must—
***(x) Include a review and update of a resident's POLST if applicable and with resident consent.***

**§483.21 (c)(1)(iv) Caregiver support**
Consumer Voice recognizes the critical role that family caregivers play in providing services and supports that permit many older adults and persons with disabilities to return to the community. We believe that the capacity, capability and willingness of a caregiver/support person to perform required care must not only be considered, but also assessed. Some may think they can do more than they really can, and others may not want to perform care at all.

**Recommendation:**
**§483.21 (c)(1)(iv)** Consider caregiver/support person availability, and ***assess*** the resident's or caregiver's/support person's capacity***,*** ~~and~~ capability***, and willingness*** to perform required care, as part of the identification of discharge needs.

**§483.21 (c)(1)(vii) Returning to the community**
We thank CMS for proposed requirements that would emphasize and underscore the facility's role in providing information to residents about nursing home transitions and assisting them in connecting to outside agencies to return to the community, if possible. In a recent report conducted by the Consumer Voice, nursing home residents we interviewed repeatedly told us that facility staff did not tell them about or provide them with any information about the possibility of returning to the community - many residents found out from other residents or the ombudsman. Far too often, facility staff assume that residents cannot leave the facility and live in the community. We believe that the provision mandating that the facility document who made the determination that discharge to the community is not feasible and why is essential to changing this facility mentality and practice.

**§483.21(c)(2) Discharge summary**
We are pleased to see that the requirements related to the discharge summary have been expanded to include reconciliation of all pre-discharge medications with the resident's post-discharge medications and agree with CMS that this would help avoid situations in which residents are mistakenly placed on duplicate prescriptions leading to an adverse event and unnecessary hospitalization. As with the care plan, the post-discharge plan should be written so that residents can access and understand it, and a copy of the plan should be given to the resident, and with the resident's consent, to his or her representative.

**Recommendation:**
**§483.21(c)(2)(iv)** A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, his or her family, which will assist the resident to adjust to his or her new living environment. The post discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge. ***The information in the plan must be provided to each resident in a form and manner the resident can access and understand, including in an alternative format or in a language that the resident can understand. A copy must be given to the resident and his/her representative with resident consent.***

**Discharge Assistance**
From our examination of nursing home transitions, we observed that nursing home staff are not providing adequate assistance to residents as they prepare to leave the facility and at the time of the actual move/discharge. Former nursing home residents reported that staff did not help them make phone calls, pack, obtain prescriptions for medications they would need immediately upon leaving the facility, get paperwork together or ensure they left with their remaining medications. While individuals transitioning out of a nursing home often have family or friends to help them, this is not always the case.

**Recommendation:**
***§483.21(d) Upon request of the resident, the facility must assist a resident who is returning to the community or relocating to another healthcare facility with the tasks necessary for the relocation, including but not limited to: assisting with phone calls, packing, and obtaining remaining medications and prescriptions needed post-discharge.***

**§483.25 QUALITY OF CARE AND QUALITY OF LIFE**
Consumer Voice's comments for this section fall into two categories 1) restructuring and reorganization; and 2) specific provisions.

Restructuring/Reorganization
Consumer Voice strongly opposes combining the Quality of Care and Quality of Life sections and recommends that Quality of Life be a separate section.

One of the groundbreaking and revolutionary aspects of the Nursing Home Reform Law (NHRL) has always been that it entitles nursing home residents to quality of life as well as quality of care. The law establishes that a facility:

> *…must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.*

This language was front and center in the NHRL - the very first standard under "Requirements Relating to Provision of Services." Never before - either in the pre-1987 nursing home regulations or in other health care settings - had quality of life featured so prominently in a law and been elevated to the same level of importance as quality of care.

Deleting the Quality of Life section undoes that by sending a strong message that quality of life is not essential. In the preamble, CMS argues that making care planning a stand-alone section raises its importance: "we believe that relocating the requirements to a new section dedicated solely to care planning would emphasize the importance of care planning…." It follows that the reverse is true – eliminating the section on Quality of Life reduces its importance. This seems contrary to CMS's stated intent to promote person-centered care.

Also troubling is that CMS has scattered the provisions under the Quality of Life section in the current Requirements of Participation throughout the proposed regulations. The requirement that a facility must maintain or enhance each resident's quality of life is under Facilities Responsibilities, while most of the other provisions are under Resident

Rights. They no longer come together to form a coherent whole that gives a comprehensive sense of the components of quality of life. Just one provision remains in the proposed Quality of Care and Quality of Life section – activities.

A second major concern is that CMS limits this section to concerns that, according to CMS, do not fit elsewhere and moves some of the specific care areas to other sections. We join the Center for Medicare Advocacy (CMA) in being particularly concerned about moving medications to pharmaceutical services. A resident/family/advocate looking at the proposed §483.25 would not know that medications are addressed elsewhere and would not know where to look. At the same, CMS includes restraints and bed rails in the Quality of Care and Quality of Life section, which we oppose; restraints are not an appropriate method for providing care and do not belong in the Quality of Care section.

We also urge CMS to reorganize some of the proposed provisions within Quality of Care, in particular those listed as special care needs. We agree with CMA that care requirements common to all or most residents should be separately identified, without the modifier of "special care needs." The term "special care issues" should be restricted to issues that are truly special, in the sense of "unusual."

**Recommendation:**
We make the following recommendations regarding structuring of this section:

- Restore Quality of Life as its own section that includes language from the beginning of proposed rule §483.11; (treat each resident with respect and dignity, etc.); self-determination language from proposed rule §483.11(e); social services provisions (proposed rule §483.40(d)); and safe environment language (proposed rule §483.11(g), in addition to the language in the proposed rule about activities.
- Create a new section on physical restraints that includes bed rails.
- Retain assisted nutrition and hydration, prostheses, dialysis, and trauma-informed care as special care issues and move the rest of the issues to another part of the section.

<u>Specific provisions</u>
We commend CMS for adding several new provisions to the Quality of Care section. These include CPR, oral care, fecal incontinence, foot care, mobility, pain management, dialysis and trauma-informed care. Each of these areas is critical for resident health and well-being. We also appreciate the language added to (d)(8) regarding enteral feeding as it ensures a resident's consent is required to for such medical action.

**However, we believe there are a few ways in which the proposed rule should be improved.**

**§483.25 Attaining and maintaining highest practicable physical, mental, and psychosocial well-being**
Residents cannot maintain or improve their highest level of well-being without good staffing practices that consist of adequate numbers of competent, consistently assigned

staff working well with the whole care team. CMS should reinforce the need for strong staffing practices in the proposed rule.

**Recommendation:**
**§**485.25 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care~~,~~ ***and through staffing practices that maximize competency, continuity, and coordination of care.***

**§483.25(d)(4) Skin integrity**
The current regulation begins with the statement that the resident who enters the facility without pressures should not develop them unless the resident's clinical condition demonstrated that they were unavoidable. The proposed §483.25(d)(4)(i)(A) omits that language entirely, beginning instead with the requirement that the facility provide care to prevent development of pressure ulcers. This undermines one of the central principles of the Nursing Home Reform Law - that a resident who enters a facility without a particular problem should not get it unless it was medically unavoidable for that individual. This point is missing in the proposed regulation about pressure ulcers. Since the development of avoidable pressure ulcers continues to be a major problem in nursing homes today, the current language should be restored.

**Recommendation:**
**§483.25(d)(4)(A)** ~~A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and~~ ***A resident who enters the facility without pressure ulcers*** does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable;

**483. 25 (d)(1) PHYSICAL RESTRAINTS**
As noted above, a separate section should be created for physical restraints. That section should include more detailed language and additional safeguards.

The proposed language adds a sentence about using the least restrictive alternative for the least amount of time and documenting ongoing evaluation of the need for the physical and chemical restraints. Although this new language is helpful, the proposed regulation does not adequately protect residents. Such protections should include an environmental assessment, informed consent, an in-person evaluation by the resident's physician, and release and monitoring.

**Recommendation:**
*Restraints*. The facility must ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. ~~When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.~~

***~~(a)~~ Physical restraints. The facility must ensure that it:***

***(i) Attempts to identify and meet the resident's medical, social, psychosocial needs, including an assessment of the environment to determine whether there is an environmental cause of the resident's discomfort, before considering use of restraints, except in an emergency, as discussed in ( ).***

***(ii) Determines that the resident's physician has conducted an in-person physical examination before ordering the restraint and***

***(A) Has determined that the resident does not have any unaddressed medical condition that could be causing the resident pain or discomfort;***

***(B) Has reviewed the risk and benefits of the physical restraint with the resident and resident's representative and obtained informed consent prior to the use of the physical restraint.***

***(C) Has included in the order for a physical restraint,***

***a. the duration of the restraint (ensuring that the restraint is used for the least amount of time) and***

***b. the frequency of staff releasing the restraint (ensuring that the restraint is released no less frequently than every two hours);***

***(iii) When the use of restraints is indicated, the facility must***

***(A)*** use the least restrictive restraint for the least amount of time***, as specifically ordered by the resident's physician***

***(B) monitor the resident in a restraint as ordered by the physician, but no less frequently than every two hours***

(C) Document ongoing re-evaluation of the need for restraints.

**Bed rails**

CMS currently defines bed rails as physical restraints when they prevent a resident from voluntarily getting out of bed. While some residents use bed rails to reposition themselves in bed or assist them when getting out of bed, for physically frail residents – especially those with dementia, delirium, or confusion – the risks of serious injuries and death from falls or entrapment, entanglement, and asphyxiation contradict claims that bed rails make patients safer. Alternatives, such as lowered beds and padding on the floor, provide better protection from fall-related injuries. Between 1985 and 2013, 531 bed rail deaths, 151 nonfatal injuries, and 220 interventions that prevented injuries were reported to the FDA under a voluntary system.

We support CMS's proposed language to improve protection of residents from bed rail injuries through measures such as trying alternatives, assessing residents for entrapment risks, and regularly inspecting bed rail systems. However, Consumer Voice does not believe these measures are sufficient. We urge CMS to further strengthen the proposed regulations in the following ways.

<u>Right to be free from bed rails used as a physical restraint or without the consent of the resident to treat a medical symptom</u>

Consumer Voice supports the recommendation of the California Advocates for Nursing Home Reform (CANHR) to create in §483.10(d) a standalone resident right to be free

from bed rails used as physical restraints or for any reason for which the resident himself or herself has not requested them to treat a medical symptom, such as assistance to facilitate mobility and independence; for which safety assessments proposed in the sections designated as §483.25(2) and §483.90(c)(3) have not been met; for which alternatives have not been attempted; and for which informed consent has not been given by the resident. Inability to give informed consent should be considered as a risk factor for endangerment.

Even if a resident is fully informed about bed rail hazards, decides that there are benefits that outweigh any risks, and requests a bed rail, informed consent does not obviate the responsibility of the facility to comply with the requirements in this regulation. Eliminating dementia and other factors that affect cognition reduces but may not eliminate risk, especially if the resident's medical condition or mental status changes unexpectedly or even temporarily. A resident who ordinarily realizes that trying to climb over a bed rail would be foolish may forget if a new drug or a urinary tract infection makes her confused. The movement of a mattress away from a bed rail, the addition of a mattress overlay, or the loosening or breaking of a bed rail's attachment to the bed frame could create a hazard. Periodically scheduled assessments of facilities' bed systems must be conducted, as well as prompt reassessments when there are even temporary changes in the resident's health, physical condition, or mental status, or when there is any change in the bed or bed rail. Alternative devices marketed as mobility assists (such as bed handles, bed canes, and halo rings) should be subject to the same concern and scrutiny as side rails because they carry the same entrapment hazards; and portable bed rails should be prohibited for use with any resident.

**Recommendation:**
We support the language proposed by CANHR:
***The resident has the right to be free from bed rails used as a physical restraint, for purposes of discipline or staff convenience, or for any purpose for which the resident himself or herself has not requested them to treat a medical symptom, such as the need to improve mobility and increase independence; for which all safety protocols in §483.25(2) and §483.90(c)(3) have not been complied with; for which alternative methods have not been attempted; and for which written informed consent has not been given by the resident. For a resident who gives informed consent, the facility must document that he or she has received information about the risks of entrapment and falls prior to installation of bed rails. Such consent shall not obviate the need for proper initial and ongoing assessment of residents and equipment.***

<u>Requirements When a Facility Uses Bed Rails</u>

As noted by CANHR, when other criteria for using a bed rail for a resident have been met (§483.10(d) and §483.90(c)(3)), a protocol should be in place for a risk assessment to be conducted by a qualified interdisciplinary team. Determining a resident's risk for bed rail injury and the safety of bed rails and bed components should not be left to a review by staff who may not have the knowledge to conduct such assessments.

**Recommendation:**
Consumer Voice once again supports CANHR's suggested language, which we would include in the separate section regarding physical restraints we call for above.

***When the requirements in §483.10(d) – The right to be free from bed rails used as a physical restraint or without the consent of the resident – are met, the facility shall have an interdisciplinary team of licensed staff, including at least a registered nurse, physician, and licensed physical and/or occupational therapist with knowledge of how to conduct risk assessments of residents and bed components. Risk assessments shall follow a protocol that includes:***

***(1) Documentation of alternatives the facility attempted with the resident prior to installing a bed rail.***

***(2) An interdisciplinary individualized risk assessment of a resident prior to installing bed rails and a reassessment each time there is a change in the resident's medical, physical or mental condition, including medications that may cause confusion or impaired cognition and reduced mobility. Risks include but are not limited to: small body dimensions, dementia, confusion, agitation, reduced mental capacity, and limited mobility.***

***(3) A safety assessment of each bed that is used with a resident, including the position of the bed rail(s) and mattress; the security of the attachment of the bed rail to the mattress; the type of mattress used (including air mattresses, mattress overlays, air fluidized beds, and flotation therapy beds, which pose greater entrapment risk); and gaps within rails and between rails and the mattress, the headboard, and the footboard, regardless of whether the bed rail used is a side rail or other rail-type device, such as a bed handle, bed cane, or halo ring.***

***(4) An assessment of the bed for potential movement of the rail or mattress and for spaces between the parts of the rail large enough to trap a resident's head or chest; and a regular process for repeating this assessment when any components of the bed system are changed, or bed systems are obtained from rental agencies.***

***(5) Prohibition of portable bed rails because variables that increase risks to residents—such as mattress type, width rail position, and secure installation – cannot be adequately controlled.***

***(6) Documentation of the results of the assessment.***

***(7) A provision to ensure that all staff have basic knowledge about bed rail risks and facility protocols and observe and immediately report any condition or incident involving a resident and a bed rail that has the potential for injury or death.***

***(8) Requirements for all personnel who provide care or services to residents in the facility (such as hospice) to comply with the facility's bed rail protocols.***

<u>Inspection and Maintenance of Bed Frames, Mattresses and Bed Rails, Section §483.90(c)(3)</u>

We agree with CANHR that proposed §483.90(c)(3) related to inspection and maintenance of bed frames, mattresses, and bed rails needs to be significantly strengthened.

**Recommendation:**
**§483.90(c)(3)** *The facility must:*
(3) Conduct regular inspection***s*** of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program ~~to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible~~ ***and compliance with facility risk assessment protocols, including the use of an interdisciplinary team of licensed staff with knowledge of bed rail safety assessment.***
***(4) Ensure that all components are compatible when bed rails and/or mattresses are used or obtained separately from a bed frame for which they were designed to be used.***
***(5) Ensure that when bed rails or bed systems with bed rails are purchased or rented already assembled or configured by a supplier, the facility should follow its own protocol to assess the bed's components to ensure that there is no risk of entrapment.***
***(6) Ensure that the bed and bed rail are assembled according to the manufacturer's specifications and do not have gaps within or between components that could cause entrapment.***
***(7)Repeat inspections whenever any component of the bed system is replaced since even "look-alike" parts can have differences that effect entrapment safety.***
***(8)Replace bed systems for which compatible components are no longer available; and discard bed rails that do not have a manufacturer's label because they cannot be identified in case of a recall or properly reported in the case of an incident.***

**§483.30 PHYSICIAN SERVICES**
Delegation of orders
Consumer Voice supports permitting physicians to delegate writing admission orders to physician assistants, nurse practitioners or clinical nurse specialists; dietary orders to qualified dietitians; and therapy orders to qualified therapists. Our observation has been that physician assistants, nurse practitioners and clinical nurse specialists often spend more time assessing a resident than a physician and that this can benefit the resident. Research shows that advanced practice nurses improve residents' care in nursing homes, so increasing their role with nursing home residents makes sense. We have also noted that dietitians and therapists frequently know the residents better than the physician, have a better understanding of the resident's strengthens and weaknesses, and have more in-depth knowledge of their areas of expertise. Furthermore, the physician can choose to not delegate to a dietitian or therapist, and if he or she does, the health care professional receiving that authority remains under the physician's supervision. This provides oversight and accountability.

In-person evaluation
Consumer Voice opposes this proposed requirement as it is currently written. While we understand and agree with the need to reduce unnecessary hospitalizations, we believe that this approach could have devastating negative consequences on residents, and even result in death. We are aware of situations in which families have advocated for a resident to be transferred to the hospital, but the facility has refused. In many of these instances, families called an ambulance to take the resident to the hospital out of

desperation and later learned that their loved one would have died had they not done so. Requiring an on-site evaluation would make it even more difficult than it currently is for a resident to be sent to the hospital.

In addition, the dividing line between whether an in-person evaluation of a resident must be made is whether the transfer to the hospital is emergent or non-emergent. However, this decision must be made by someone who has the appropriate training, knowledge and skills. There is currently no health care professional in a nursing facility 24 hours a day who could make that decision. Registered nurses are the only nursing personnel in a nursing home with the education and licensure to conduct the assessment necessary for such a determination. Although Consumer Voice respects and values the work of licensed practical nurses (LPNs), assessment is not within their scope of practice. However, facilities are only required to have a registered nurse 8 hours a day, 7 days a week. Consequently, many nursing homes will not have a RN round-the-clock who can evaluate whether or not a situation is an emergency. The decision will therefore be left to a LPN who must make a determination for which he or she has not been adequately prepared. If the wrong decision is made, there can be life-threatening consequences.

**Recommendation:**
Delete §483.30(e).

## §483.35 NURSING SERVICES

The Consumer Voice is deeply concerned that CMS has chosen not to mandate a specific minimum staffing standard and 24-hour registered nurse coverage in the proposed regulations. The lack of these provisions has been a major obstacle to quality care since the Nursing Home Reform Law was passed in 1987 and will continue to be until these standards are adopted.

### Relationship between staffing levels and quality

One of the major reasons CMS cites for not requiring a specific number of staff or hours of nursing care per resident is that it does not believe there is "sufficient information at this time to require a specific number of staff or hours of nursing care per resident."

We could not disagree more. The evidence supporting the critical importance of the amount and type of nurses needed in nursing homes to ensure quality of care is strong and convincing. Over the past 25 years, numerous research studies have examined the relationships between nurse staffing and quality (Bostick, Rantz, Flesner, and Riggs, 2006;[4] Castle, 2008;[5] Dellefield, Castle, McGilton, and Spilsbury, 2015).[6] On the whole,

[4] Bostick, J.E., Rantz, M.J., Flesner, M.K. and Riggs, C.J. (2006). Systematic review of studies of staffing and quality in nursing homes. *J. Am Med Dir Assoc*. 7:366-376.

[5] Castle, N. (2008). Nursing home caregiver staffing levels and quality of care: A literature review. *Journal of Applied Gerontology, 27*: 375-405.

[6] Dellefield, M.E., Castle, N.G., McGilton, K.S., and Spilsbury, K. (2015). The relationship between registered nurses and nursing home quality: An integrative review (2008-2014). *Nursing Economic$*, 33 (2):95-108 and 116.

many studies have documented a strong positive impact of nurse staffing on both the process and the outcomes of nursing home care, particularly RN staffing and the outcomes of care (IOM, 2003). A systemic review of 87 research articles and reports from 1975-2003 found that high total staffing levels, especially licensed staff, were associated with higher quality of care in terms of resident outcomes, particularly functional ability, pressure ulcers, and weight loss (Bostick, et al., 2006). Castle's (2008) review of 59 studies on nursing home staffing from 1991-2006 found that 40 percent of the indicators had significant positive associations with staffing and only 5 percent had negative associations. Further, Dellefield, Castle, McGilton, and **Spilsbury** (2015) reviewed 67 articles on RN staffing published between 2008 and 2014. They found many studies showed that higher RN staffing levels were associated with better resident quality in terms of fewer pressure ulcers, better quality measures, lower restraint use, reduced hospitalizations, fewer deficiency citations, decreased mortality, and decreased urinary tract infections. Many studies have also shown a strong relationship between increases in skilled nurse levels and reduced nursing home hospitalizations (Grabowski, Stewart, Broderick, and Coots, 2008;[7] Konetzka, Spector and Limcangco, 2007[8]).

A CMS 2011 study by Abt Associates showed that across the entire distribution of staffing levels (measured at the decile level), there is a strong association between higher staffing levels and better outcomes. Moreover, Abt's (2011) analysis shows a strong relationship between higher staffing and lower odds of hospitalization from nursing homes. The current CMS Technical Users Guide for the Medicare Nursing Home Compare 5-Star Rating System states, **"There is considerable evidence of a relationship between nursing home staffing levels, staffing stability, and resident outcomes. The CMS Staffing Study found a clear association between nurse staffing ratios and nursing home quality of care, identifying specific ratios of staff to residents below which residents are at substantially higher risk of quality problems."** Yet another Abt study of staffing levels based on 2014 data[9] shows that facilities with lower deficiencies from health inspections tend to have higher staffing levels. A number of other recent studies have also found a relationship between higher staffing of some or all types of nursing staff and lower deficiencies: Castle and Engberg (2010);[10] Castle, Wagner, Fergerson, and Handler, 2011;[11] CMS, 2001; Kim, Harrington,

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[7] Grabowski, D.C., Stewart, K.A., Broderick, S.M. & Coots, L.A. (2008). Predictors of nursing home hospitalization: A review of the literature. *Medical Care Research and Review,* 65 (1):3-39.

[8] Konetzka, R.T., Spector, W. & Limcangco, M.R. (2007). Reducing hospitalizations from long-term care settings. *Medical Care Research & Review,* 65:40-66.

[9] Abt Associates (2014). Analysis of www.data.medicare.gov (5-star archived data) and the Medicare Cost Report data (https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports/?redirect=/CostReports/

[10] Castle, N.G., Engberg, J. & Men, A. (2008). Nurse aide agency staffing and quality of care in nursing homes. *Medical Care Research and Review,* 65 (2):232-52.

[11] Castle, N.G., Wagner, L.M., Ferguson, J.C. & Handler, S.M.. (2011). Nursing home deficiency citations for safety. *J. Aging and Social Policy,* 23 (1):34-57.

and Greene 2009;[12] Kim, Kovner, Harrington, Greene, and Mezey 2009;[13] Schnelle et al., 2004;[14] Wan, Zhang, and Unruh, 2006[15]).

Yet CMS discounts the numerous studies cited above that support the relationship between nursing staff and quality and instead cites only two studies to support its argument against specific number of staff or hours: Spilsbury, Hewitt, Stirk, and Bowman (2011)[16] and Bowlis (2011). We would reduce that number to one because a close review of the Bowlis study shows that the research actually does support minimum staffing requirements. The study looked at the impact of Minimum Direct Care Staffing (MDCS) requirements on nurse staffing levels, nurse skill mix, and the quality of nursing home care from 1999 to 2004 and found:

- Higher MDCS requirements increase the total number of nurse staff employed in nursing homes.
- The effect is larger the higher the level of staffing that is mandated and for nursing homes that are more reliant on Medicaid.
- There is evidence that nursing homes in states with high MDCS requirements employ more RNs, but the result is only found for nursing homes that are more reliant on Medicaid.
- High Medicaid-reliant nursing homes hire more RNs relative to LPNs.
- MDCS requirements improve quality in terms of resident health outcomes and meeting federal standards (i.e., fewer deficiencies) for all nursing homes, regardless of reliance on Medicaid.
- Nursing homes that are more reliant on Medicaid are more likely to show greater improvements in health outcomes after increases in MDCS requirements.

**Facility assessment**

Instead of establishing a minimum staffing standard or requiring 24-hour RN coverage, CMS proposes a competency-based staffing approach that stems in part from a facility assessment. This assessment would call for the facility to base staffing plans and assignments on an evaluation of its population and resources, including the number and acuity of residents, the range of diagnoses and resident needs, and the training, experience, and skill sets of staff. This assessment appears to be put forth as the answer to requiring a specific number of staff or hours of nursing care.

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[12] Kim, H., Harrington, C. & Greene, W. (2009). Registered nurse staffing mix and quality of care in nursing homes: A longitudinal analysis. *Gerontologist*, 49 (1):81-90.

[13] Kim, H., Kovner, Harrington, C., Greene, W. & Mezey, M. (2009). A panel data analysis of the relationships of nursing home staffing levels and standards to regulatory deficiencies. *J. of Gerontology: Social Sciences*, 64B (2):269-278.

[14] Schnelle, J.F., Simmons, S.F., Harrington, C., Cadogan, M., Garcia, E., & Bates-Jensen, B. (2004). Relationship of nursing home staffing to quality of care? *Health Services Research*, 39 (2):225-250.

[15] Wan, T.T.H., Zhang, N.J. & Unruh, L. (2006). Predictors of Resident Outcome Improvement in Nursing Homes. *Western J. Of Nursing Research.* 28 (8):974-993.

[16] Spilsbury, K., Hewitt, C., Stirk, L. and Bowman, C. (2011). The relationship between nurse staffing and quality of care in nursing homes: A systematic review. *Int. J. Nursing Studies.* Epub.

Consumer Voice has several major concerns with relying on this assessment rather than requiring a minimum staffing standard. CMS states that this assessment is in line with current industry practice, thereby not requiring facilities to do anything different than they have been doing. This is alarming since the current industry practice has led us to where we are today and would simply be maintaining the status quo. CMS also states that "we believe a competency based approach will help to maintain flexibility in facility staffing and capability." This, too, would maintain the status quo since facilities have had flexibility for almost 25 years.

We do, however, believe that the facility assessment could be useful in addition to a minimum staffing standard if revised to include staffing practices and used as a factor to consider in adjusting staffing levels upward based on resident needs. See our recommendations below in this section and under Facility Assessment.

*The following sections address the need for both a minimum staffing standard of 4.1 hours of direct care nursing per resident per day and a registered nurse around the clock.*

**Minimum staffing standard**

Why a minimum is needed

The proposed requirement that the facility must have sufficient nursing staff to meet residents' needs would fail to address the long-standing problem that "sufficient" is vague and ambiguous. This lack of specificity means that the decision about staffing levels is up to individual nursing homes. This is what one resident had to say about this approach:

> *It's very clear why there needs to be a number - the current language is open too much to interpretation. Many facilities are corporate-owned businesses. Decisions about staffing are made outside the nursing home and over the heads of administrators. As long as the language is vague, corporations can do anything they want. We know insufficient staffing results in poor care and abuse. The time has come to address this issue.*

Establishing a minimum staffing standard creates a floor below which nursing homes cannot go. It protects against cost cutting measures taken by corporate owners and operators that impact nursing home quality and harm residents. A dramatic transformation in the nursing home industry since the regulations were first promulgated in 1991 underscores the need for those protections.

The industry has changed in three critical ways.

A. Sixty-eight percent (68%) of nursing homes are for-profit facilities and more than half of all facilities are part of a chain,[17]signaling an increasing shift in ownership to multistate corporations. This shift impacts quality: research has shown that for-profit facilities, particularly those owned by multistate chains, are more likely to reduce spending on care for residents and to divert spending to profits and corporate overhead. In 2011, the first-ever analysis of the ten largest for-profit nursing home chains reported that between 2003 and 2008, compared to all other ownership groups, facilities owned by the top ten for-profit chains had:

- The lowest staffing levels;
- The highest number of deficiencies identified by public regulatory agencies; and
- The highest number of deficiencies causing harm or jeopardy to residents.[18]

A recent situation in Massachusetts illustrates how chain ownership can affect care. Synergy, a nursing home chain, bought ten nursing homes in the state. According to a May 2015 article in the *Boston Globe*, "state inspection reports of Synergy's nursing homes routinely show striking increases in problems since the company arrived. In one home, a patient's pressure sores were neglected for weeks. In another, racks of dishes and utensils floated in dirty water just before they were used to serve food. And in a third, there were not enough nurses."[19]

B. A new trend has emerged - the purchase of nursing home chains by private equity firms. Private equity generally includes a range of investments that are not publicly traded. The goal is to improve the financial performance of the organizations purchased in order to recoup investments and yield high returns. A recent study in the *Journal of Health Care Finance* found that Florida nursing facilities owned by private equity firms have fewer registered nurses and more deficiencies than chain-owned for-profit facilities and that the longer the facilities are owned by private equity firms, the fewer registered nurses they employ and the more deficiencies they have.[20]

C. The third major shift in the nursing home industry is the rapid movement toward Medicaid managed long-term services and supports (MLTSS). A 2012 report projected that 26 states would have MLTSS programs in place by 2014.[21]

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[17] http://kff.org/medicaid/fact-sheet/overview-of-nursing-facility-capacity-financing-and-ownership-in-the-united-states-in-2011/

[18] Ibid.

[19] https://www.bostonglobe.com/metro/massachusetts/2015/05/04/out-state-chain-buys-massachusetts-nursing-homes-and-trail-complaints-follows/s6qSqABvSkHsc3bPhxIizO/story.html

[20] *Private Equity Ownership of Nursing Homes: Implications for quality*. Rohit Pradhan, Robert Weech-Maldonado, Jeffrey S. Harman, Mona Al-Amin, Kathryn Hyer,. June/July. 2014),http://healthfinancejournal.com/pdf/Pradhan%2C_MoldanadoEtAl_PrivEquityNursingHomes.pdf,

[21] *The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update*. Truven Health Analytics. Paul Saucier, Jessica Kasten, Brian Burwell, and Lisa Gold. July 2012. Prepared for the Centers for Medicare & Medicaid Services (CMS), Disabled and Elderly Health Programs Group under Contract #: HHSM-500-2005-00025I, Task Order No. 0002.

Under MLTSS, the state contracts with selected managed care organizations (MCOs) that, in turn, contract with nursing homes to provide care and services. In most situations, state Medicaid agencies pay contracted MCOs a set amount of money per member, and MCOs must then provide all covered services within that rate.

This creates an incentive for MCOs to contract with the least expensive nursing homes in order to maximize their profits. A study by the Long Term Care Community Coalition in New York examined the quality of nursing homes with managed care organization contracts in the state. Study results showed that almost 40% of the nursing homes were one star or two star facilities.[22] Under the CMS nursing home five star rating system, a facility can receive a rating ranging from one to five - with one being "much below average" and 5 being "much above average."

Without robust, explicit and detailed requirements, nursing homes seeking managed care organization contracts or owned by corporations or private equity firms are incentivized to reduce costs in ways that are harmful to residents.

For years, Consumer Voice has heard directly from residents, families and ombudsmen about how residents are hurt by inadequate numbers of staff. Here are just a few of those stories:

*Mrs. W, an 84 year old resident, appeared un-groomed when the ombudsman entered her room for a visit. The ombudsman noticed body odor, Mrs. W's hair was dirty and greasy, she had yellow film on her teeth and food crumbs from dinner on her shirt. She had dirt under her finger nails. The ombudsman asked Mrs. W how she was doing, and Mrs. W said, "Not too good. I haven't had a bath in 9 days. I would give anything to have a bath, change into some clean clothes, and wash these sheets." The ombudsman asked her if she had pressed her call bell and asked for these things, and Mrs. W said that she had, but the girls working told her they didn't have enough people. Mrs. W said she feels bad for the girls working because they're always busy, overwhelmed, and never have enough help. Mrs. W said she had not asked for a bath or to be changed in the last four days because she had asked so many times before and nobody did anything. She had given up hope of ever being cleaned up. Mrs. W's mental health and emotional well-being were jeopardized because she was degraded and felt as though she had been abandoned with no one to help her.*

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http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/mltssp_white_paper_combined.pdf

[22] *Mandatory Managed Care in New York State Nursing Homes: A Review and Assessment of Current Access & Quality as the State Mandates Medicaid Managed Long Term Care for Nursing Home Residents.* Richard J. Mollot, Executive Director; Victoriya Baratt, Public Policy & Law Intern; Joanna Smykowski, Public Policy & Law Intern. The Long Term Care Community Coalition. 2013

*A resident was wandering the halls in her wheelchair. There was one staff person assigned to the 30 residents on her hall, which was not enough staff to monitor residents who wander. The resident was in the front hallway by the lobby, away from the nurse's stations and rooms when she fell out of her wheelchair. She laid on the floor, unable to get back into her wheelchair until a visitor for another resident happened by and saw her. The nursing staff was not aware that the resident was gone, let alone that she had fallen onto the hard tile floor.*

*A resident used to eat in his room without any assistance. He began suffering a decline in his condition, but the nurses and aides hardly had time to assist him with his other ADLs and did not notice his decline. The resident continued to have his meals brought to his room, but he could not feed himself. The nursing staff often took his trays away after meals with his food hardly touched – not even unwrapped. The resident continued to decline, which was sped along by his malnutrition and dehydration. When the ombudsman came in to visit, she saw that his lips were dried and cracked. He tried to reach for his ice water on his bedside table but the water was out of reach. When the ombudsman moved the water closer, he drank two whole cups of water. The resident appeared listless, and asked the ombudsman if she could help reposition him in the bed. She explained that she needed staff to help with that, so she pushed his call bell and waited with the resident. Over 30 minutes passed, and no one had come by to help or even ask what he needed. The ombudsman went to the nurse's station and said that the resident wanted to be repositioned. Twenty minutes later, staff came to the room to reposition him. While they were moving him, he yelled out in pain. They checked to see what was causing him pain and found a pressure ulcer on his buttocks.*

CMS notes that a minimum staffing requirement does not take into consideration "other factors that are important in improving the quality of care for each resident." It cites one of the key principles of the International Council of Nurses (ICN), which states that safe staffing "involves a range of factors including (but not limited to) a sufficient number of staff available, an appropriate level and mix of skills, a manageable workload of both teams and individuals." CMS says it agrees with this principle ***and then completely ignores the fact that the ICN principle specifically includes "sufficient number of staff available."*** We agree that other factors, such as training and competency, are vitally important. Nevertheless, it defies comprehension that skills and competency levels of staff can overcome insufficient numbers of staff. The most skilled, competent and caring nurses and nursing assistants cannot meet the needs of residents if there are not enough of them.

Another argument CMS raises against a specific staffing standard is that it could result in staffing to the number rather than to the needs of the resident population. We agree this could be the case, which is why we propose that the requirement state that "at least" 4.1 hours per resident per day be provided and that staffing levels should be adjusted upward based on residents' needs and taking into consideration the facility assessment.

<u>Why the minimum should be 4.1 hours of direct care nursing per resident day</u>

Although CMS says that there is not sufficient information at this time to require a specific number of staff or hours of nursing care, we have indicated numerous studies above that support a relationship between staffing levels and quality care. There are also several studies that support a minimum staffing standard of at least 4.1 hours per resident per day. One of those studies is CMS's own report, "Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes." CMS then discounts the findings of its study by stating that the HHS Secretary rejected the threshold of 4.1 due to concerns the data were not reliable at the facility level. However, additional studies and reports noted below support the 4.1 HPRD staffing level.

- An expert panel convened by the John A. Hartford Institute for Geriatric Nursing[23]
- A study by Schnelle and colleagues (2004)[24]
- The Institute of Medicine study, *Keeping Patients Safe: Transforming the Work Environment of Nurses (2004 )*[25]
- A Coalition for Geriatric Nursing Organizations Survey[26]

**Recommendation:**

**§483.35** The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at § 483.70(e~~).~~, ***and utilizing staffing practices that maximize consistency, continuity, and coordination to provide person-centered care and prevent adverse events.***

(a) * * *

(1) * * *

(ii) Other nursing personnel, including but not limited to nurse aides. ***The facility must provide at least 2.8 hours of certified nursing assistant time, 0.55 hours of licensed vocational/practical nurse time, and 0.75 hours of registered nurse time per resident per day for a total of at least 4.1 hours per resident per day. Staffing levels shall be adjusted upward based on residents' needs and taking into consideration the facility's assessment. Nursing staff time includes only time spent providing direct nursing care by RNs, LPNs/LVNs, and CNAs, and excludes the Director of Nursing in facilities with more than 60 beds. It does not include time spent on administrative tasks.***

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[23] Harrington, C., Kovner, C., Kayser-Jones, J., Berger, S., Mohler, M., Burke R. et al. (2000). Experts recommend minimum nurse staffing standards for nursing facilities in the United States. *Gerontologist,* 40 (1):1-12.

[24] Schnelle, J.F., Simmons, S.F., Harrington, C., Cadogan, M., Garcia, E., & Bates-Jensen, B. (2004). Relationship of nursing home staffing to quality of care? *Health Services Research*, 39 (2):225-250.

[25] http://books.nap.edu/openbook.php?record_id=10851&page=182 (p. 182)

[26] http://www.aanac.org/docs/white-papers/cgno-press-release-6-27-14---research-supports-4-1-hprd-minimum.pdf?sfvrsn=2

Alternative approaches

While Consumer Voice believes its recommended minimum staffing requirement should be implemented when the revised rules go into effect, an alternative approach would be to phase the staffing standards in incrementally over a five year period. A number of states, such as Florida and Illinois, have used an incremental phase-in period. This approach would give facilities ample time to increase staffing to the required levels.

## Twenty-four hour registered nurse

Why a registered nurse is needed 24 hours a day

The current Requirements of Participation only mandate that facilities use a registered nurse (RN) eight continuous hours each day, seven days a week. These eight hours do not have to be spent providing care; they can be used to carry out any type of administrative tasks. Registered nurses by training and licensure have skills that are essential for timely assessment, intervention and treatment.

Three Institute of Medicine studies[27] have recommended that at least one RN be on duty at all times. Twenty-four hour RN coverage is essential because:

- The acuity level of nursing home residents has increased dramatically since the federal law was passed.[28] A resident who is elderly and frail may be discharged from the hospital to the nursing home only one to two days after surgery for a fractured hip or other acute treatment. The nursing home resident may also have congestive heart failure, diabetes, kidney disease requiring dialysis, Chronic Obstructive Pulmonary Disease (COPD), digestive disorders or other complex conditions. In these instances, expert nursing skills are required to anticipate, identify and respond to changes in condition; ensure appropriate rehabilitation, and maximize the chances for a safe and timely discharge home. This high level of skill and knowledge for oversight and care is needed 24 hours a day, seven days a week. RN coverage for only eight hours a day leaves residents vulnerable, undermining effective prevention of complications and possibly delaying important interventions.

- A resident's condition can destabilize or deteriorate at any time. When that occurs, the individual must be immediately assessed and a determination made about whether the resident needs to go to the hospital for treatment or whether he or she can be properly cared for in the nursing home. Because physicians do not have to be on-site, registered nurses are often the only medical personnel in a nursing home with the education and licensure to conduct the assessment required

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[27] Institute of Medicine. (2001). *Improving the quality of long term care*. Washington, DC Academy of Medicine. Institute of Medicine. 2004. *Keeping patients safe: transforming the work environment of nurses.* Washington, DC: National Academy of Medicine.National Academy of Medicine. Institute of Medicine 1996, Nursing staff in hospitals and nursing homes: Is it adequate?. Washington, DC National Academy of Medicine

[28] Mor, V et al. *Changes in the quality of nursing homes in the U.S.: A review and data update*. 2009.

for diagnosis and treatment. While licensed practical nurses (LPNs) are critically important for quality care, assessment is outside their legal scope of practice. Since deterioration or destabilization can occur in the evening or at night when there is no RN present, the absence of RN staffing for up to 16 hours each day places residents' lives at risk.

The story below, shared with us by a family member, underscores this point:

*Mr. G. had been run over by a car resulting in a crushed pelvis, a crushed leg and massive internal bleeding. After hospital care, surgeries, and rehabilitation, he became a long-stay nursing home resident. One evening, Mr. G's geriatric nursing assistant (GNA) came to prepare him for the night. The GNA lifted Mr. G in the bed and felt that something wasn't quite right. He explained to Mr. G that his right leg felt very cold. Because this facility had a RN round-the-clock, the GNA called the RN on duty to come and assess Mr. G. This RN was responsible for the entire building of 200+ residents, but he responded quickly when called. The RN noted a small amount of blood on the inner thigh, near the scarred incision point for the leg bypass. With the pulse, leg temperature, and other vital signs, he determined that this needed a compression bandage, not just a covering. His evaluation resulted in his reporting to the physician that Mr. G. needed immediate transport to the hospital. At the hospital, it was discovered that Mr. G had an aneurysm which had ruptured in the leg. The vascular surgeon explained that Mr. G would have bled out within a short time if the nurse had not assessed him quickly and properly.*

- Higher RN levels result in lower antipsychotic use; fewer pressure ulcers; less restraint use and cognitive decline; less weight loss and decrease in function; fewer urinary tract infections and catheterizations; and a decrease in unnecessary hospitalizations of nursing home residents.

Evidence supporting RN staffing as a key element for safe and effective resident care in U.S. nursing homes has grown substantially over the last two decades, typically using quality measures or deficient practice from the CMS survey data. All four literature reviews of nurse staffing in nursing homes that have been published in the last six years find evidence of a positive association between levels of RN staffing and quality (Bostic, Rantz, Flesner, Riggs, 2006), (Collier and Harrington, 2008)[29], (Castle, 2008), (Spilsbury, Hewitt, Stirk, Bowman, 2011). Each of the articles describes the difficulty of finding the evidence out of the vast array of staff definitions, quality measures, risk adjustment, study size, and cross-sectional design; however, recent research with a new approach to ferreting out the evidence, has been able to show significant relationship between RN staffing and quality. (Castle and Anderson, 2011)[30].

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[29] Collier, E. & Harrington, C. (2008). *Staffing characteristics, turnover rates, and quality of resident care in nursing facilities*. Research in Gerontological Nursing, 1(3, 157-170.

[30] Castle, N.G. and Anderson, R.A. (2011). Caregiver staffing in nursing homes and their influence on quality of care. *Medical Care*, 49(6):545-552.

There is mounting research evidence that higher levels of RN time are associated with positive outcomes:

- **Unnecessary hospitalizations:** Of particular relevance to today's health care improvement initiatives is the positive effect of RNs in decreasing unnecessary hospitalizations of nursing home residents (Decker 2008), (O'Malley, Caudry & Brabowski 2011), (Dorr, Horn and Smout 2005), (Horn, Buerhaus, Bergstrom and Smout 2005).[31] Most importantly, Dorr et al showed that the savings in hospitalizations paid for the increased RN time.
- **Antipsychotics and other outcome measures:** Higher RN levels significantly and positively affect quality resident outcomes including lower antipsychotic use, and fewer pressure ulcers, restraint use and cognitive decline ( Meret Hanke, Neff, and Mor 2004); reduced incidences in four related conditions: catheterizations, urinary tract infections (UTIs), antibiotic use and pressure sore development (Cherry, 1991); decreased pressure ulcers and UTIs (Konetzka, Stearns, Park 2007); and less decrease in function and weight loss, and fewer urinary tract infections, catheterizations, and pressure ulcers (Horn et al).

CMS itself makes the case for why a 24-hour RN is needed and addresses one of the concerns that is sometimes raised regarding such a mandate:

> We note that a number of states already require this. Increased presence of RNs in nursing facilities would address several issues. First, greater RN presence has been associated in research literature with higher quality of care and fewer deficiencies. Second, it has been reported in the literature that LPNs or LVNs may find themselves practicing outside of their scope of practice because, at least in part, there are not enough RNs providing direct patient care. Increasing the number of hours a day that an LTC facility must have RNs in the nursing home would alleviate this issue. While imposing a mandate for more RNs raises concerns about the adequacy of the supply of registered nurses, a December 2014 HRSA report on the future of the nursing workforce suggests that growth in RN supply will actually outpace demand in the period between 2012 and 2025 (U.S. Department of Health and Human Services. ''The Future of the Nursing Workforce: National- and State-Level Projections, 2012–2025.'' Health Resources and Services Administration, Bureau of Health Workforce, National Center for Health Workforce Analysis. December 2014).

Consumer Voice would add two additional points to the arguments in support of requiring a RN round-the-clock.

1. **Only 11%** of nursing facilities nationwide report to CMS that they do not have enough RNs on staff for 24-hour RN coverage.

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[31] Decker, F.H. 2008. "The Relationship of Nursing Staff to the Hospitalization of Nursing Home Residents," *Research, Nursing and Health.* 31 (3):238-51; Dorr, D.A., S.D. Horn, and R.J. Smout. 2005. Cost Analysis of Nursing Home Registered Nurse Staffing Times. J. *American Geriatric Society.* 53 (5):840-5; Horn, S.D., P. Buerhaus, N. Bergstrom, and R.J. Smout. 2005. "RN Staffing Time and Outcomes of Long-stay Nursing Home Residents: Pressure Ulcers and Other Adverse Outcomes Are Less Likely as RNs Spend More Time on Direct Patient Care". *American J. of Nursing.* 105 (11):58-70.

This was calculated based on 2012 CMS Expected Staffing Data with the following assumptions:

- **There is no data available indicating the number of RNs on each shift in nursing homes.** Facilities are not required to provide this information. Therefore assumptions must be made in order to arrive at any estimate.
- To have 24-hour coverage, a facility would have at least one RN on each shift, for a total of three RNs. Each facility must also have a RN as its Director of Nursing (DoN). We would therefore expect a nursing home that has 24-hour RN coverage to have a minimum of 4 RNs.
- Each of the three RNs is on a different shift, so all three shifts are covered.
- All DoNs are RNs, but there may possibly be some LPNs functioning as DoNs since this is permitted under a waiver.

**Hours per Resident Day:**

*We calculated the hours per resident day for 4 RNs to be 0.3618 RN HPRD.*

The number of RN HRS Per Resident day calculated at .3618, was determined as follows: 32 hrs. /day (includes 1 DoN plus 3 RNs-one on each shift) x 15,649 (based on the number of facilities reported on the **CMS Expected Staffing Data File 01-2012.xls**) = 500,768 total RN hours for the reporting period.

We then took the average residents per day reported by the American Health Care Association (AHCA) LTC Stats March, 2012 – 88.44 x the number of facilities (reported on the CMS Expected Staffing Data File 01-2012.xls) – 15,649

88.44 x 15,649 = 1,383,997.56 total resident days

500,768 RN hours (as reported by the CMS Expected Staffing Data File 01-2012.xls) divided by 1,383,997.56 total resident days = .3618 HPRD

*Next we calculated that 11% of Medicare and/or Medicaid certified facilities have less than 0.3618 HPRD.*

Based on the CMS Expected Staffing Data File 01-2012.xls, 1,777 facilities have less than 0.3618 HPRD.

There were 15,649 Medicaid and/or Medicare facilities on the CMS Expected Staffing Data File 01-2012.xls.

1,777 facilities divided by 15,649 facilities = **11%**

**This information shows that the vast majority of nursing homes - 89% - are already meeting this requirement. If 89% of the country's nursing homes can provide 24 RN coverage, it is not unreasonable to expect the remaining 11% to be able to do so as well.**

2. As CMS notes in the preamble, a number of states already require some version of 24-hour RN coverage. The nursing home industry in these states has not suffered as a result of this mandate. The most recent state to implement this requirement is Washington DC; we are unaware of any facilities that were forced to close because they could not meet this regulation.

Finally, we note that the SNF Value Based Purchasing System, which is based on a hospital readmission measure, will go into effect in 2019. SNFs' Medicare payment rates will be based in part on their performance scores beginning on October 1, 2018. The HHS Secretary must ensure SNFs with the highest rankings receive the highest incentive payments, and SNFs with the lowest rankings receive the lowest (or zero) incentive payments. The lowest 40 percent of SNFs (by ranking) will be reimbursed less than they otherwise would be reimbursed without the SNF VBP program. Because of the effect of RNs in decreasing unnecessary hospitalizations of nursing home residents cited above, we anticipate that nursing homes themselves will be seeking to employ RNs round-the-clock.

**Recommendation:**
The facility must use the services of ~~a~~ ***at least one*** registered nurse ~~for at least 8 consecutive hours a day~~ ***24 hours a day***, seven days a week ***to provide direct care, assessment and resident monitoring.***

**COST**
Consumer Voice strongly supports the comments submitted to CMS by several noted researchers (Harrington, Hawes, Phillips, Schnelle and Simmons, September 2, 2015) that it is not necessary for CMS to increase Medicare and Medicaid nursing home payment rates if CMS requires minimum staffing standards. The letter's authors note that the actual facility-reported average RN staffing levels increased to 0.85 hours per resident day (hprd), LVN staffing increased to 0.83 hprd, and total staffing steadily increased to 4.15 hprd in 2015 (CMS, 2015b).[32] Because the average nursing home staffing is already 4.1 total hprd and 0.8 RN hprd, most homes should be able to meet these standards without an increase in reimbursement rates. In fact, the for profit chains who in general report lower staffing levels are in the best position to increase staffing without additional reimbursement (Harrington, Olney, Carrillo, and Kang, 2012).[33]

The nursing home industry has often argued that nursing homes would like to provide higher nurse staffing levels, but that federal and state government would need to guarantee to pay for higher staffing levels. Although the nursing home industry claims that state Medicaid programs pay about $22 per patient day less than what is needed to provide adequate care (AHCA, 2012), there is no evidence for this claim. Research in California showed nursing homes spent only 36 percent of total revenues on nursing

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[32] US Centers for Medicare and Medicaid Services. (2015b). Medicare nursing home compare. http://www.medicare.gov/NursingHomeCompare/search.aspx?bhcp=1 See website data on www.Medicare.data.gov

[33] Harrington, C., Olney, B, Carrillo, H., and Kang, T. 2012. Nurse Staffing and Deficiencies in the Largest for-Profit Chains and Chains Owned by Private Equity Companies. *Health Services Research,* 47 (1), Part I: 106-128.

staffing and over 20 percent on administration and profits, with limited financial accountability for funding in 2010 (Harrington, Ross, Mukamel, and Rosenau, 2013[34]). Moreover, the Medicare Payment Advisory Commission (2014)[35] has found that Medicare payment rates and profits are high. The Medicare prospective payment system, which pays higher rates for higher resident acuity, gives facilities incentives to upcode resident acuity and reduce staffing because nursing homes are not required to use their Medicare payments for nurse staffing and therapy.

## CMS Cost Estimates

Consumer Voice joins the Service Employees International Union (SEIU) in being concerned about the accuracy of the cost estimates CMS presents for the proposed rule. We agree with SEIU that the salary figures appear to be overly inflated. Following the methodology that CMS provided of using the BLS OES national median hourly wage for the specified job classification and applying an upward adjustment of 48% to account for fringe benefits and overhead, we note that SEIU's calculations are substantially less. We ask CMS to review its cost estimates.

As noted in the comments submitted by SEIU, we suggest that CMS use the BLS OES wage data that is specific to Skilled Nursing facilities. Additionally, the 48% fringe benefit and overhead factor appears overly generous, and it would be helpful for CMS to provide additional information on the justification and methodology for determining the benefit factor and what the specific elements of overhead costs are. We refer CMS to SEIU's comments for further details.

## SAVINGS

Given the relationship between staffing and outcomes, increased staffing levels could save the Medicare and Medicaid programs billions of dollars. Poor care is expensive. While the trauma inflicted upon nursing home residents and their loved ones is not easily categorized and calculated, the financial costs are quantifiable. We have cited just a few studies and reports demonstrating the possible cost savings. Consumer Voice supports the list of additional reports and research provided by the Center for Medicare Advocacy in its comments.

1. **Consumer Voice: The High Cost of Poor Care: The Financial Case for Prevention in American Nursing Homes.** **http://theconsumervoice.org/uploads/files/issues/The-High-Cost-of-Poor-Care.pdf**

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[34] Harrington, C., Ross, L., Mukamel, D., and Rosenau, P. (2013). Improving the financial accountability of nursing facilities. Washington, DC: Kaiser Commission on Medicaid and the Uninsured, June. http://kff.org/medicaid/report/improving-the-financial-accountability-of-nursing-facilities/

[35] Medicare Payment Advisory Commission (MedPac). (2014). *Report to Congress: Medicare payment policy: skilled nursing facility services, Chapter 8.* Washington, DC: MedPac, March, 185-208.

This report examines the costs of several different preventable conditions and discusses each in detail. Examples include:

- Pressure ulcers: Pressure ulcers are largely preventable, but nevertheless prevalent in nursing homes. The costs to treat them are high. The total annual cost of treating all pressure ulcers (not just those of nursing facility residents) is $11 billion.
- Falls: Studies indicate that three-quarters of all residents have at least one fall each year, and a quarter of the falls require medical attention. Twenty to thirty percent of the falls are preventable. Falls cost, on average, $19,440 and hip fractures, more than $35,000.
- Urinary incontinence: Two-thirds of residents have urinary incontinence, with direct costs of $5.3 billion per year.
- Malnutrition: Malnourished residents are more likely to have pressure ulcers and fractures and to be hospitalized more frequently.
- Dehydration: Each hospitalization of a dehydrated resident costs, on average, more than $18,000. Dehydration is often avoidable if residents are given more fluids. Insufficient staffing leads to less fluid intake by residents.
- Ambulatory care-sensitive diagnoses and avoidable hospitalizations: Ambulatory care-sensitive diagnoses are diseases for which hospitalization can typically be avoided with adequate primary care. They are often used as a proxy for avoidable hospitalizations. A high percentage of resident hospitalizations are for conditions that fall into this category, such as congestive heart failure, asthma or diabetes. Research found that New York State spent more than $1.2 billion for avoidable hospitalizations over a five-year period.

2. **Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries. Department of Health and Human Services, Office of Inspector General. 2014.**

   An estimated 22 percent of Medicare beneficiaries experienced adverse events during their SNF stays. An additional 11 percent of Medicare beneficiaries experienced temporary harm events during their SNF stays. Physician reviewers determined that 59 percent of these adverse events and temporary harm events were clearly or likely preventable. They attributed much of the preventable harm to substandard treatment, inadequate resident monitoring, and failure or delay of necessary care. **Over half of the residents who experienced harm returned to a hospital for treatment, with an estimated cost to Medicare of $208 million in August 2011. This equates to $2.8 billion spent on hospital treatment for harm caused in SNFs in FY 2011.**

3. **Cost Analysis of Nursing Home Registered Nurse Staffing Times. *Journal of the American Geriatrics Society*. 2005. May; 53(5):840-5.**

This cost-benefit analysis found an annual net societal benefit of $3,191 per resident per year in high-risk, long-stay nursing home facilities that achieve 30-40 minutes of RN direct care per resident per day versus those that have less than 10 minutes.

**Director of Nursing:**

Currently, the Requirements of Participation permit the requirement that a registered nurse serve as the Director of Nursing (DoN) to be waived.

As stated in the July 2, 2012 letter from the Coalition of Geriatric Nursing Organizations to CMS, research shows the importance of the Director of Nursing: high retention levels of DoNs are associated with better outcomes (Anderson, Issel, McDaniel, 2003)[36]. These same authors also showed that an experienced DoN is associated with lower immobility prevalence (Anderson, Issel, McDaniel, 2003).

The role of the DoN is critical to quality resident care. The DoN is responsible for administrative, clinical, educational, staff and public relations; the core competencies include such skills as conducting root cause analysis, setting benchmarks, directing change, and mentoring and teaching.

In addition, the increased acuity level and medical complexity of nursing home residents necessitates a DoN with the expertise, training and skills of a RN.

**Recommendation:**

Delete the waiver so the regulation reads: ***The facility must designate a registered nurse to serve as the director of nursing on a full time basis.***

**§483.40 BEHAVIORAL HEALTH SERVICES**

Consumer Voice is very pleased to see this new section added to the proposed rules. We hear frequently from our network that the number of nursing home residents with some type of mental illness is increasing and that their needs are not being met. We support the recommendation of the National Association of Social Workers (NASW) in their comments that the section be retitled "Mental and Behavioral Health Services" because "Behavioral Health" is distinct from mental health and includes substance use disorders. NASW also notes that because substance use disorders are an under-addressed and growing problem among older adults (and, potentially, other nursing home residents), it is essential for CMS to specify such disorders within the regulations rather than using "mental illnesses and psychosocial disorders" as a catch-all term.

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[36] Nursing homes as complex adaptive systems: relationship between management practice and resident outcomes. Anderson, RA, Issel LM, McDaniel Jr RR. Nurs Res. 2003 Jan-Feb;52(1):12-21.

We also share NASW's concerns that limited resident access to clinical social workers (CSWs) poses a significant barrier to facilities' ability to meet residents' mental and behavioral health needs. The current inability of clinical social workers to bill Medicare Part B for psychotherapeutic services to residents has created this barrier, and we support NASW's statement that the current rulemaking process affords CMS an ideal opportunity to rectify this CSW reimbursement limitation.

**§483.40(a) Appropriate competencies and skills**
While it is important for a facility to have sufficient staff with "the appropriate competencies and skills sets," the behavioral needs of residents cannot be met unless the facility also has staffing practices that include number and types of staff, staffing assignments (such as rotating or consistent assignment), schedules, and systems that affect communication, teamwork, and participation.

**Recommendation:**
§483.40 Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.
(a)***The facility must have staffing practices designed to maximize stability and continuity in delivery of person-centered care and prevention of adverse events.***
***(b)*** The facility must have sufficient direct care/direct access staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial wellbeing of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with § 483.70(e). These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for:

**§483.40(d) Social services**
The only mention of medically-related social services in the entire regulations is found in this section on behavioral health. This implies that such services are for individuals only with mental or psychosocial adjustment difficulty, history of trauma and/or post-traumatic stress disorder. However, social workers provide services that benefit all residents, such as contributing to ongoing care planning, facilitating transitions of care, and advocating for residents' rights and helping facilities.

**Recommendation:**
Move this provision to a stand-alone section on Quality of Life as recommended earlier.

<u>483.40 Dementia</u>
While the word "dementia" is not mentioned under Behavioral Health, CMS implies in the preamble that the proposed regulation would apply to residents with diagnoses such as dementia and BPSD. We agree with the California Advocates for Nursing Home Reform (CANHR) that the Behavioral Health section is not well designed to care for

residents with dementia. We urge CMS to instead create a separate and new standard for dementia care.

Nothing is more central to the purpose of nursing homes than providing good care to people with dementia. As HHS points out in the preamble to the proposed regulations, about half of all nursing home residents have some type of dementia, dementia among nursing home residents is increasing, and two-thirds of those dying with dementia die in nursing homes. We hear from consumers and advocates that the quality of care for persons who have dementia is frequently poor. Too often, residents who have dementia are chemically restrained, deprived of needed care and treated without dignity. Setting standards for dementia care in nursing homes is a necessity.

**Consumer Voice endorses CANHR's recommendation to establish dementia care standards, as well as the specific standards proposed by CANHR.**

## §483.45 PHARMACY SERVICES

### Reorganization

Consumer Voice opposes the reorganization of this section to include regulations regarding psychotropic medications and unnecessary drugs. As CANHR states in its comments: "Moving these requirements in this manner creates the impression that misuse of antipsychotic drugs is primarily a "pharmacy" problem to be solved by pharmacists rather than the fundamental human rights and quality of care problem that it is." Restructuring would diminish the importance of this critical issue.

We are deeply concerned that the proposed regulations do not meaningfully address the pervasive use of antipsychotic drugs and other types of psychotropic drugs as chemical restraints. There are epidemic levels of chemical restraint in nursing homes today. Nursing homes report they are currently giving antipsychotic drugs to over 281,000 residents. Even without taking into account the likely underreporting, this is a staggeringly high number of people being drugged. Nearly all of them have dementia – 88 percent according to Inspector General Daniel Levinson – a population the FDA has warned faces a significantly increased risk of death from these drugs. The right to be free from chemical restraints is a central tenant of the Reform Law and its importance must be recognized and restored in the final regulations.

### Recommendation:

Consumer Voice strongly supports CANHR's recommendations to revise language related to §483.45(c)(3) - definition of psychotropic drugs; §483.45(d) - unnecessary drugs; §483.45(e) - psychotropic drug and to move these provisions, along with requirements related to chemical restraints, to a new section, "Freedom from Chemical Restraints and Unnecessary Psychotropic Drugs."

We also join CANHR in recommending that this new section on chemical restraints and unnecessary use of psychotropic drugs be based on regulations HHS proposed in 1992.

The final regulation should establish a presumption that chemical restraint is harmful to residents, require written informed consent before use of psychotropic drugs, strengthen rather than diminish focus on misuse of antipsychotic drugs, require physicians to examine residents before prescribing antipsychotic drugs and justify that the potential benefits clearly outweigh the potential harmful effects,

**§483.45(c) Drug regimen review**
To better ensure that residents are receiving appropriate medications, we strongly recommend that CMS mandate that pharmacists be independent of ties to long-term care pharmacies and drug manufacturers. These ties create strong incentives for consultant pharmacists to recommend unnecessary and inappropriate drugs. In the April 12, 2012 Federal Register response to public comments [77 FR 22072], CMS itself concluded that commenters had corroborated that industry practices pressure pharmacists to recommend certain drugs and allow them to benefit directly from the rebates and price breaks that pharmaceutical companies give to long-term care pharmacies.

Commenters also described other aspects of the financial relationships among drug manufacturers, long-term care pharmacies, nursing homes, and consultant pharmacists that "subvert" drug regimen reviews required to ensure resident safety, such as quotas and other policies that limit the amount of time consultant pharmacists are allocated to conduct reviews and that make reviews perfunctory.

Consultant pharmacists must be able to review residents' drug regimens in an objective way and make recommendations based on what is best for the residents. In order to do so, consultant pharmacists must be independent of the interests or control of long-term care pharmacies, pharmaceutical manufacturers and distributors, or their affiliates.

**§483.45(c)(2) Review of medical record**
We support the proposed requirement to have the pharmacist review the resident's medical record at certain key times. We agree with CMS that such reviews would assist in detecting irregularities and could be particularly useful in determining that medications are only used when medically appropriate. We ask CMS to consider requiring these reviews at least quarterly, rather than at least every six months, given their importance. Detecting a problem as early as possible would promote better resident outcomes.

**§483.45(c)(4) Reporting, responding to irregularities**
We are pleased to see that any report of irregularities would be required to be sent to the facility's medical director in addition to the attending physician and director of nursing. Because the medical director is responsible for the overall medical care in the facility, he or she needs to know if the pharmacist is finding irregularities in the prescribing of one or more attending physicians so that he or she can address this issue if necessary. We also thank CMS for proposing that the attending physician be mandated to not only review the irregularity, but document what action has been taken. If no action has been taken, the physician would document the rationale. This review and documentation would better ensure that irregularities are given serious attention and build additional safeguards into the system.

While these measures would be a step in the right direction, they need to be even stronger. Facilities should develop policies, including time frames, for handling the identification, reporting and response to irregularities. These policies should contain a process for fast tracking a response when an irregularity that could harm a resident is found. Additionally, the resident or the resident's representative should also receive a copy of the pharmacist's written report identifying the irregularity and the physician's written response. Residents have the right to this basic information about their care. Transparency of this process will help ensure that nursing homes comply with their legal duty to keep residents fully informed about their health status and treatments.

**Recommendation:**
**§483.45(c)(4)** We support the language submitted in CANHR's comments with this additional language:

***The facility must develop written policies and procedures for identifying, reporting and responding to irregularities, including in cases where an irregularity could result in immediate harm to a resident.***

**§483. 50 LABORATORY, RADIOLOGY, AND OTHER DIAGNOSTIC SERVICES**
We agree with CMS that it is appropriate to relocate requirements regarding laboratory, radiology and other diagnostic services in a separate, new section. This restructuring makes it easier to find these provisions.

**§483.50(a), (b) Delegation to nurse practitioners, clinical nurse specialists, physician assistants**
We support permitting these health care practitioners to order and receive the results of these tests in accordance with state law. As noted under "Physician Services," our observation has been that physician assistants, nurse practitioners and clinical nurse specialists often spend more time visiting with a resident than a physician and that this can benefit the resident. Research shows that advanced practice nurses improve resident care in nursing homes, so increasing their role with nursing home residents makes sense.

**483.50(a)(2)(ii), (b)(2)(ii) Notification of results**
Any results that fall outside of clinical reference ranges need to be immediately reported to the ordering health care professional regardless of facility policy or physician order. This is already the current standard of practice for nurses and should be codified.

In addition, facilities should be required to notify the resident and his her representative if applicable of the results as well as the prescribing provider. Currently, residents are far too often left out of the health care loop. Yet obtaining information about one's health care is an essential part of directing one's own care and should be considered part of a resident's right to receive information about their total health status. When the Obama Administration released a rule in 2014 permitting patients to obtain lab results directly

from labs without going through their doctor, former HHS Secretary Kathleen Sebelius said, "Information like lab results can empower patients to track their health progress, make decisions with their health care professionals, and adhere to important treatment plans."[37] We agree.

**Recommendation:**
**§483.50(a)(2)(ii)** ~~Promptly~~ ***Immediately-***notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges ~~in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders~~ ***and inform the resident and resident's representative.***

**483.50(b)(2)(ii)** ~~Promptly~~ ***Immediately-***notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of results that fall outside of clinical reference ranges ~~in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders~~ ***and inform the resident and resident's representative.***

**§483.55 DENTAL SERVICES**
We commend CMS for expanding and enhancing assistance to residents needing dental services. New requirements specifying that facilities must assist residents with arranging transportation to and from dental services locations, not only if necessary, but also *if requested*, is a positive addition, as is the new language stating that facilities must assist residents who are eligible to apply for reimbursement of dental services as an incurred medical expense under the Medicaid state plan.

**§483.55 (a) (3) Loss or damage of dentures**
We thank CMS for the addition of new language in this section that would prohibit nursing homes from charging a resident for the loss or damage of dentures when such loss/damage is the facility's responsibility. Dentures can be expensive and difficult to replace. Residents should not be charged with replacing dentures that were lost as a result of facility inattention, mistakes or failure to put measures in place to prevent loss.

However, we are concerned about language stating that facilities would only be prohibited from charging residents for the loss or damage of dentures in situations where it is "determined in accordance with facility policy to be the facility's responsibility." If the facility policy is to not take responsibility for loss or damage of dentures or to do so only in extremely limited circumstances, then this new requirement would be meaningless. We recommend that CMS delete this language.

In the NPRM, CMS explained that it considered specifying the circumstances in which facilities would be responsible for the loss or damage of dentures, but chose not to

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[37] https://www.washingtonpost.com/national/health-science/new-rule-allows-patients-to-get-test-results-directly-from-labs-without-doctors-clearance/2014/02/03/49c624ec-8d12-11e3-98ab-fe5228217bd1_story.html

because facilities "already make this determination." We hear directly from residents and families that far too often facilities make the determination not to take responsibility. For that reason we urge CMS to identify the situations when a facility would be responsible for replacing or repairing dentures. We believe this would serve residents better than assuming that all facilities would have policies in place regulating themselves to provide payment for damaged or lost dentures in every appropriate case. We recommend making the following change to the proposed language.

**Recommendation:**
**§483.55(a)(3)** May not charge a resident for the loss or damage of dentures that is ~~determined in accordance with facility policy to be~~ the facility's responsibility~~.~~. ***The facility is responsible when it fails to:***

- ***(i) Put preventive measures in place for all residents. These include, but are not limited to, denture engraving; providing each resident with a personal belongings case for storing dentures; and identifying the location of a resident's dentures on each shift and at meal times.***
- ***(j) Implement care plan interventions for residents who have a history of or who are at risk of losing or damaging their dentures.***

**§483.55 (a)(5) Referral of residents with lost or damaged dentures**
We appreciate the inclusion of a timeline for when facilities must make a referral on behalf of residents for lost or damaged dentures. Specifying that a prompt referral means that the referral occurs within 3 business days (unless there is documentation of extenuating circumstances) will help to prevent untimely referrals and the adverse circumstances, such as weight loss and loss of dignity, that occur when residents are without dentures.

**§483.60 FOOD AND NUTRITION SERVICES**
We are very supportive of new language in this section that would create a more person-centered dining experience for residents. The inclusion of a requirement for facilities to ensure that "menus reflect the religious, cultural and ethnic needs and preferences of the resident" is a welcome addition, since honoring resident choice in food is a critical part of culture change and is particularly important when alternative food is being requested for religious or cultural reasons. We also commend CMS for requiring facilities to have suitable and nourishing alternative meals and snacks for residents who want to eat at non-traditional times or outside of scheduled meal times. Residents *should* be able to eat when they choose just as they would in their own homes. Furthermore, language explicitly stating that residents have the right to eat food not procured by the facility and that facilities must have procedures in place for the storage of food brought in by family and visitors supports greater resident choice and increases opportunities for residents to eat food that they like and that gives them pleasure.

**§483.60(a) Staffing; 483.60(a)(3) Support staff**
Consumer Voice is concerned about the proposed language calling for "sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food

and nutrition service" and "sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service." As discussed in the section on Nursing Services, the term "sufficient" is unclear and impossible to objectively measure. A staffing ratio of 4.1 hours of nursing care per resident per day should be mandated in order to ensure there is adequate direct care nursing staff to help residents eat.

We also suggest that CMS define what it means by "support personnel" or "support staff."

**§483.60(a)(1) Qualified dietitian**
Consumer Voice joins the Academy of Nutrition and Dietetics in opposing the proposed changes to the definition of "qualified dietitian" that would permit a person to be a qualified dietitian solely based on state standards for licensure. As noted by the Academy, there are multiple states where one can become licensed as either a "dietitian" or a "nutrition professional" without ever having attended an accredited dietetics or nutrition program and without having received *any* training in food service management, food safety, or other competencies that the proposed rule declares are necessary in a facility. As a result, the proposed change would weaken professional standards and enable unqualified practitioners without necessary training or skills to oversee facilities' food and nutrition services.

**Recommendation:**
We support the Academy's recommendation to adopt the definition of "qualified dietitian" in §482.94(e): "***A qualified dietitian is an individual who meets practice requirements in the State in which he or she practices and is a registered dietitian with the Commission on Dietetic Registration."***

We also support the Academy's alternative proposal that CMS either retain the existing definition for qualified dietitians in long-term care facilities or define "qualified dietitian" consistent with the definition of "registered dietitian or nutrition professional" in §1861(vv)(2) of the Social Security Act (42 U.S.C. 1395(x)(vv)(2)).

**§483.60(a)(1)(iii) Five years to come into compliance**
The proposed requirements for dietitians hired or contracted with prior to the effective date of the final rule allow for a five year period to obtain the needed qualifications. We believe this time period is too long and join NASOP in recommending a two year period.

**§483.60(a)(2) Director of food and nutrition services**
Consumer Voice believes that because the director of food and nutrition services only receives consultation from a dietitian, this employee should be a certified dietary manager. Dietary Managers are trained to apply nutrition principles and document nutrition information, as well as manage menus, food purchasing, and food preparation; ensure food safety; manage work teams; and more. This nutrition-related training makes certified dietary manager more equipped and better qualified to meet residents' nutritional and dietary needs. Consumer Voice supports the Academy's recommendation

that the director of food and nutrition service must, *at a minimum*, be a Certified Dietary Manager and have obtained the ServSafe® certification:

Additionally, the proposed requirement that the director of food and nutrition services meet these qualifications within five years is too long a period of time.

**Recommendation:**
**§483.60(a)(2)** If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who:
(i) For designations prior to [effective date of final rule], meets the following requirements no later than ~~5~~ ***2*** years after [effective date of final rule~~], is~~:
(A) Is ~~A~~ ***a*** certified dietary manager; ~~or~~ ***and***
B) ~~A certified food service manager, or~~ ***Has obtained the ServSafe® certification.***
~~(C) Has similar national certification for food service management and safety from a national certifying body; or~~
~~(D) Has an associate's or higher degree in food service management or hospitality from an accredited institution of higher learning; or (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers~~

**§483.60 (a)(2)(iii) Consultations**
Requiring that there be "frequently" scheduled consultations is too vague and subjective to interpretation. We suggest changing "frequently" to "at least quarterly."

**§483.60 (c)(1) Nutritional needs**
We oppose allowing menus to meet "industry standards" instead of established national guidelines. The term "industry standards" is not a defined term and has no meaning. In addition, since we know that there is often great pressure in facilities to keep food costs down, any such standards could be so low that they would result in menus with foods that residents would not want to eat.

**Recommendation:**
**§483.60 (c)(1)** Meet the nutritional needs of residents in accordance with established national guidelines. ~~or industry standards.~~

**§483.60 (h) Paid feeding assistants**
We urge CMS to eliminate paid feeding assistants. The concept of feeding assistants was created in response to the lack of sufficient numbers of staff to help residents eat. Residents who need help with eating have physical or cognitive problems that prevent them from being able to feed themselves. Feeding assistants, who have extremely little training, are ill-equipped to help residents who may have difficulty swallowing or who may resist being fed. Staff who assist such residents need the skills and training of a certified nursing assistant to provide services to these residents. Furthermore, assigning staff to provide such assistance does not promote continuity of care or respond to what

certified nursing assistants say is most rewarding in their jobs – their ongoing relationships with individual residents.

**§483.65 SPECIALIZED REHABILITATIVE SERVICES**

Consumer Voice agrees with the addition of respiratory therapy to this section and supports the recommendations from the Coalition to Preserve Rehabilitation (CPR) that:

- CMS change the term "specialized rehabilitative services" to "rehabilitative services *and devices*," to be consistent with CMS's final rule *Patient Protection and Affordable Care Act; CMS Notice of Benefit and Payment Parameters for 2016*.[38]
- The final rule adopt a federal regulatory definition of "rehabilitative services" that includes explicit recognition of coverage of *devices.*
- Rehabilitative devices should also be covered whether or not they are considered part of the skilled nursing facility (SNF) per diem rate or separately billable to the Medicare program.
- There should be more robust definitions for rehabilitative devices so that the term includes durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).

**Compliance with *Jimmo v. Sebelius***

Consumer Voice strongly supports CPR's recommendation that the proposed rule relative to rehabilitative services and devices be revised in any way necessary to ensure compliance with the recent *Jimmo v. Sebelius* decision, i.e., that Medicare coverage is available for skilled services to maintain an individual's condition. The rule should make explicitly clear that a resident need not demonstrate improvement in order for skilled services to be covered as reasonable and necessary services.

**§483.67 Outpatient Rehabilitation Services**

We agree with CPR that CMS should modify §483.67 to be consistent with the suggested changes related to devices in the above section (Specialized Rehabilitative Services) and that this section should be revised to ensure compliance with the *Jimmo v. Sebelius* decision.

**§483.70 ADMINISTRATION**

**§483.70(d)(2)(i), (ii) Governing body**

We appreciate that CMS would make the administrator report to and accountable to the governing body. While this may be implied, the proposed specificity clarifies this point. Given the governing body's responsibility for implementing the management and operations of the facility, we agree with CMS that the administrator must keep the governing body informed and knowledgeable about these issues. Consumer Voice

[38] *Patient Protection and Affordable Care Act; CMS Notice of Benefit and Payment Parameters for 2016*, Federal Register, Vol. 79, No. 228 (November 26, 2014), at 70717.

supports the governing body also being responsible and accountable for the facility's Quality Assurance and Performance Improvement Program (QAPI). This program cannot be successful unless the facility leadership is involved.

**§483.70 (3) Facility assessment**

CMS is assigning a great deal of importance to the facility assessment, calling it "a central feature of our revisions to subpart B." Given its significance, Consumer Voice is very concerned that CMS has not prescribed a specific methodology for the facility assessment. Without a standardized approach, each nursing home will calculate and determine its resources in differing ways, making the results impossible to compare and enforce.

Furthermore, in order for the facility assessment to be as useful as possible, CMS needs to expand the circumstances under which the facility assessment should be reviewed and updated. The assessment should be modified based on the prevalence of adverse events since the facility would need to evaluate what is necessary in order to reduce existing adverse events and prevent future ones. Nursing homes would also need to adapt their assessments to reflect QAPI and performance improvement project determinations. Consumer Voice also believes that the facility assessment must address or include the following additional elements:

- **Fiscal resources.** It is astounding that CMS provides a lengthy list of the resources the facility must include in its assessment, yet omits the facility's budget/fiscal resources. The amount of money available to the facility is among the most important considerations in determining what resources are necessary to care for its residents.
- **Staffing practices.** Good staffing practices are necessary for facilities to deliver preventive, person-centered care. Staff numbers and competencies are pivotal, as are systems that promote consistency, communication, and continuity. The evaluation of personnel resources needed must therefore include review of all aspects of staffing, including numbers, types, competencies, assignments, and systems for coordination and continuity.

Finally, we urge CMS to require that both the facility assessment process and outcome be more inclusive and transparent. Facilities should be required to obtain resident and family input in developing their assessment. No one is more impacted by whether the facility has adequate resources to care for residents than residents themselves. Residents should be asked what they believe is needed to provide quality care, and family members' feedback should be gathered as well.

Once completed, the most recent version of the assessment should be posted in a publicly accessible place. Current residents and their families should know what the nursing home determines is needed to care for its residents so they can monitor to see if the facility obtains the necessary resources, while prospective residents and their families should have access to this information to consider when selecting a home.

**Recommendation:**

**§483.70(e)** Facility assessment. The LTC facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. ***The facility must review and update that assessment based on prevalence of adverse events. The facility must review and update this assessment through QAPI and performance improvement project determinations***. The facility assessment must address or include:

1) The facility's resident population, including, but not limited to,

(i) Both the number of residents and the facility's resident capacity;

(ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;

(iii) The staff competencies ***and staffing practices*** that are necessary to provide the level and types of care needed for the resident population;

***(iv) Staffing practices that are necessary to prevent adverse events and promote the highest practicable physical, mental, and psychosocial well-being of each resident;***

~~(iv)~~ ***(v)*** The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and

~~(v)~~ ***(vi)*** Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

(2) The facility's resources, including but not limited to,

(i) All buildings and/or other physical structures and vehicles;

(ii) Equipment (medical and nonmedical);

(iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;

(iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care~~;~~, ***and staffing practices that affect their ability to provide optimal care;***

(v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.

(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.

***(vi) The facility's budget and/or fiscal resources.***

(3) A facility-based and community-based risk assessment, utilizing an all hazards approach.

***(4) The facility must seek input from residents, their representatives and their family members in preparing the assessment and make the assessment publically available.***

**§483.70(n) Binding Arbitration**

CMS has asked for comments on "whether agreements for binding arbitration should be prohibited." Our answer is an emphatic "yes." More precisely, we recommend that agreements for arbitration not be allowed during admission or at any time prior to a dispute arising. It is unfair for nursing facilities to bind residents to arbitration at the time of admission. As a practical matter, residents (or resident representatives) sign arbitration agreements at admission not because they think arbitration is a good choice, but because they are routinely signing everything put in front of them.

Unlike other types of pre-dispute arbitration agreements, which may cover a single transaction or a specific type of dispute, arbitration agreements in nursing facilities cover every single aspect of a resident's life, and may apply through weeks, months or years that the resident lives in the facility. Also, nursing facility arbitration agreements often involve claims involving (for example) pressure sores, infections, malnutrition, dehydration, asphyxiation, sexual assault, and death. It is unreasonable to expect residents and their representatives to make decisions regarding such catastrophic events during admission, long before the events have occurred.

Furthermore, the arbitration process tends to be slanted against consumers such as nursing facility residents. Arbitration companies have a financial incentive to side with the nursing facilities who are responsible for sending them cases on an ongoing basis. Also, discovery is limited in arbitration, hindering plaintiffs from developing their cases. Arbitration proceedings are secretive, often protected by confidentiality rules. And, while court filing fees are relatively nominal, arbitrators charge by the hour, with the extensive costs generally split between the parties.

As part of the proposed regulations, CMS rightly recognizes the significant negative impact of pre-dispute arbitration agreements, proposing regulatory language that would set various procedural protections. CMS's proposed language, however well-intentioned, would make matters worse. No amount of procedural protections can change the basic power dynamic of the admissions process — incoming residents and their families are generally in a time of great stress, and the terms of the admission agreement are drafted exclusively by the facility. Worse, if CMS's proposed language were to become law, nursing facilities would cite the regulatory language to courts as evidence that CMS approves nursing facility arbitration, and would argue that compliance with the regulation was proof that the arbitration agreement and the circumstances surrounding its signing were fair.

We emphasize that our recommendation would not prohibit a resident or resident's representative from choosing arbitration after a dispute has arisen, if the resident or representative at that time concludes (likely through legal counsel) that arbitration is the best option. Any pre-dispute arbitration agreement, however — particularly if it is signed during the admission process — is unfair to residents and should not be allowed.

**§483.70(p) Social Worker**

The psychosocial needs of residents in nursing homes are complex. Yet facilities with more than 120 beds must have a qualified social worker, while smaller facilities do not. This makes little sense since the needs of a resident in a nursing home with 120 and fewer beds are no less critical than those in larger facilities; these residents still require the services of a social worker.

An appropriate number of social workers is a key factor contributing to quality of care and quality of life for nursing home residents. In facilities that actually have one full-time social worker, that individual cannot meet the needs of all residents. According to an Office of Inspector General report in 2003, some 39% of residents with psychosocial needs had care plans that were inadequate to meet those needs; 41% of those with psychosocial needs addressed in their care plans did not receive all of their planned psychosocial services, and 5% received none of these services; and a total of 45 % of social workers reported barriers to providing psychosocial services, including not having enough time, and insufficient staff.[39]

In a 2010 study of a nationally representative sample of more than 1,000 nursing home social services directors, almost three-fourths commented that an appropriate ratio would be one full-time worker for 60 long-stay residents, and more than half suggested a ratio of one full-time worker per fewer than 20 subacute residents.[40]

We agree with the recommendation of the National Association of Social Workers (NASW) in its written comments that CMS decrease the 121:1 ratio.

Consumer Voice also supports the National Association of Social Workers' (NASW) recommendations related to social worker qualifications. We agree with NASW that all nursing home residents deserve high-quality psychosocial care provided by a professional social worker—defined by the *NASW Standards for Social Work Services in Long-Term Care Facilities* (2003) as someone with a bachelor's (or advanced) degree in social work from a program accredited by the Council on Social Work Education (CSWE).

However, CMS's current definition of a qualified social workers which recognizes degrees in psychology, rehabilitation counseling, sociology, special education, and other "human services" fields results in individuals serving in a role for which they do not have sufficient preparation. These paraprofessional social services staff members who lack social work education—including people with degrees in gerontology or with a bachelor's or master's degree in any discipline but social work—may not be adequately prepared to identify and address psychosocial issues.[41],[42] The enhanced requirements

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[39] Psychosocial Services in Skilled Nursing Facilities. Office of Inspector General. Department of Health and Human Services. March 2003.)

[40] Nursing home social services directors' opinions about the number of residents they can serve. Bern-Klug M[1], Kramer KW, Sharr P, Cruz I. J Aging Soc Policy. 2010 Jan;22(1):33-52. doi: 10.1080/08959420903396426.

[41] Bern-Klug, M., Kramer, K.W.O., Chang, G., Kane, R., Dorfman, L.T., & Sanders, J. B. (2009). Characteristics of nursing home social services directors: How common is a degree in social work? *Journal of the American Medical Directors Association 10*, 36–44.

[42] Envisioning Quality Psychosocial Care in Nursing Homes: The Role of Social Work Kelsey Simons PhD, MSWa,*, Mercedes Bern-Klug PhD, MSW, MAb, Sofia An MSWc 2012 JAMDA article

within the proposed rule further underscore Medicaid and Medicare beneficiaries' need for professional social work services.

Consumer Voice therefore joins NASW in opposing the inclusion of other "human service" fields, including gerontology, as sufficient preparation for nursing home social work, and we oppose use of the term "social worker" to apply to anyone who does not have a baccalaureate, master's, or doctoral degree in social work.

**Recommendation:**
**§483.70(p)** Social worker. A~~ny~~ facility ~~with more than 120 beds~~ must employ ***at least one full-time a qualified social worker for every 50 long-stay residents and at least one full-time qualified social worker for every 15 short-stay residents*** ~~on a full-time basis~~. A qualified social worker is:

(1)~~A A~~n individual with a minimum of a bachelor's ***or master's*** degree in social work**.** ~~or a bachelor's degree in a human services field including, but not limited to, sociology, gerontology, special education, rehabilitation counseling, and psychology; and (2) One year of supervised social work experience in a health care setting working directly with individuals.~~

Alternatively, Consumer Voice suggests the following language:
**§483.70(p)** Social worker. A~~ny~~ facility ~~with more than 120 beds~~ must employ ***at least one a*** ~~-~~qualified social worker on a full-time basis. A qualified social worker is:

**§483.75 QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT**
Consumer Voice believes that facilities should engage in quality assurance and performance improvement efforts. We appreciate that CMS is calling for the governing body and/or executive leadership with full legal authority and responsibility for operation of the facility to be accountable for the QAPI program. QAPI cannot be successful without involvement and accountability from the top of the operation. We are also glad to see that the Medical Director has been added as a member of the quality assessment and assurance committee.

We suggest a number of ways to strengthen the rule below.

- The analysis and action needed to deliver quality person-centered care and prevent adverse events must include analysis of staffing practices to determine if any changes are needed in numbers, types, competencies, assignments, and systems for coordination and continuity.
- Residents and family members should be educated about the QAPI program, including its elements and goals, and involved in all aspects of QAPI activities. We are glad to see that there would need to be systems to obtain and use feedback and input from residents and resident representatives, including how such information will be used to identify problems and opportunities for improvement.

However, residents and resident representatives are not mentioned in any other aspect of the QAPI program. Consumer Voice urges CMS to require that residents and resident representatives be part of the process of identifying data; providing input into what corrective actions should be taken; monitoring and evaluating the effectiveness of the measures taken; and selecting the performance improvement projects.

- Worker safety issues should be included when addressing resident safety issues. In its comments, the Service Employees International Union (SEIU) notes that the Joint Commission report found that there are synergies of resident and worker safety activities, and that effective practices integrating safety-related activities improve processes and outcomes for both patients and health care workers.[43]
- The Quality Assessment and Assurance committee should include at least one direct care/direct access worker. We agree with SEIU that it is important that a committee member that cares directly for residents on a full-time basis provide input and be part of the team coordinating and evaluating the QAPI program.
- Facilities should make available the annual QAPI plan to residents and resident representatives and staff. In order to be successful, QAPI activities must involve everyone. The more information that residents, representatives and staff have available to them, the more they can be involved in making the QAPI program effective in accomplishing its goals. The QAPI plan should not be a secret, hidden document that only a few can see.

**Recommendation:**

**§483.75** Quality assurance and performance improvement

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

(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section;

(2) Present its QAPI plan to the State Agency Surveyor at the first annual recertification survey that occurs after [the effective date of this regulation];

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

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

***(5) Make its plan available to residents, resident representatives and staff.***

[43] The Joint Commission. Improving Patient and Worker Safety: Opportunities for Synergy, Collaboration and Innovation. Oakbrook Terrace, IL: The Joint Commission, Nov 2012. http://www.jointcommission.org/assets/1/18/TJC-ImprovingPatientAndWorkerSafety-Monograph.pdf

(b) *Program design and scope*. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must:
(1) Address all systems of care and ***staffing and*** management practices;
(2) Include, clinical care, quality of life, and resident choice;
(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care, ***staffing practices***, and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF.
(4) Reflect the complexities, unique care, and services that the facility provides.

(c) *Program feedback, data systems and monitoring.* A facility must establish and implement written policies and procedures for feedback, data collection systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:
(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care/direct access workers, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.
(2) Facility maintenance of effective systems to identify, collect, and use data from all departments, including but not limited to the facility assessment required at §483.75(e) and including how such information will be used to develop and monitor performance indicators.
(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.
(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including ***whether adverse events are the result of organizational systems and staffing practices that produce a cascading diminution and*** how the facility will use the data to develop activities ***and staffing practices*** to prevent adverse events.
***(5) Involvement of residents, resident representatives and staff in (2), (3) and (4).***

d) *Program systematic analysis and systemic action.*
(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.
(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach (such as root cause analysis, reverse tracer methodology, or health care failure and effects analysis) to determine underlying causes of problems impacting larger systems;
(ii) Development of corrective actions that will be designed to effect change at the systems level ***and staffing levels*** to prevent quality of care, quality of life, or ***resident or worker*** safety problems; and ***promote person-centered care;***
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

***(iv) How residents, resident representatives and staff will be involved in (i), (ii) and (iii).***
***(v) How the facility will use QAPI processes and adverse event monitoring to trigger review and subsequent updating of the facility assessment to determine what resources and staffing practices are necessary in accordance with 483.70(e).***
***(vi) How the facility will use QAPI processes and adverse event monitoring to determine nursing staff needs in accordance with 483.35.***

(e) *Program activities.*
(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident ***and worker*** safety, resident autonomy, resident choice, and quality of care;
(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.
(3) The facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at § 483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

(f) *Governance and leadership.* The governing body and/or executive leadership (or organized group or
individual who assumes full legal authority and responsibility for operation of the facility) is responsible
and accountable for ensuring that:
(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities.
(2) The QAPI program is sustained during transitions in leadership and staffing;
(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed;
(4) The QAPI program identifies and prioritizes problems and opportunities based on performance indicator data, and resident and staff input that reflects ***staffing practices,*** organizational processes, functions, and services provided to residents.
(5) Corrective actions address gaps in systems ***and staffing practices***, and are evaluated for effectiveness; and
(6) ***Corrective actions trigger review and updating of staffing practices in accordance with the facility assessment at §483.70(e), nursing services at §483.35, and quality of care and quality of life at §483.25.*** (~~6~~***7***) Clear expectations are set around safety, quality, rights, choice, and respect.

(g) *Quality assessment and assurance.*
(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:

(i) The director of nursing services;
(ii) The Medical Director or his/her designee;
(iii) At least 3 other members of the facility's staff, at least one of whom must be the administrator, owner, a board member or other individual in a leadership role, ***and at least one of whom must be a direct care/direct access worker who is not in a management position;*** and
(iv) The infection control and prevention officer.
(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:
(i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary; and
(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; ***and link corrective action to staffing practices in accordance with the facility assessment at §483.70(e), nursing services at §483.35, and quality of care and quality of life at §483.25;*** and
(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.

**§483.80 INFECTION CONTROL**

**§483.80 (a)(1) System for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases**
Consumer Voice commends CMS for proposing to significantly enhance the infection control requirements given the physical harm to residents and financial costs of health-care acquired infections. These measures are an important step forward. Nevertheless, we are concerned that infection control and prevention efforts cannot be effective without adequate numbers of consistently assigned, well-trained and well-supervised direct care nursing staff. Nurses and nursing assistants are essential for prevention, detection and intervention. Once again, we urge CMS to require a minimum staffing standard of at least 4. 1 hours of direct care nursing per resident day, 24-hour RN coverage, and staffing practices to promote successful infection prevention.

In addition, we support NASOP's suggestions that the facility's infection prevention and control system follow national standards that include guidelines from the Centers for Disease Control and Prevention.

**Recommendation:**
**§483.80(a)** Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.75(e)***, staffing practices,*** and following accepted national standards~~;~~ ***including, but not limited to guidelines from the Centers for Disease Control and Prevention***;**"**

**§483.80(a)(2)(iv) Isolation of residents**

The infection prevention and control program called for by CMS would require facilities to develop written standards, policies and procedures that address, among other issues, "When isolation should be used for a resident." Consumer Voice has heard directly from residents, families and ombudsmen about situations in which facilities have barred all visitors from accessing residents for a significant period of time due to the outbreak of certain infectious viruses among residents and/or facility staff. The practice of facilities restricting visitation as part of infection control protocol has been regularly reported in the news. In January of 2014, a type A flu outbreak in a Washington state nursing home resulted in the facility prohibiting visitation for all residents until the outbreak was contained.[44] In 2012, a similar norovirus outbreak at a California nursing home also resulted in complete visitation restriction.[45]

However, the current interpretive guidelines recognize the important need for facilities to take into consideration the potential adverse psychological impact on residents when instituting any precautions to control outbreaks. According to the guidelines, "because of the potential negative impact that a resident may experience as a result of the implementation of special precautions, the facility is challenged to promote the individual resident's rights and well-being while trying to prevent and control the spread of infections," and it is appropriate for facilities to "use the least restrictive approach" to infection control while adequately protecting residents and others.[46]

Consumer Voice recommends that CMS include this interpretive guideline language in the proposed rule in order to strike a balance between protecting the health of residents and their psychosocial well-being.

**Recommendation:**

**§483.80(a)(2**) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(iv) When isolation should be used for a resident~~;~~***. The facility must isolate infected residents only to the degree needed to isolate the infecting organism. The method used must be the least restrictive possible;***

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[44]Toledanes, Lyxan. "Flu outbreak forces Woodland nursing home to tighten visitation rules." *Longview Daily News*. 9 January 2014.http://tdn.com/news/local/flu-outbreak-forces-woodland-nursing-home-to-tighten-visitation-rules/article_ab13df98-79a1-11e3-b3cb-001a4bcf887a.html.

[45] Debolt, David. "Norovirus outbreak at Fairfield nursing home sickens 27." *Daily Republic*. 21 January 2012. http://www.dailyrepublic.com/news/fairfield/norovirus-outbreak-at-fairfield-nursing-home-sickens-27/.

[46] Centers for Medicare and Medicaid Services. State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities (Rev. 70, 01-07-11): §483.65 Infection Control/Tag F441.

**§483.80(b) Infection prevention and control officer**
Consumer Voice supports NASOP's recommendation that there be stronger language to make it clear that the individual designated to be the infection prevention and control officer is dedicated to that role.

**Recommendation:**
**§**483.80(b) Infection prevention and control officer. The facility must designate one individual as the infection prevention and control officer (IPCO) for whom the IPCP at that facility is a ~~major~~ ***primary*** responsibility.

**§483.85 COMPLIANCE AND ETHICS PROGRAM**
Consumer Voice is pleased to see that CMS is finally issuing regulations governing compliance and ethics programs required under the Affordable Care Act. We support the proposed rule and would only suggest that all facilities should adhere to additional required components referenced at 483.85(d)(1), (2), and (3).

**§483.90 PHYSICAL ENVIRONMENT**

**§483.90(d)(1)(i) Number of residents per room**
Resident rooms should be as much as possible like rooms that people have in their own homes. We would not put four people together in one bedroom in our houses, so residents should not be forced to share a room with three other people. This infringes on resident privacy and can negatively affect their quality of life. CMS would greatly advance person-centered care by requiring no more than two residents in a room. Moreover, the proposed rule is an important opportunity to vastly improve resident well-being by requiring private rooms for any facilities receiving approval or construction or reconstruction or newly certificated after the effective date of the final rule. Research literature provides strong evidence that elderly adults overwhelmingly prefer single rooms over shared rooms. Single rooms provide privacy and give residents a greater sense of control over their environment. Interviews and focus groups conducted with staff and families also support single rooms. Nursing home staff have noted that shared rooms sometimes prevented family members from visiting as long as they would have preferred. Family members reported that when they were visiting dying relatives, being in the presence of roommates made them feel uncomfortable. An AARP study found that older adults (over age 50) prefer private to shared rooms by 20 to 1.[47]

Furthermore, there must be far greater privacy for those who share a room. The current system in most semi-private rooms is to use ceiling suspended curtains. These are woefully inadequate and do not provide residents with sufficient visual and auditory privacy. In fact, one could argue that "semi-private" rooms are not private at all. Privacy

[47] The Gerontologist, April 2007, 47(2):169–83. Margaret Calkins, Ph.D., Christine Cassella.

is important to all of us, yet many residents are forced to live exposed and without refuge because the only place they can go for privacy is a room without privacy.

**Recommendation:**
**§483.90(d)(1)(i)** Accommodate no more than ~~four~~ ***two*** residents. For facilities that receive approval of construction or reconstruction plans by State and local authorities or are newly certified after [effective date of final rule], ***there must be private*** bedrooms ***to*** ~~must~~ accommodate ***all residents who wish to live by themselves*** ~~no more than two residents~~.
***(ii) Each semi-private room must include a barrier that provides each resident with total visual and auditory privacy.***

**§483.90(e) Toilet facilities**
We commend CMS for requiring that each resident room have its own bathroom with at least a toilet, sink and shower in facilities that receive approval of construction or reconstruction plans by State and local authorities or are newly certified after the effective date of the final rule.

**§483.95 Training requirements**

We are pleased to see that CMS proposes training requirements for all staff, contractual employees, and volunteers on a number of important topics, including communication, residents' rights, and abuse, neglect and exploitation. Ensuring that everyone who works or volunteers in a nursing home is knowledgeable in these areas will improve both quality of care and quality of life. Consumer Voice urges CMS to expand these topics to also cover:

- The aging process. All residents are aging and staff/contractors/volunteers need to have a good understanding of how human beings change as they grow older.
- Appropriate dementia care (we believe this is a much more person-centered term than "dementia management") and resident abuse prevention, which CMS is currently only proposing for certified nursing assistants. Since the National Alzheimer's Association states that nearly 60 percent of nursing home residents currently have Alzheimer's or another dementia,[48] and we know this number will grow, all direct care/direct access staff, contractors and volunteers need to be able to interact with and serve residents with dementia.
- Resident abuse prevention. The proposed training requirements for all individuals who are not direct nurse aides do not include this critical topic, but focus only on what constitutes abuse and reporting requirements. Situations where knowing how to prevent abuse can arise at any time. Non-nurse aides need to be prepared as well.

[48] http://www.alz.org/join_the_cause_special_care_units.asp

Finally, we believe that all operating organizations should be required to provide training on compliance and ethics annually, not just those that operate five or more facilities. We see no reason why the number of facilities should be a factor.

**Recommendation:**

**§483.95** Training requirements. A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at §483.70(e). Training topics must include but are not limited to—

***(a) Aging process. A facility must provide training on various aspects of the aging process.***

~~(a)~~***(b)*** Communication. A facility must include effective communications as mandatory training for direct care/direct access personnel.

~~(b)~~ ***(c)*** Resident's rights and facility responsibilities. A facility must ensure that staff members are educated on the rights of the resident and the responsibilities of a facility to properly care for its residents as set forth at § 483.10 and § 483.11, respectively.

~~(c)~~ ***(d)*** Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on—

(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.

(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property

***(3) Resident abuse prevention.***

~~(f)~~***(e) Appropriate dementia care***

~~(g)~~ ***(f)*** Quality assurance and performance improvement. A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at § 483.75. (e) Infection control. A facility must include as part of its infection prevention and control program mandatory training that includes the written standards, policies, and procedures for the program as described at § 483.80(a)(2).

~~(e)~~***(g)*** Infection control. A facility must include as part of its infection prevention and control program mandatory training that includes the written standards, policies, and procedures for the program as described at § 483.80(a)(2).

~~(f)~~ ***(h)***Compliance and ethics. The operating organization for each facility must include as part of its compliance and ethics program, as set forth at § 483.85—

(1) An effective way to communicate that program's standards, policies, and procedures through a training program or in another practical manner which explains the requirements under the program.

(2) Annual training ~~if the operating organization operates five or more facilities~~.

**§483.95(g) Required in-service training for nurse aides**

We support including dementia management and resident abuse prevention in in-service trainings for nurse aides. A noted above, we hope CMS will change the name of this topic to "appropriate dementia care" since "management" of residents has a negative connotation and is not person-centered.

In the 2008 Institute of Medicine Study, *Retooling for An Aging America: Building the Health Care Workforce*, the authors note that the education of direct care workers appears to be inadequate and that direct care workers "identified a number of areas in which their knowledge and skills needed further development, including dementia, end-of-life care, teamwork, and problem solving."[49] We agree and urge CMS to require that in-service training include these last three topics.

**Recommendation:**

**§483.95(~~g~~*g*)** *(i)* Required in-service training for nurse aides. In-service training must—

(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year.

(2) Include ~~dementia management~~ training ***in appropriate dementia care,*** ~~and~~ resident abuse prevention ~~training~~***, end-of-life care, teamwork and problem solving***.

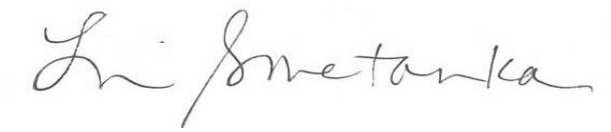
**Increased hours of in-service training**

Finally, we are concerned that the minimum number of hour per year of in-service training has not been increased. Given that there are new required topics for in-service training, facilities may choose to drop other important training topics. We encourage CMS to study this issue in order to determine what this minimum requirement should be in order to make in-service training as comprehensive as possible to enhance staff continued competency.

[49] Institute of Medicine Study, Retooling for An Aging America: Building the Health Care Workforce. pp 215-216.

Consumer Voice thanks CMS for its consideration of our comments on these critically important proposed nursing home regulations.

Sincerely,



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Alamo Area Council of Governments, TX
Alaska State Long-Term Care Ombudsman Program, AK
Albemarle Commission Area Agency on Aging, NC
Area Agency on Aging - Flathead County, MT
Area Agency on Aging District 7 Ohio Regional Long-Term Care Ombudsman Program, OH
Area Agency on Aging/Lower Rio Grande Valley, TX
Area Agency on Aging of East Texas, TX
California Office of the State Long-Term Care Ombudsman
Caring Across Generations (national organization)
Center for Advocacy for the Rights and Interests of the Elderly (CARIE), PA
Center for Medicare Advocacy (national organization)
Center in the Park/Philadelphia Long-Term Care Ombudsman Program, PA
Citizens Advocacy for Resident Empowerment (CARE), IL
Coalition of Citizens With Disabilities in Illinois, IL
Coalition of Institutionalized Aged and Disabled, NY
Columbia-Montour Aging Office, Inc., PA
Denver Regional Council of Governments Long Term Care Ombudsman Program, CO
Disability Law Colorado, CO
Disability Network West Michigan, MI
East Tennessee Long-Term Care Ombudsman Program of the East TN Human Resource Agency, Inc., TN
Elder Justice Committee of Metro Justice of Rochester, NY
Elder Law of East Tennessee, TN
Families for Better Care (national organization)
Family Council of Elicott City HealthCare Center, MD

Forsyth County Department of Social Services, NC
Harford County Long Term Care Ombudsman Program, MD
Harris County Long-Term Care Ombudsman Program, TX
Helping Hand Family Council at Transitions Healthcare Capitol City, D.C.
High Country Area Agency on Aging, NC
Illinois Citizens for Better Care, IL
Illinois State Long-Term Care Ombudsman Program
Kansas Advocates for Better Care
Kansas Office of the State Long-Term Care Ombudsman
Lehigh County Office of Aging and Adult Services, PA
Long Term Care Community Coalition, NY
Long Term Care Ombudsman Program of NE Indiana, IN
Lower Savannah Council of Governments-Regional Long-Term Care Ombudsman Program, SC
Massachusetts Advocates for Nursing Home Reform, MA
Massachusetts State Long-Term Care Ombudsman Program, MA
Maine Veteran's Homes, ME
Michigan Poverty Law Program, MI
Michigan State Long-Term Care Ombudsman Program
Minnesota Office of Ombudsman for Long-Term Care
Montgomery County Maryland Long-Term Care Ombudsman Program
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National Association of State Long-Term Care Ombudsman Programs (national organization)
National Council on Aging (national organization)
NC Regional Long Term Care Ombudsman Association, NC
New York Office of the State Long Term Care Ombudsman
New Mexico State Long-Term Care Ombudsman Program, NM
Nursing Home Victim Coalition, Inc., TX
Nursing Home Ombudsman Agency of the Bluegrass, Inc., KY
Office of the Georgia State Long-Term Care Ombudsman, GA
Office of the Iowa State Long-Term Care Ombudsman, IA
Office of the Rhode Island Long-Term Care Ombudsman, RI
Ohio Association of Regional Long-Term Care Ombudsmen
Ohio Region 5 Long-Term Care Ombudsman Program, OH
Oklahoma Office of the State Long-Term Care Ombudsman, OK
Our Mother's Voice, SC
Perquimans County Nursing Home Community Advisory Committee, NC
Pikes Peak Area Agency on Aging Ombudsman Program, CO
Resident Councils of Washington, WA
The Retirement Research Foundation, IL
Senior Care Institute, FL
Senior Law Project of Indiana Legal Services, Inc., IN
The Senior Source-Dallas County Ombudsman Program, TX
South Central Council of Governments, CO
Southwestern Commission-Area Agency on Aging, NC

Statewide Coalition of Presidents of Resident Councils, CT
Terence Cardinal Cooke Nursing Home Family Council, NY
Texas State Long-Term Care Ombudsman Program
Vermont Ombudsman Project, VT
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