Comments on the Proposed PA State Nursing Facility Regulation – Proposed Rulemaking 1: 10-221

The announcement of Acting Secretary Beam to revise the current state nursing facility regulation is exciting and encouraging to those of us in the Ombudsman program who have witnessed the inadequate staffing of facilities as resident's basic needs go unmet and issues of quality of life and dignity become increasingly difficult to attain. After reviewing the language in the proposed regulations, we have some concerns that this proposal, as written, will fail to meet the intent to increase the quality of care received by Pennsylvania's nursing care residents for the following reasons.

The greatest concern is that the section 211.12 does not contain language that will allow the licensing bureau to enforce the change that is attended.

- How is the increased number of "general nursing care hours provided per shift" to be determined?
    - Without the **calculation** formula to determine what this, enforcement of the regulation is no likely. Secretary Beam alluded to a formula that is a work-in-progress, but if it is not included in the regs, how will it be enforceable?
        - The language states that the increase is to provide a minimum of 4.1 hours of direct resident care for each resident each day. However, this language is misleading because the rest of the document supports the notion of an average as it is measured still in 24-hour periods and totaled for the entire facility.
        - What would be better?
            - A more concrete definition of how this will be measured.
            - Despite the intent the language still supports the use of an average. If this is to remain then the language should reflect that in 211.12 (i) at the end of the second sentence it should read "a minimum of 4.1 hours of direct resident care for each resident on average."
            - Inclusion of the newly added language "during each shift" at every mention of "each 24-hour period" instead of only reflecting the change once. So that it is clear this is the new standard.
            - Instead of an average over 24-hour period for the entire facility, it would be better to have a minimum reflected in each shift or level of care or literally per resident.
    - **Definitions for language** including "general nursing care" and "direct resident care" would more clearly determine what counts as direct care and can be included in the 4.1 calculation. How will "the highest practicable physical, mental, and psychosocial well-being or each resident" be measured and assessed? Without further definition it will be hard if not impossible for licensing to enforce these regulatory changes.
        - Equally important **who** is qualified to provide that care. For example, If the Director of Nursing does not provide direct care as her role is to oversees the nursing staff and operations, her presence at work should not count toward the "general nursing care" calculation. Similarly, a receptionist who has been strong-

armed into getting a CNA certification to maintain employment, should not count toward those 4.1 hours as the receptionist is not providing direct care or meeting resident needs for "physical, mental, and psychosocial well-being."

- Similarly, how will "appropriate competencies and skills" of staff be defined. It is our hope that this will be addressed in "proposed rulemaking 4" when staff development is addressed but this definition may impact the calculation as well.
- **Other sections of 211.12** The intent of this proposal would surely impact more than sections (a) and (i) of 211.12. It would be worthwhile to update the other sections with the new language to further clarify the impact of this historic change.
- **Compensation.** Secretary Beam made mention in her announcement that the State Office will provide support to the industry in the for the form of workforce development on recruitment, staff development, and compensation. The financial considerations in the document are based solely on current pay scales. Surely, this is not realistic if staffing numbers are to increase and required competencies are to increase.

- **Definitions.** Definitions of the proposed regulations are assigned to the initial package only. How can the changes to the definitions become established before the rest of the document is released and reviewed? It would be best to have the definitions included in each package so that appropriate changes are reflected throughout the process.
- **Siting**. Several of the references in the proposed regulation do not reference what version is being sited or what is latest version. It would be better to have these references properly sited.

Section 201.1 Applicability – Exception clause 51.31- 51.34. Also of concern is the provision for exceptions to this regulation, as exceptions continue to be allowable if "compliance would create an unreasonable hardship and an exception would not impair or endanger the health, safety or welfare of a patient or resident." This should not be open-ended. The exception must be more limited (time-limited or something) or the standard for care may be to survive (avoiding endangerment) rather than to thrive (highest practicable physical, mental, and psychosocial well-being) thereby undermining the intent of the regulation.

Lastly, the changes proposed in the **definition of the word "abuse**" will eliminate "involuntary seclusion" as a form of abuse. Given the reality of long-term care residents throughout the Covid-19 pandemic, it is understandable to consider removing this, however, we would be doing residents a great disservice to minimize the cruel impact of this measure especially when you consider that seclusion an intended punishment in the criminal justice system. It would be best to leave this definition intact to further define then unacceptability of seclusion.