Regulatory Analysis Form

(Completed by Promulgating Agency)

(All Comments submitted on this regulation will appear on IRRC's website)

INDEPENDENT REGULATORY REVIEW COMMISSION

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Independent Regulatory Review Commission

IRRC Number:

(1) Agency
Department of Health

(2) Agency Number: 10

Identification Number: 224

(3) PA Code Cite: 28 Pa. Code §§ 201.18—201.21, 201.24, 201.26, 201.29, 201.31, 209.3, 211.2—211.10, 211.12, 211.15— 211.17 and deleting §§ 201.25, 201.30, 207.2, and 211.11

(4) Short Title:

Long-term care nursing facilities: *Rulemaking 4 – Qualifications, Training, Job Duties, Recordkeeping, Program Standards, and Resident Rights and Services*

Please note that this is the last of four final-form rulemaking packages, with respect to long-term care nursing facilities, to be promulgated by the Department.

(5) Agency Contacts (List Telephone Number and Email Address):

Primary Contact: Ann Chronister, Director, Bureau of Facility Licensure and Certification, 717-547-3131, RA-DHLTCRegs@pa.gov

(6) Type of Rulemaking (check applicable box):

- ☐ Proposed Regulation
- ☒ Final Regulation
- ☐ Final Omitted Regulation
- ☐ Emergency Certification Regulation;
  - ☐ Certification by the Governor
  - ☐ Certification by the Attorney General

(7) Briefly explain the regulation in clear and nontechnical language. (100 words or less)

This is the last of four rulemaking packages that amend Subpart C (relating to long-term care facilities) of Part IV of Title 28 of the Pennsylvania Code. Subpart C consists of 6 different chapters: Chapters 201, 203, 205, 207, 209 and 211.

This final-form rulemaking amends various qualifications, trainings, program standards, and resident rights and services provisions. Specifically, other amendments include increasing the number of licensed practical nurses (LPNs) and nurse aides required under § 211.12 (relating to nursing services), establishing minimum staffing ratios for LPNs and nurse aides, adding a requirement that facilities have a full-time or part-time qualified social worker based on the size of the facility, requiring facilities to have admissions policies and procedures that include introductions and orientation for new residents to key personnel and services, and adding an anti-discrimination provision and training regarding resident rights, including nondiscrimination and cultural competency.

The purpose of this final-form rulemaking is to update the health and safety standards for the licensure of nursing facilities, including programmatic and training standards. In addition, this final-form rulemaking aims to create consistency between Federal and State requirements for long-term care nursing facilities.

(8) State the statutory authority for the regulation. Include specific statutory citation.

Sections 601 and 803 of the Health Care Facilities Act (HCFA or act) (35 P.S. §§ 448.601 and 448.803) authorize the Department to promulgate, after consultation with the Health Policy Board, regulations necessary to carry out the purposes and provisions of the HCFA. Section 801.1 of the HCFA (35 P.S. § 448.801a) seeks to promote the public health and welfare through the establishment of regulations setting minimum standards for the operation of health care facilities. The minimum standards are to assure safe, adequate and efficient facilities and services and to promote the health, safety and adequate care of patients or residents of those facilities. In section 102 of the HCFA, the General Assembly has found that a purpose of the HCFA is, among other things, to assure that citizens receive humane, courteous and dignified treatment. 35 P.S. § 448.102. Finally, Section 201(12) of the HCFA (35 P.S. § 448.201(12)) provides the Department with explicit authority to enforce its rules and regulations promulgated under the HCFA.

The Department also has the duty to protect the health of the people of this Commonwealth under section 2102(a) of the Administrative Code of 1929 (71 P.S. § 532(a)). The Department has general authority to promulgate regulations under section 2102(g) of the Administrative Code of 1929 (71 P.S. § 532(g)) for this purpose.

(9) Is the regulation mandated by any federal or state law or court order, or federal regulation? Are there any relevant state or federal court decisions? If yes, cite the specific law, case or regulation as well as, any deadlines for action.

The regulations are not mandated by any Federal or State statute, court order, or Federal regulation. With respect to State law, the Department is authorized under the HCFA to promulgate regulations that promote the health, safety and adequate care of patients and residents in health care facilities, which includes residents in long-term care nursing facilities. 35 P.S. §§ 448.604 and 448.803. In addition, the act states that the Department shall take into consideration Federal certification standards, as appropriate, when developing rules and regulations for licensure of health care facilities. 35 P.S. § 448.806(b).

(10) State why the regulation is needed. Explain the compelling public interest that justifies the regulation. Describe who will benefit from the regulation. Quantify the benefits as completely as possible and approximate the number of people who will benefit.

The percentage of adults aged 65 or older in Pennsylvania is increasing. In 2010, approximately 15% of Pennsylvanians were aged 65 or older. In 2017, this number increased to 17.8%. In 2020, just under 20 percent of the population in Pennsylvania was 65 years of age or older. For every 10 individuals under 25 years of age lost in Pennsylvania since 2010, the state gained 21 persons aged 65 or older. The Commonwealth also has a higher percentage of older adults when compared to other states. In 2017,

this Commonwealth ranked fifth in the Nation in the number (2.2 million) of older adults and seventh in percentage (17.8%). The increase in older Pennsylvanians is expected to continue. It has been estimated that by 2030, there will be 38 older Pennsylvanians (65 years of age or older) for every 100-working age Pennsylvanians (15 years of age to 64 years of age). Penn State Harrisburg, Pennsylvania State Data Center. (July 2018). Population Characteristics and Change: 2010 to 2017 (Research Brief). Retrieved from https://pasdc.hbg.psu.edu/data/research-briefs/pa-population-estimates; Penn State Harrisburg, Pennsylvania State Data Center. (July 2018). (June 2022). Trends in Pennsylvania's Population by Age. (Research Brief). Retrieved from https://pasdc.hbg.psu.edu/sdc/pasdc_files/researchbriefs/June_2022.pdf.

As the number of older Pennsylvanians increases, the number of those needing long-term care nursing will also increase. It has been estimated that an individual turning 65 years of age today has an almost 70% chance of needing some type of long-term services or support during the remainder of their lifetime; 20% will need long-term care support for longer than 5 years. More people use long-term care services at home and for longer; however, approximately 35% utilize nursing facilities for this type of care. Administration for Community Living. (February 2020). How Much Care Will You Need? Retrieved from https://acl.gov/ltc/basic-needs/how-much-care-will-you-need.

Further, the COVID-19 pandemic highlighted the vulnerability of older adults, with a larger percentage of deaths occurring in individuals 65 years of age and older. Centers for Disease Control and Prevention (CDC). Demographic Trends of COVID-19 Cases and Deaths in the US Reported to CDC. Retrieved from https://covid.cdc.gov/covid-data-tracker/#demographics. *See also*, CDC. COVID-19 Weekly Cases and Deaths per 100,000 Population by Age, Race/Ethnicity and Sex, United States, March 1, 2020—June 25, 2022. Retrieved from https://covid.cdc.gov/covid-data-tracker/#demographicsovertime. Further, it is estimated that at least a quarter of COVID-19 deaths occurred in long-term care nursing facilities. The COVID Tracking Project. (March 2021). Long-Term-Care COVID Tracker. Retrieved from https://covidtracking.com/nursing-homes-long-term-care-facilities. In this Commonwealth alone, there have been approximately 11,000 confirmed deaths of residents in long-term care nursing facilities since January 2020. AARP. (June 16, 2022). AARP Nursing Home COVID-19 Dashboard Fact Sheets. Retrieved from https://www.aarp.org/ppi/issues/caregiving/info-2020/nursing-home-covid-states.html.

The Department's long-term care nursing facilities regulations have not been updated since 1999, with the last significant update occurring in 1997 after the 1996 amendment to the Health Care Facilities Act (the HCFA or act) (35 P.S. §§ 448.101—448.904b). Since that time, there have been substantial changes in the means of delivering care and providing a safe environment for residents in long-term care nursing facilities, with the pandemic further highlighting the need for change.

Approximately 72,000 individuals reside in the 682 long-term care nursing facilities currently licensed by the Department. These 72,000 individuals, and their family members, will benefit from this final-form regulation. Further, the current residents for the three private pay facilities will benefit with the updated standards from 1998. Since the Department's adoption of the 1998 regulations 23 years ago, there have been expanded requirements for emergency preparedness; quality assurance and infection control; abuse, neglect and exploitation protections; and admission and discharge protections to ensure the health and safety of residents. These three facilities had a reported, combined census of 79 residents for the Department's 2020-2021 annual report. Department of Health. (2021). Nursing Home Reports. Retrieved from: https://www.health.pa.gov/topics/HealthStatistics/HealthFacilities/NursingHomeReports/Pages/nursing-home-reports.aspx.

Further, the regulated community will benefit from the efficiency of the consistent adoption and application of the Federal requirements for health and safety at 42 CFR Part 483, Subpart B (relating to requirements for long-term care facilities). The Commonwealth generally will also benefit from the efficiency of Department surveyors applying consistent health and safety standards.

(11) Are there provisions that are more stringent than federal standards? If yes, identify the specific provisions and the compelling Pennsylvania interest that demands stronger regulations.

Yes, there are some provisions that are more stringent than Federal standards, as described below.

In § 201.19 (relating to personnel records), the Department is requiring facilities to maintain certain specific employee personnel records, including the employee's job description, records of trainings, criminal background checks, and documentation regarding determinations of suitability for employment.

In § 201.24(e) (relating to admission policy), the Department is requiring the governing body of a facility to establish written policies and procedures for the admission process for residents, and through the administrator, to develop and adhere to procedures implementing those policies. The Department has been made aware of residents being left on their own for hours and even up to a day after admission to a facility, without receiving any information or services, which can be confusing or disorienting to a resident. Requiring a facility to have in place policies and procedures to introduce and orient a resident to a facility will ensure that residents are provided with essential information concerning their stay at the facility, at the time of admission when they are likely to feel the most vulnerable.

In § 201.29(p) (relating to resident rights), the Department is adding language to make it clear that a resident has the right to care without discrimination based upon race, color, familial status, religious creed, ancestry, age, sex, gender, sexual orientation, gender identity or expression, national origin, ability to pay, handicap or disability, use of guide or support animals because of the blindness, deafness or physical handicap of the resident or because the resident is a handler or trainer of support or guide animals.

In § 211.2(c) (relating to medical director), the Department is adding a requirement that the medical director complete at least 4 hours annually of continuing medical education (CME) pertinent to the field of medical direction or post-acute and long-term care medicine. The Department has determined that this addition, which is not included in the Federal requirements, is necessary to ensure that the medical director of a facility remains current in the field. Having a knowledgeable medical director is critical to the provision of quality care. Additionally, requiring 4 hours of CME pertinent to the field of medical direction or post-acute and long-term care medicine will not present a burden for medical directors as these hours would count towards the 100 minimum CME hours required annually for physicians to maintain their licensure in this Commonwealth.

In § 211.6(a) (relating to dietary services), the Department is requiring menus to be posted in the facility or distributed to residents at least 2 weeks in advance. The Department is requiring this provision promote more resident-centered environments in facilities.

In § 211.12 (relating to nursing services), the Department is requiring a graduated increase in the hours of direct resident care. Effective July 1, 2023, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 2.87 hours of direct resident care for each resident. The following year, effective July 1, 2024, the total number of hours of

general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum 3.2 hours of direct resident care for each resident. Further, effective July 1, 2023, a facility is required to have a minimum of 1 nurse aide per 12 residents during the day, 1 nurse aide per 12 residents during the evening, and 1 nurse aide per 20 residents overnight. Effective July 1, 2023, a facility is also required to have a minimum of 1 LPN per 25 residents during the day, 1 LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight. The following year, effective July 1, 2024, a facility is required to have a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight.

In § 211.16 (relating to social services), the Department is requiring a full-time social worker generally; however, a facility with 26 to 59 beds may employ a part-time qualified social worker if the facility assessment indicates that a full-time qualified social worker is not needed. Further, facilities with 25 beds or less may either employ a part-time qualified social worker or share the services of a qualified social worker with another facility.

(12) How does this regulation compare with those of the other states? How will this affect Pennsylvania's ability to compete with other states?

The Department reviewed regulations for the states surrounding Pennsylvania (Delaware, Maryland, New York, New Jersey, Ohio and West Virginia). As a whole, the Department's amendments are comparable to the regulations of these states, with no substantial differences regarding personnel records, admission, employee training, and resident care, for example. The Department's ability to compete, therefore, will not be affected by these amendments

In addition, the final rate of 3.2 hours of direct resident care for each resident, effective July 1, 2024, is comparable to surrounding states and similarly situated states: Delaware 3.28 hours; Maryland 3.00 hours; New York 3.50 hours; New Jersey 2.50 hours; District of Columbia 3.50-4.10 hours; Ohio 2.50 hours; Florida 3.6 hours; Rhode Island 3.58 hours; and West Virginia 2.25 hours. https://www.macpac.gov/publication/state-policies-related-to-nursing-facility-staffing/. Specifically,

- Delaware requires a minimum of 3 direct care hours per resident. Delaware requires a ratio of 1 RN or LPN per 20 residents and 1 nurse aide per 9 residents during the day; 1 RN or LPN per 25 residents and 1 nurse aide per 10 residents in the evening; and 1 RN or LPN per 40 residents and 1 nurse aide per 22 residents at night. 16 Del. Admin. Code § 1162.

- Maryland requires a minimum of 3 hours of bedside care per resident, provided by RNs, LPNs and nurse aides. The ratio of nursing service personnel on duty providing bedside care may not be less than one to 15. Maryland also requires the following ratios for full-time RNs based on resident census: one RN for 2-99 residents, two RNs for 100-199 residents, three RNs for 200-299 residents, and 4 RNs for 300-399 residents. Md. Code Regs. 10.07.02.19.

- Ohio requires 2.5 hours of direct resident care per day to be provided by nurse aides, RNs and LPNs. Ohio Admin. Code 3701-17-08(C). New Jersey requires 2.5 hours of resident care per day provided by RNs, LPNs and nurse aides. New Jersey also requires a specific number of direct care hours based on types of services, including wound care, tube feeding, oxygen therapy, and other types of care delineated in regulation. N.J. Admin. Code § 8:85-2.2.

- New York recently passed legislation that became effective January 1, 2021, which requires a facility to maintain a daily average of staffing hours equal to 3.5 hours of care per resident per day. This care is to be provided by a certified nurse aide, a licensed nurse or a nurse aide. No less than 2.2 hours shall be provided by a certified nurse aide or nurse aide, and no less than 1.1 hours per day shall be provided by a licensed nurse. New York's Department of Health has proposed regulations to implement this legislation. NY Department of Health. Minimum Staffing Requirements for Nursing Homes. Retrieved from: https://regs.health.ny.gov/sites/default/files/proposed-regulations/Minimum%20Staffing%20Requirements%20for%20Nursing%20Homes.pdf

- West Virginia requires at least 2.25 hours of nursing personnel time per resident per day. West Virginia requires a certain number of personnel per day based on the number of residents in a facility, multiplied by the number of hours needed per resident. This is broken down into a detailed table for every possible resident census. For example, per the table, 60 residents will require a total of 135 hours of care per day, which will require a facility to have a total of 17 nursing personnel to provide this care; 120 residents will require a total of 270 hours of care per day, which will require a facility to have a total of 34 nursing personnel to provide this care. W. Va. Code R. § 64-13-8; § 64-13 Table A.

The Department's amendment in § 211.16 to require that all facilities have a full-time or part-time qualified social worker will not affect Pennsylvania's ability to compete. Social work requirements for the surrounding states vary. Delaware requires all facilities to employ a full-time social worker, except facilities with fewer than 100 beds may designate other personnel to perform these duties. 16 Del. Admin Code § 3201-2.0. New York only requires a full-time social worker for facilities with more than 120 beds; those with 120 or less, are still required to have a social worker, but the social worker may be either full-time or part-time. N.Y. Comp. Codes R. & Regs. tit. 10 § 415.5. New Jersey requires a full-time social worker for every 120 residents. N.J. Admin. Code § 8:85-2.2. Maryland requires a facility to provide or arrange for social services and requires social services to be assigned to a social worker. However, Maryland does not specifically require a facility to have a full-time social worker. Md. Code. Regs. 10.07.02.30. Ohio and West Virginia do not appear to specifically require a social worker to provide social services, in their regulations.

The Department's amendments to align with Federal requirements will not affect Pennsylvania's ability to compete. All long-term care nursing facilities that participate in Medicare or Medical Assistance (MA) are required to comply with the Federal requirements regardless of where they are located. Of the surrounding states, Delaware has expressly adopted the Federal requirements at 42 CFR Part 483, Subpart B. Ohio, New Jersey and West Virginia have not. Maryland and New York have not expressly adopted the Federal requirements. However, New York has a general provision requiring long-term care nursing facilities to comply with all "pertinent" Federal regulations.

(13) Will the regulation affect any other regulations of the promulgating agency or other state agencies? If yes, explain and provide specific citations.

This final-form rulemaking will not affect the regulations of any other state agency. As provided above, the Department is currently updating the various regulatory chapters relating to long-term care facilities. This final-form rulemaking is the first of four rulemaking packages that amend the 6 chapters of Subpart C (relating to long-term care facilities) of 28 Pa. Code Part IV.

This final-form rulemaking amends the qualifications, trainings, job duties, recordkeeping, program standards, and resident rights and services provisions under Chapters 201, 207, 209 and 211.

The other three nursing facility regulatory packages are as follows:

Rulemaking 1 – *General Applicability and Definitions*

Rulemaking 2 – *General Operation and Physical Requirements*

Rulemaking 3 – *Applications for Ownership, Management and Changes of Ownership; Health and Safety*

(14) Describe the communications with and solicitation of input from the public, any advisory council/group, small businesses and groups representing small businesses in the development and drafting of the regulation. List the specific persons and/or groups who were involved. ("Small business" is defined in Section 3 of the Regulatory Review Act, Act 76 of 2012.)

The Department's outreach has included various representatives from industry stakeholders and consumer advocacy groups, including small businesses and those groups representing them. As analyzed in further detail below, at least 91% of nursing facilities in the Commonwealth meet the definition of a small business due to $30 million or less in annual receipts.

The Department began the process of updating the current long-term care nursing facilities regulations in late 2017. The Department sought review, assistance and advice from members of a long-term care work group (LTC Work Group) consisting of relevant stakeholders. The members of the LTC Work Group were drawn from a diverse background and included representatives from urban and rural long-term care facilities and various stakeholder organizations and consumer groups that work in the area of resident care and delivery of services. The LTC Work Group members consisted of representatives from the following organizations: American Institute of Financial Gerontology; Baker Tilly Virchow Krause, LLP; Berks Heim and Rehabilitation; Fulton County Medical Center; Garden Spot Community; HCR ManorCare; Inglis House; Landis Communities; Leading Age; Legg Consulting Services; LIFE Pittsburgh; Luzerne County Community College; The Meadows at Blue Ridge; Mennonite Home, Lutheran Senior Life Passavant Community; PA Coalition of Affiliated Healthcare and Living Communities; Pennsylvania Home Care Association; University of Pittsburgh; and Valley View Nursing Home.

The members of the LTC Work Group met regularly during 2018 with the LTC Work Group's primary focus being the simplification and modernization of the existing long-term care regulations. After these discussions were complete, the Department reviewed the recommendations of the LTC Work Group and consulted with other potentially impacted agencies in 2019 and 2020. In 2020, 2021 and 2022, the Department continued its efforts to draft amendments to the long-term care nursing facility regulations while also handling the day-to-day challenges of protecting the residents of those facilities, who were being hit the hardest by the COVID-19 pandemic.

In 2019 and 2020, the Department consulted with the Department of Aging, Department of Human Services (DHS) and Department of Military and Veterans Affairs (DMVA), who also participated in the above LTC Work Group discussions. The Department presented the regulations to the Health Policy Board on October 29, 2020

In addition to considering comments on the four regulatory packages during and outside of the four public comment periods, the Department also met with stakeholders on three occasions following the receipt of public and IRRC comments to discuss their concerns and to gain additional insight into comments that were received.

The first of these meetings occurred on December 15, 2021. Representatives from AARP, Alzheimer's Association – Delaware Valley and Greater Pennsylvania Chapters, Center for Advocacy for the Rights & Interests of the Elderly (CARIE), Community Legal Services, LeadingAge, Pennsylvania Health Care Association (PHCA), Pennsylvania Coalition of Affiliated Healthcare & Living Communities (PACAH), and SEIU Healthcare Pennsylvania attended that meeting.

The second meeting, for proposed Rulemaking 3, occurred on June 8, 2022. Representatives from AARP, Alzheimer's Association, CARIE, Community Legal Services, LeadingAge, PHCA, Pennsylvania Health Law Project (PHLP), and SEIU attended that meeting. The Department explicitly stressed to stakeholders during this June 8, 2022, meeting that it would be considering comments on all proposed rulemakings, and that it would welcome any additional comments or feedback that stakeholders might have after the meeting regarding proposed amendments to the regulations. The Department also indicated in a press release on June 3, 2022, that it would be considering comments on all four proposed rulemakings before submitting final-form regulations.

The Department held a third stakeholder meeting in August 2022 after the public and IRRC comment periods ended for proposed Rulemaking 4. The Department presented the final-form regulations to the Health Policy Board on August 10, 2022, and met with stakeholders one last time on August 17, 2022, to present the final-form regulations for final discussion and feedback. At this meeting, the Department presented stakeholders with an overview of the amendments that were made from proposed to final-form in response to their comments, on all four rulemakings, and provided them with an opportunity to comment and provide feedback on the final-form regulations. Present at that meeting were representatives from the Alzheimer's Association, CARIE, Community Legal Services, County Commissioners Association (CCAP), Disability Rights, LeadingAge, PHCA, PHFC, and SEIU.

In addition to this public outreach, the Senate Health and Human Services and Aging and Youth Committees held a joint legislative hearing regarding proposed Rulemaking 1 on September 15, 2021. The Department participated in the hearing and provided testimony and a commitment to continue working with stakeholders to address workforce challenges in the long-term care industry. The Department maintains this commitment and will continue to engage with stakeholders to provide guidance and technical assistance as the regulations are implemented and commits to continued engagement with stakeholders and other agencies to support ongoing workforce development in the long-term care industry.

(15) Identify the types and number of persons, businesses, small businesses (as defined in Section 3 of the Regulatory Review Act, Act 76 of 2012) and organizations which will be affected by the regulation. How are they affected?

Long-Term Care Nursing Facilities

The final-form rulemaking will affect the 682 long-term care nursing facilities licensed by the Department since these facilities will have to comply with the rulemaking. These facilities provide health services to approximately 72,000 residents. This total includes 19 county-owned and operated facilities, 6 veterans' homes that are operated by the Department of Military and Veterans Affairs, 654

privately-owned facilities that participate in the Medicare and/or MA Programs, and 3 private-pay facilities that do not participate in either Medicare or MA.

The 19 county-owned long-term care nursing facilities licensed by the Department account for approximately 7.5% (6,524 beds) of licensed nursing facility beds across the Commonwealth. Allegheny County owns four of the nursing homes; the remaining homes are in the following 15 counties: Berks, Bradford, Bucks, Chester, Clinton, Crawford, Delaware, Erie, Indiana, Lehigh, Monroe, Northampton, Philadelphia, Warren and Westmoreland.

All 19 county-owned long-term care nursing facilities participate in the Medicare or MA program and thus, are already required to comply with the Federal health and safety standards. Similarly, the 654 privately-owned facilities that participate in the Medicare or MA programs are already required to comply with the incorporated Federal health and safety standards.

The three private-pay facilities have a combined capacity of 102 licensed beds of the approximate 72,000 residents. Further, these facilities had a reported, combined census reported of 79 residents for the Department's 2020-2021 annual report. Department of Health. (2021). Nursing Home Reports. Retrieved from: https://www.health.pa.gov/topics/HealthStatistics/HealthFacilities/NursingHomeReports/Pages/nursing-home-reports.aspx. These facilities are presently required to comply with the Federal requirements, as they existed on October 1, 1998, except for specified provisions relating to resident rights, admission, transfer and discharge, resident assessment, nursing, physician and dental services, physical environment and administration.

The existing regulations of the Department already incorporate many of the Federal health and safety requirements. Further, the incorporation of additional requirements impacts only those long-term care nursing facilities that do not participate in Medicare or MA. There are currently 3 private-pay long-term care nursing facilities that do not participate in either Medicare or MA.

The regulated community will benefit from the efficiency of the consistent adoption and application of the Federal requirements for health and safety at 42 CFR Part 483, Subpart B (relating to requirements for long-term care facilities).

Some long-term care nursing facilities will be financially impacted by the requirements in § 211.16, which will require facilities to employ a full-time or part-time social worker or permit sharing of the services of a social worker, depending on the size of the facility. This cost, which is broken down further in question 19, will be approximately $6,882,304. Approximately 75.82% or $5,218,163 of this cost will be covered by the MA program, for facilities that participate in MA. Applying the Federal share of approximately 52% to this estimate results in an estimated Federal match of $2,713,445 and a State general fund investment of $2,504,718.

Long-term care nursing facilities will be financially impacted by the additional training requirements in § 201.20. As explained further in question 19, the Department estimates that the statewide total cost to all facilities will be $4,827,048 (or $67 per resident) in fiscal year 2023-2024. The requirement for 4 hours annually of continuing medical education, required by § 211.2(c), is not an additional cost since physicians are already required to complete 100 hours of this training. However, the Department estimates the 4 hours of time expended by physicians to attend the training would be approximately $552 per physician.

Some long-term care nursing facilities will be financially impacted by the requirements in § 211.12 (relating to nursing services). This cost is broken down further in question 19.

Small Business Analysis

Under section 3 of the Regulatory Review Act, 71 P.S. § 745.3, a small business is "defined in accordance with the size standards described by the United States Small Business Administration's Small Business Size Regulations under 13 CFR Ch. 1 Part 121 (relating to Small Business Size Regulations) or its successor regulation." Under 13 CFR 121.101 (relating to what are SBA size standards), the Small Business Administration's (SBA) "size standards determine whether a business entity is small." Size standards are developed under the North America Industry Classification System (NAICS). The Department applied the NAICS standards to determine how many long-term care nursing facilities, licensed by the Department, are small businesses. Based on these federal standards, the Department determined that a long-term care nursing facility is a small business if it has $30 million or less in annual receipts.

Based on the analysis of the latest long-term care nursing facility cost reports from the Centers for Medicare & Medicaid Services (CMS), the Department determined that 623 facilities that participate in Medicare and/or MA have $30 million or less in annual receipts. In making this determination, the Department applied current Federal Standards of Accounting to this data to determine each facility's annual receipts. The latest cost report data from CMS is 2018. Data.CMS.gov. Skilled Nursing Facility Cost Report. Retrieved from https://data.cms.gov/provider-compliance/cost-report/skilled-nursing-facility-cost-report/data. Although the data from CMS is from 2018, the Department expects a consistent number of facilities to meet the definition of a small business.

The Department also asked stakeholders during the meetings held in 2021 and 2022 for assistance in determining the impact to small businesses. The stakeholders were not able to provide the Department with specific information regarding how the Department's proposed regulations would impact small businesses. However, during the stakeholder meeting for Rulemakings 1 and 2, a stakeholder suggested that the Department search GuideStar, which provides financial information regarding nonprofit entities, to determine whether the three private-pay facilities are small businesses. The Department searched the GuideStar website at https://www.guidestar.org/ for the three private-pay facilities that are licensed by the Department. Based on this data, one of the private-pay facilities, Friends Home in Kennett/Linden Hall, meets the definition of a small business under NAICS standards. Another private-pay facility, Foulkeways at Gwynedd does not meet the definition of a small business under NAICS standards because its gross receipts exceed $30 million. Data for the third private-pay facility, Dallastown Nursing Center, is not available on GuideStar, but for the purposes of this analysis, the Department assumes that Dallastown, similar to other nursing facilities, is a small business.

In sum, at least 91% of nursing facilities meet the definition of a small business. Consistent with the HCFA and function of licensure, the purpose of these regulatory amendments is to ensure the health, safety, and welfare of all residents of long-term care nursing facilities in this Commonwealth by providing the minimum health and safety standards. Given that most nursing facilities are a small business and the need for surveying for the health and safety of residents, the Department did not establish differing criteria for nursing facilities that are small businesses compared to the minority of facilities that are not small businesses. Further, in determining the minimum health and safety requirements, the Department considered the myriad of received comments, feedback from meetings and stakeholder groups and attempted to balance the interests between consumers and the stakeholder industry. The Department's responsibility to ensure that residents receive safe, quality care applies to all residents of long-term care nursing facilities in this Commonwealth, and it is critical that all residents of

long-term care nursing facilities receive the same level of high-quality care, regardless of whether the facility they reside in is a small business.

Residents of Long-Term Care Nursing Facilities
More than 72,000 residents in the 682 licensed long-term care nursing facilities will benefit from the adoption of the Federal requirements because the same standards will now be applied to all long-term care nursing facilities, regardless of whether those facilities participate in the Medicare or MA programs. Residents will also benefit from the increased minimum staffing requirements. Numerous studies have found a direct correlation between the quality of resident care, quality of resident life, and the number of direct care hours that the resident receives. The benefits of higher staffing ratios include improved activity levels, lower mortality rates, fewer infections, less antibiotic use, fewer pressure ulcers and fewer catheterized residents, improved eating patterns and pain levels, and improved mental health.

Department
The Department licenses long-term care nursing facilities. The Department's surveyors perform the function of surveying and inspecting long-term care nursing facilities for compliance with both Federal and State regulations. The Department does not expect there to be an increase in costs associated with its responsibility to license and survey long-term care nursing facilities as a result of this rulemaking. It is anticipated that the adoption of the Federal requirements will create consistency in the licensing and survey process for long-term care nursing facilities because the same standards will now apply to all long-term care nursing facilities in the Commonwealth. This will result in a more streamlined licensing and inspection process for both the Department and long-term care nursing facilities operating in the Commonwealth.

Department of Human Services
Although the provisions of this final-form rulemaking, which relate to incorporation of federal health and safety standards and the updating of definitions, will not have a cost impact to the Department of Human Services, a substantial increase in funding for nursing facilities, including new nursing facility funding and increased MA payments beginning January 2023, was enacted under Act 2022-54 and appropriated under the General Appropriations Act of 2022 (Act 2022-1A).

Department of Military and Veterans Affairs
This final-form rulemaking will not have a cost impact to Department of Military and Veterans Affairs since its facilities already participate in the Medicare and MA Programs.

(16) List the persons, groups or entities, including small businesses, that will be required to comply with the regulation. Approximate the number that will be required to comply.

All 682 licensed long-term care nursing facilities in the Commonwealth will be required to comply with the health and safety standards of this final-form rulemaking. At least 91% of nursing facilities meet the definition of a small business. These facilities provide care to approximately 72,000 residents.

As provided above, pursuant to section 3 of the Regulatory Review Act (71 P.S. § 745.3), the Department applied the NAICS standards to determine how many long-term care nursing facilities licensed by the Department are small businesses. Based on the latest cost report from CMS, the Department determined that 623 facilities that participate in the Medicare and/or MA Programs meet the definition of small business since they have $30 million or less in annual receipts. The latest cost report

data from CMS is available at https://data.cms.gov/provider-compliance/cost-report/skilled-nursing-facility-cost-report/data.

Based on GuideStar, which provides financial information regarding nonprofit entities, one of the private-pay facilities, Friends Home in Kennett/Linden Hall meets the definition of a small business under NAICS standards. Another private-pay facility, Foulkeways at Gwynedd does not meet the definition of a small business under NAICS standards because its gross receipts exceed $30 million. Data for the third private-pay facility, Dallastown Nursing Center, is not available on GuideStar, but for the purposes of this analysis, the Department assumes that Dallastown, similar to other nursing facilities, is a small business. https://www.guidestar.org/

(17) Identify the financial, economic and social impact of the regulation on individuals, small businesses, businesses and labor communities and other public and private organizations. Evaluate the benefits expected as a result of the regulation.

This final-form rulemaking applies to all 682 licensed long-term care nursing facilities in the Commonwealth. At least 91% of nursing facilities meet the definition of a small business. These facilities provide health services to approximately 72,000 residents. These residents, and their family members, will benefit from the adoption of the Federal requirements because the same standards will now apply to all long-term care nursing facilities, regardless of whether these facilities participate in Medicare or MA. It is also expected that those who currently reside in facilities, as well as those who may need long-term care nursing in the future, will benefit from improved quality of care and life due to the increase in direct care hours provided by RNs and LPNs. Detailed information regarding the financial impact of the final-form rulemaking is further provided in response to Question 19.

The existing regulations of the Department already incorporate many of the Federal requirements and the expansion to incorporate the remaining Federal requirements at 42 CFR Part 483, Subpart B (relating to requirements for long-term care facilities) will impact the 3 long-term care nursing facilities that do not participate in either the Medicare or MA programs.

The Department consulted with DMVA to determine the impact of the increase to the nursing personnel staffing requirements in § 211.12. DMVA operates six veterans' homes across the state with the bed capacity to serve 1,526 total residents and employs more than 2,000 clinical and professional staff. The increase in LPNs in § 211.12(f.1)(4) and the increase in nurse aides in §§ 211.12(f.1)(2) and (3) will not impact DMVA staffing requirements. DMVA will also not be impacted by the increase in general nursing care hours per resident per day in § 211.12(i). DMVA staff levels are established by the resident acuity level which generally requires staffing between 3.6 and 3.8 hours of direct nursing care per resident per day.

(18) Explain how the benefits of the regulation outweigh any cost and adverse effects.

The approximately 72,000 individuals that reside in the 682 long-term care nursing facilities licensed by the Department will benefit from the increased minimum staffing requirements and increased training requirements. The Department determined the lowest acceptable level of nursing services personnel based on the experience and expertise of Department staff with first-hand knowledge of the administration of long-term care nursing facilities.

The cost to hire additional staff to meet this level, while significant, is outweighed by the need for higher levels of care to ensure the health and safety of residents in these facilities. Benefits of higher staffing ratios to residents include improved activity levels, lower mortality rates, fewer infections, less antibiotic use, fewer pressure ulcers and fewer catheterized residents, improved eating patterns and pain levels, and improved mental health. The Department is establishing per-shift staffing ratios to ensure that increased care is provided around the clock. The Department is requiring a higher rate of nurse aides on each shift compared to LPNs and RNs to ensure adequate time is devoted to attending residents' basic needs, as nurse aides are often the ones responsible for such basic care, which includes assisting residents with toileting and dressing and psychosocial needs. In addition, the Department is requiring higher staffing ratios for LPNs and nurse aides during the day compared to evening and night shifts because residents are generally awake during the day, the majority of interactions with physicians, pharmacies and other healthcare professionals typically occur during the day, the majority of admissions and discharges take place during the day, most treatments and medications are administered during the day, residents receive visitors during the day, and care planning typically occurs during the day.

The Department is also requiring a full-time or part-time social worker, based on the size of the facility. While there will be a cost to some facilities as a result of this requirement, the cost is strongly outweighed by the benefits of having a full-time or part-time social worker. Social workers have specialized education and training and are well-suited to assist residents and their families with all aspects of their stay in a long-term care nursing facility, including the social, emotional, financial, and psychological aspects, and preparing residents and their families for life post-discharge. In addition, over time, the condition of residents seeking care in the long-term care nursing environment has changed, and there has been an increase in the number of residents presenting with a wide range of psychosocial or behavioral issues. For example, facilities may have younger residents with mental health conditions, veterans with post-traumatic stress disorder, or older residents with dementia. These residents require engaged social workers to assist with their care planning and to provide psychosocial support.

The Department anticipates little to no costs for these facilities as a result of the elimination of sections that are duplicative of the Federal requirements.

(19) Provide a specific estimate of the costs and/or savings to the **regulated community** associated with compliance, including any legal, accounting or consulting procedures which may be required. Explain how the dollar estimates were derived.

The amendments will apply to all 682 long-term care nursing facilities licensed by the Department. These facilities provide health services to approximately 72,000 residents. This total includes nineteen county-owned and operated facilities, six veterans' homes that are operated by the Department of Military and Veterans' Affairs, 645 privately-owned facilities that participate in the Medicare or MA Programs, and three private-pay facilities that do not participate in Medicare or MA.

Cost to add qualified social worker

Some long-term care nursing facilities will be financially impacted by the requirements in § 211.16 (relating to social services), which require facilities to employ a full-time or part-time social worker or permit sharing of the services of a social worker, depending on the size of the facility.

To estimate the number of facilities that will be impacted by the increased requirements in § 211.16, the Department pulled data from the most recent, available annual report, for fiscal year 2020-2021. This report is available on the Department's website. Department of Health. (2021). Nursing Home Reports. Retrieved from: https://www.health.pa.gov/topics/HealthStatistics/HealthFacilities/NursingHomeReports/Pages/nursing-home-reports.aspx. Data within the report is obtained through an annual survey of facilities. The data, therefore, is dependent on self-reporting from the facilities who complete the survey.

According to this Commonwealth's Center for Workforce Information & Analysis, the median annual wage for a healthcare social worker is $55,890. Center for Workforce Information & Analysis. (2021). Occupational Wages. Retrieved from https://www.workstats.dli.pa.gov/Products/Occupational%20Wages/Pages/default.aspx. This does not include the cost of benefits. According to the U.S. Bureau of Labor Statistics, benefits make up approximately 31 percent of an employer's cost for compensation in the private sector. U.S. Bureau of Labor Statistics. (2021). Economic News Release: Employer Costs for Employee Compensation Summary. Retrieved from https://www.bls.gov/news.release/ecec.nr0.htm. The Department therefore estimates that the cost to hire a full-time social worker to be $73,216, which includes wages + benefits. The Department estimates the cost to hire a part-time social worker to be approximately half that amount, or $36,608. This assumes that a part-time social worker is working approximately 20 hours per week.

Under existing § 211.16, facilities with 120 beds or more are already required to have a full-time social worker. The amendment to § 211.16(a) will require facilities with 60 beds to 119 beds to have a full-time social worker. Based on data pulled from the annual report, the Department estimates that 9 facilities will need to staff up from a part-time social worker to a full-time social worker, at an approximate cost of $329,472 ($36,608 x 9). These facilities are all privately-owned facilities that participate in the MA program. According to data obtained from DHS, approximately 75.82%, or $249,806 of the total costs to MA facilities will be covered by the MA program. Applying the Federal share of approximately 52% to the total costs to the MA program results in an estimated Federal match of $129,899 and a State general fund investment of $119,907. There are 83 facilities that do not currently have a social worker, that will need to hire a full-time social worker, at an approximate cost of $6,076,928 ($73,216 x 83). Out of these 83 facilities, 3 are Medicare-only facilities ($219,648) and 80 are privately-owned MA facilities ($5,857,280). According to data obtained from DHS, approximately 75.82%, or $4,440,990 of the total costs to MA facilities will be covered by the MA program. Applying the Federal share of approximately 52% to the total costs covered by the MA program results in an estimated Federal match of $2,309,315 and a State general fund investment of $2,131,675. These estimates are for fiscal year 1.

The amendment to § 211.16(a)(1) will require facilities with 26 to 59 beds to employ at least a part-time social worker if their facility assessment indicates that a full-time social worker is not needed. There are 22 facilities that currently do not employ a social worker, that will need to hire a part-time social worker under this requirement, for an estimated cost of $805,376 ($36,608 x 22). Out of these 22 facilities, 3 are Medicare-only ($109,824) and 19 are privately-owned MA facilities ($695,552). According to data obtained from DHS, approximately 75.82%, or approximately $527,368 of the costs to MA facilities will be covered by the MA program. Applying the Federal share of approximately 52% to the total costs results in an estimated Federal match of $274,231 and a State general fund investment of $253,136. These estimates are for fiscal year 1.

The amendment to § 211.16(a)(2) will require facilities with 25 beds or less to employ either a part-time social worker or share the services of a social worker with another facility. Based on the annual report, all facilities that have 25 beds or less are currently meeting this requirement. Thus, there will be no fiscal impact on these facilities by the addition of § 211.16(a)(2).[1]

The cost to facilities to employ a full-time or part-time social worker is outweighed by the need to have a social worker on staff. As state above, social workers have specialized education and training and are well-suited to assist residents and their families with all aspects of their stay in a long-term care nursing facility, including the social, emotional, financial, and psychological aspects, and preparing residents and their families for life post-discharge. In addition, over time, the condition of residents seeking care in the long-term care nursing environment has changed, and there has been an increase in the number of residents presenting with a wide range of psychosocial or behavioral issues. These residents require engaged social workers to assist with their care planning and to provide psychosocial support.

Training requirements

Under § 201.20 of the final-form regulation, facilities will be required to have annual in-service training on accident prevention, restorative nursing techniques, resident rights, including nondiscrimination and cultural competency, and training needs identified through a facility assessment. Also, under § 201.20, orientation shall also include dementia management and communication skills, which is in addition to the current requirement of resident abuse prevention, detection and reporting training. These trainings are in addition to the training requirement under 42 CFR Part 483 (relating to requirements for States and Long-Term Care Facilities). Given that facilities have already incorporated various portion of these required trainings into their annual training curriculum, the Department anticipates an estimated 2 hours of additional training per year under this final-form regulation. The training costs are estimated as follows:

- The average hourly rate for physicians is $110/hour = $220 training costs per person. A 5% wage increase is applied in year 2 and thereafter.
- The average hourly rate for orderlies, aides and attendants is $16/hour = $32 training costs per person. A 5% wage increase is applied in year 2 and thereafter.
- The average hourly rate other professionals, including therapists, technicians and nursing, is $32/hour = $64 training costs per person. A 5% wage increase is applied in year 2 and thereafter.

Statewide, the estimated total additional training costs, in the aggregate, is:

- FY 2023-2024 - $4,827,048 (or $67 per resident)
- FY 2024-2025 - $5,118,229 (or $71 per resident)

These aggregate costs are based on the following estimations:

Physicians:

- FY 2023-2024 – 1,990 * $220 = $437,800
- FY 2024-2025 – 1,990 * $231 = $459,690

[1] DMVA indicated to the Department that the six veterans' homes that it operates will not be affected by the Department's amendment to § 211.16. In addition, out of the 19 county-owned facilities, 18 have more than 120 beds and thus, are already required to have a full-time social worker. The one county-owned facility with 120 or less beds reported having a full-time social worker in the 2020-2021 annual report. If this continues to be the case, there will be no impact to this facility.

Orderlies, aides and attendants:

- FY 2023-2024 – 61,310 * $32 = $1,961,920
- FY 2024-2025 – 62,793 * $33.60 = $2,109,845

Other professionals:

- FY 2023-2024 – 37,927 * $64 = $2,427,328
- FY 2024-2025 – 37,927 * $67.20 = $2,548,694

The totals for FY 2023-2024 include the additional social workers that will be needed to comply with § 201.16, as well as the LPNs and nurse aides that will be needed to comply with §§ 211.12(f.1)(2) and (4). The totals for FY 2024-2025 include both a 5% wage increase as well as the additional nurse aides that will be needed to comply with § 211.12(f.1)(3).

In addition, although the requirement for 4 hours annually of continuing medical education is not an additional cost since physicians are required to obtain 100 hours, the Department estimates the 4 hours of time would approximate $552 per physician.

Nursing Services

Privately-owned and MA Program; 2023-2024

The increase in LPNs set forth in § 211.12(f.1)(4), is projected to require the 589 privately-owned facilities that participate in MA[2] to employ an additional 522 FTE LPNs in the aggregate. In fiscal year 2023-2024, the cost for an LPN is projected to be $85,276, which is an increase of 13% from the average LPN wage across all industries in 2021, according to data from the Bureau of Labor Statistics. This estimate for the increased cost includes wages and benefits and is based on the 75th percentile of Bureau of Labor Statistics (BLS) wage data reported for these professions across all industries in Pennsylvania. The wages were increased to reflect the most recent benefit cost percentage (28%) and trended for inflation to 2023 (5%).[3] The 75th percentile wage was used as a proxy for expected wages in 2023 due to trends in the labor market for LPNs and nurse aides and unchecked pressures on staffing agency use and pricing. The total cost to the privately-owned facilities that participate in MA to add 522 FTE LPNs is estimated to be $44,514,072 in the aggregate. The affected privately-owned facilities will also need to hire an estimated 249 FTE nurse aides to meet the requirements in § 211.12(f.1)(2), which are effective from July 1, 2023 through June 30, 2024. The nurse aide salary during that period, fiscal year 2023-2024, is projected at $54,542, which is a 14% increase from the from the average nurse aide wage across all industries in 2021, according to data from the Bureau of Labor Statistics. The total estimated cost during fiscal year 2023-2024 to add 249 FTE NAs is $13,580,958 in the aggregate. There will be no additional cost to meet the total general nursing care hours per resident per day because facilities that meet or exceed the minimum RN, LPN, and nurse aide requirements will meet or exceed the minimum requirements for direct care hours set forth in § 211.12(i).

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[3] The Department is using a 5% inflation projection in 2023, even though the Federal outlook indicates a 2.5-2.9% inflation projection. Congressional Budget Office Outlook: 2022 to 2032; Figure 2-4. Inflation and Interest Rates. Retrieved at https://www.cbo.gov/publication/58147#_idTextAnchor075. The Department, however, erred on the side of a 5% projection due to the historic inflation rates and the desire to account for a potential higher rate if the 2023 projections are missed.

In fiscal year 2023-2024, the total increased cost for privately-owned MA facilities to meet the requirements of both §§ 211.12(f.1)(4) and 211.12(f.1)(2) will be approximately $58,095,030 in the aggregate. According to data obtained from DHS, approximately 75.82%, or about $44,047,652, of this cost will be covered by the MA program. Applying the Federal share of approximately 52% to the total costs results in an estimated Federal match of $22,904,779 and a state general fund investment of $21,142,873.

Privately-owned and MA Program; 2024-2025

In the following year, the requirements for nurse aides in § 211.12(f.1)(4) that go into effect on July 1, 2024 will require the privately-owned facilities that participate in MA to hire an additional 1,389 nurse aides, for a total of 1,638 FTE NAs in fiscal year 2024-2025. The nurse aide salary during that period, fiscal year 2024-2025, is projected at $57,958, which is a 21.5% increase from the from the average nurse aide wage across all industries in 2021, according to data from the Bureau of Labor Statistics. Therefore, the total estimated cost during fiscal year 2024-2025 for 1,638 FTE NAs is $ 94,935,204 in the aggregate. The annual LPN salary for that period is projected to increase to $90,281, which is a 20% increase from the from the average LPN wage across all industries in 2021, according to data from the Bureau of Labor Statistics. The cost to employ the 522 FTE LPNs in fiscal year 2024-2025 will, therefore, be approximately $47,126,682 in the aggregate.

In fiscal year 2024-2025, the total increased cost for privately-owned MA facilities to meet the requirements of both § 211.12(f.1)(4) and 211.12(f.1)(3) will be, in the aggregate, approximately $142,061,886. According to data obtained from DHS, approximately 75.82%, or about $107,711,322, of this cost will be covered by the MA program. Applying the Federal share of approximately 52% to the total costs results in an estimated Federal match of approximately S56,009,887 and a state general fund investment of approximately $51,701,435.

Medicare-only Facilities; 2023-2024

There are 59 facilities that participate only in Medicare. The increase in LPNs, set forth in § 211.12(f.1)(4), will require these 59 facilities to employ an additional 119 FTE LPNs. This estimate is based on data obtained from the Department's 2020-2021 annual report. In fiscal year 2023-2024, the cost for an LPN is projected to be $85,276. This estimate includes wages and benefits. The total cost to add 119 FTE LPNs in fiscal year 2023-2024, based on the same cost assumptions provided by DHS, will be approximately $10,147,844. In fiscal year 2023-2024, the affected Medicare facilities will also need to hire approximately 550 FTE nurse aides to meet the requirements in § 211.12(f.1)(2), which are effective from July 1, 2023 through June 30, 2024. The nurse aide salary during that period is projected at $54,542. The total estimated cost during fiscal year 2023-2024 to add 550 FTE NAs is $29,998,100. There will be no additional cost to meet the total general nursing care hours per resident per day, because facilities that meet or exceed the minimum RN, LPN, and nurse aide requirements will meet or exceed the minimum requirements for direct care hours set forth in § 211.12(i).

In fiscal year 2023-2024, the total increased cost for Medicare facilities to meet the requirements of both §§ 211.12(f.1)(4) and 211.12(f.1)(2) will be approximately $40,145,944. The Department is not able to assess to what extent these costs will be offset by Medicare as Medicare is a federally managed healthcare program and the Department does not have access to data regarding payment of Medicare to facilities.

Medicare-only Facilities; 2024-2025

In the following year, the requirements for nurse aides in § 211.12(f.1)(3) that go into effect on July 1, 2024 will require the facilities that participate only in Medicare to hire an additional 90 nurse aides, for a total of 640 FTE NAs in fiscal year 2024-2025. The nurse aide salary during that period, fiscal year 2024-2025, is projected at $57,958. Therefore, the total estimated cost during fiscal year 2024-2025 to employ 640 FTE NAs is $37,093,120. The annual LPN salary for that period is projected to increase to $90,281. The cost to employ the 119 FTE LPNs in fiscal year 2024-2025 will therefore be approximately $10,743,439. There will be no additional cost to meet the total general nursing care hours per resident per day because facilities that meet or exceed the minimum RN, LPN, and nurse aide requirements will meet or exceed the minimum requirements for direct care hours set forth in § 211.12(i).

In fiscal year 2024-2025, the total increased cost for Medicare facilities to meet the requirements of both §§ 211.12(f.1)(4) and 211.12(f.1)(3) will be approximately $47,836,559. The Department is not able to assess to what extent these costs will be offset by Medicare as Medicare is a federally managed healthcare program and the Department does not have access to data regarding payment of Medicare to facilities.

Private-pay facilities; 2023-2024

There are three private-pay facilities that do not participate in either Medicare or MA. The increase in LPNs, set forth in § 211.12(f.1)(4), will require these 3 facilities to employ an additional 4 FTE LPNs. This estimate is based on data obtained from the Department's 2020-2021 annual report. In fiscal year 2023-2024, the cost for an LPN is projected to be $85,276. This estimate includes wages and benefits. The total cost to add 4 FTE LPNs in fiscal year 2023-2024, based on the same cost assumptions provided by DHS, will be approximately $341,104 In fiscal year 2023-2024, the affected private-pay facilities will also need to hire approximately six FTE nurse aides to meet the requirements in § 211.12(f.1)(2), which are effective from July 1, 2023 through June 30, 2024. The nurse aide salary during that period is projected at $54,542. The total estimated cost during fiscal year 2023-2024 to add six FTE NAs is $327,252. There will be no additional cost to meet the total general nursing care hours per resident per day because facilities that meet or exceed the minimum RN, LPN, and nurse aide requirements will meet or exceed the minimum requirements for direct care hours set forth in § 211.12(i). In fiscal year 2023-2024, the total increased cost for private-pay facilities to meet the requirements of both §§ 211.12(f.1)(4) and 211.12(f.1)(2) will be approximately $668,356.

Private-pay facilities; 2024-2025

In the following year, the requirements for nurse aides in § 211.12(f.1)(3) that go into effect on July 1, 2024 will require the private-pay facilities to hire an additional four nurse aides, for a total of 10 FTE NAs in fiscal year 2024-2025. The nurse aide salary during that period, fiscal year 2024-2025, is projected at $57,958. Therefore, the total estimated cost during fiscal year 2024-2025 to employ 10 FTE NAs is $579,580. The annual LPN salary for that period is projected to increase to $90,281. The cost to employ the 4 FTE LPNs in fiscal year 2024-2025 will therefore be approximately $361,124. There will be no additional cost to meet the total general nursing care hours per resident per day because facilities that meet or exceed the minimum RN, LPN, and nurse aide requirements will meet or exceed the minimum requirements for direct care hours set forth in § 211.12(i). In fiscal year 2024-2025, the total

increased cost for private-pay facilities to meet the requirements of both §§ 211.12(f.1)(4) and 211.12(f.1)(3) will be approximately $940,704.

County-owned facilities; 2023-2024

The increase in LPNs set forth in § 211.12(f.1)(4), is projected to require the 19 county-owned facilities that participate in MA to employ an additional 69 FTE LPNs in the aggregate. In fiscal year 2023-2024, the cost for an LPN is projected to be $85,276, as described above. The total cost to facilities to add 69 FTE LPNs is estimated to be $5,884,044 in the aggregate. The affected county-owned facilities will also need to hire an estimated 2 FTE nurse aides to meet the requirements in § 211.12(f.1)(2), which are effective from July 1, 2023 through June 30, 2024. The nurse aide salary during that period, fiscal year 2023-2024, is projected at $54,542, as described above. The total cost to facilities to add 2 FTE nurse aides is estimated to be $109,084 in the aggregate. There will be no additional cost to meet the total general nursing care hours per resident per day because facilities that meet or exceed the minimum RN, LPN, and nurse aide requirements will meet or exceed the minimum requirements for direct care hours set forth in § 211.12(i).

In fiscal year 2023-2024, the total increased cost for county-owned MA facilities to meet the requirements of both §§ 211.12(f.1)(4) and 211.12(f.1)(2) will be approximately $5,993,128 in the aggregate. According to data obtained from DHS, approximately 75.82%, or about $4,543,990, of this cost will be covered by the MA program. Applying the Federal share of approximately 52% to the total costs results in an estimated Federal match of $2,362,875 and a state general fund investment of $2,181,115.

County-owned facilities; 2024-2025

In the following year, the requirements for nurse aides in § 211.12(f.1)(4) that go into effect on July 1, 2024 will require the county-owned facilities to hire an additional 96 nurse aides, for a total of 98 FTE NAs in fiscal year 2024-2025. The nurse aide salary during that period, fiscal year 2024-2025, is projected at $57,958, as described above. Therefore, the total estimated cost during fiscal year 2024-2025 for 98 FTE NAs is $5,697,884 in the aggregate. The annual LPN salary for that period is projected to increase to $90,281, as described above. The cost to employ the 69 FTE LPNs in fiscal year 2024-2025 will, therefore, be approximately $6,229,389 in the aggregate.

In fiscal year 2024-2025, the total increased cost for county-owned MA facilities to meet the requirements of both § 211.12(f.1)(4) and 211.12(f.1)(3) will be, in the aggregate, approximately $11,909,273. According to data obtained from DHS, approximately 75.82%, or about $9,029,611, of this cost will be covered by the MA program. Applying the Federal share of approximately 52% to the total costs results in an estimated Federal match of approximately $4,695,398 and a state general fund investment of approximately $4,334,213.

DMVA-operated facilities

The Department consulted with DMVA to determine the impact of the increase to the nursing personnel staffing requirements in § 211.12. DMVA operates 6 veterans' homes across the state with the bed capacity to serve 1,526 total residents and employs more than 2,000 clinical and professional staff. Due to increased funding under the Commonwealth's enacted budget, the increase in LPNs in § 211.12(f.1)(4) and the increase in nurse aides in §§ 211.12(f.1)(2) and (3) will not impact DMVA staffing requirements. DMVA will also not be impacted by the increase in general nursing care hours

per resident per day in § 211.12(i). DMVA staff levels are established by the resident acuity level which generally requires staffing between 3.6 and 3.8 hours of direct nursing care per resident per day.

(20) Provide a specific estimate of the costs and/or savings to the **local governments** associated with compliance, including any legal, accounting or consulting procedures which may be required. Explain how the dollar estimates were derived.

There are currently 19 county-owned long-term care nursing facilities which account for approximately 7.5 percent (6,524 beds) of long-term care nursing beds across the Commonwealth. Allegheny County owns four of the nursing homes; the remaining homes are in the following 15 counties: Berks, Bradford, Bucks, Chester, Clinton, Crawford, Delaware, Erie, Indiana, Lehigh, Monroe, Northampton, Philadelphia, Warren, and Westmoreland.

Nursing Services for county-owned facilities; 2023-2024

The increase in LPNs set forth in § 211.12(f.1)(4), is projected to require the 19 county-owned facilities that participate in MA to employ an additional 69 FTE LPNs in the aggregate. In fiscal year 2023-2024, the cost for an LPN is projected to be $85,276, as described above. The total cost to facilities to add 69 FTE LPNs is estimated to be $5,884,044 in the aggregate. The affected privately-owned facilities will also need to hire an estimated 2 FTE nurse aides to meet the requirements in § 211.12(f.1)(2), which are effective from July 1, 2023 through June 30, 2024. The nurse aide salary during that period, fiscal year 2023-2024, is projected at $54,542, as described above. The total cost to facilities to add 2 FTE nurse aides is estimated to be $109,084 in the aggregate. There will be no additional cost to meet the total general nursing care hours per resident per day because facilities that meet or exceed the minimum RN, LPN, and nurse aide requirements will meet or exceed the minimum requirements for direct care hours set forth in § 211.12(i).

In fiscal year 2023-2024, the total increased cost for county-owned MA facilities to meet the requirements of both §§ 211.12(f.1)(4) and 211.12(f.1)(2) will be approximately $5,993,128 in the aggregate. According to data obtained from DHS, approximately 75.82%, or about $4,543,990, of this cost will be covered by the MA program. Applying the Federal share of approximately 52% to the total costs results in an estimated Federal match of $2,362,875 and a state general fund investment of $2,181,115.

Nursing services for county-owned facilities; 2024-2025

In the following year, the requirements for nurse aides in § 211.12(f.1)(4) that go into effect on July 1, 2024 will require the county-owned facilities to hire an additional 96 nurse aides, for a total of 98 FTE NAs in fiscal year 2024-2025. The nurse aide salary during that period, fiscal year 2024-2025, is projected at $57,958, as described above. Therefore, the total estimated cost during fiscal year 2024-2025 to add 98 FTE NAs is $5,697,884 in the aggregate. The annual LPN salary for that period is projected to increase to $90,281, as described above. The cost to employ the 69 FTE LPNs in fiscal year 2024-2025 will, therefore, be approximately $6,229,389 in the aggregate.

In fiscal year 2024-2025, the total increased cost for county-owned MA facilities to meet the requirements of both § 211.12(f.1)(4) and 211.12(f.1)(3) will be, in the aggregate, approximately $11,909,273. According to data obtained from DHS, approximately 75.82%, or about $9,029,611, of this

cost will be covered by the MA program. Applying the Federal share of approximately 52% to the total costs results in an estimated Federal match of approximately $4,695,398 and a state general fund investment of approximately $4,334,213.

Training requirements

The training requirements set forth in § 201.20 will cost the county-owned facilities approximately $276,824 in fiscal year 2023-2024 and $290,665 in fiscal year 2024-2025, using the same cost estimations described in question 19 above. These costs are based on the following estimations:

Physicians:
- FY 2023-2024 – 98 * $220 = $21,560
- FY 2024-2025 – 98 * $231 = $22,638

Orderlies, aides and attendants:
- FY 2023-2024 – 3,885 * $32 = $124,320
- FY 2024-2025 – 3,885 * $33.60 = $130,536

Other professionals:
- FY 2023-2024 – 2,046 * $64 = $130,944
- FY 2024-2025 – 2,046 * $67.20 = $137,491

The totals for FY 2023-2024 include the additional social workers that will be needed to comply with § 201.16, as well as the LPNs and nurse aides that will be needed to comply with §§ 211.12(f.1)(2) and (4). The totals for FY 2024-2025 include both a 5% wage increase as well as the additional nurse aides that will be needed to comply with § 211.12(f.1)(3).

The requirement for 4 hours annually of continuing medical education, required by § 211.2(c), is not an additional cost since physicians are already required to complete 100 hours of this training. However, the Department estimates the 4 hours of time expended by physicians to attend the training would be approximately $552 per physician.

Cost to add qualified social worker

As noted in question 19, of the 19 county-owned facilities, 18 have more than 120 beds and thus, are already required to have a full-time social worker. The one county-owned facility with 120 or less beds reported having a full-time social worker in the 2020-2021 annual report. If this continues to be the case, there will be no impact to this facility.

(21) Provide a specific estimate of the costs and/or savings to the **state government** associated with the implementation of the regulation, including any legal, accounting, or consulting procedures which may be required. Explain how the dollar estimates were derived.

The amendments will not increase costs to the Department. The Department's surveyors perform the function of surveying and inspecting long-term care nursing facilities for compliance with both Federal and State regulations

The Department consulted with DMVA to determine the impact of the increase to the nursing personnel staffing requirements in § 211.12. DMVA operates six veterans' homes across the state with the bed capacity to serve 1,526 total residents and employs more than 2,000 clinical and professional staff. The increase in LPNs in § 211.12(f.1)(4) and the increase in nurse aides in §§ 211.12(f.1)(2) and (3) will not impact DMVA staffing requirements. DMVA will also not be impacted by the increase in general nursing care hours per resident per day in § 211.12(i). DMVA staff levels are established by the resident acuity level which generally requires staffing between 3.6 and 3.8 hours of direct nursing care per resident per day.

To address the increased staffing and related costs, a substantial increase in funding for nursing facilities, including new nursing facility funding and increased MA payments beginning January 2023, was enacted under Act 2022-54 and appropriated under the General Appropriations Act of 2022 (Act 2022-1A).

The training requirements set forth in § 201.20 will cost the DMVA facilities approximately $83,912 in fiscal year 2023-2024 and $88,108 in fiscal year 2024-2025, using the same cost estimations described in question 19 above. These costs are based on the following estimations:

Physicians:
- FY 2023-2024 – 14 * $220 = $3,080
- FY 2024-2025 – 14 * $231 = $3,234

Orderlies, aides and attendants:
- FY 2023-2024 – 1,396 * $32 = $44,672
- FY 2024-2025 – 1,396 * $33.60 = $46,906

Other professionals:
- FY 2023-2024 – 565 * $64 = $36,160
- FY 2024-2025 – 565 * $67.20 = $37,968

The totals for FY 2023-2024 include the additional social workers that will be needed to comply with § 201.16, as well as the LPNs and nurse aides that will be needed to comply with §§ 211.12(f.1)(2) and (4). The totals for FY 2024-2025 include both a 5% wage increase as well as the additional nurse aides that will be needed to comply with § 211.12(f.1)(3).

As noted in question 19, DMVA indicated to the Department that the six veterans' homes that it operates will not be affected by the Department's amendment to § 211.16.

In addition, as provided in response to questions 19 and 20, there will be costs to the MA program.

(22) For each of the groups and entities identified in items (19)-(21) above, submit a statement of legal, accounting or consulting procedures and additional reporting, recordkeeping or other paperwork, including copies of forms or reports, which will be required for implementation of the regulation and an explanation of measures which have been taken to minimize these requirements.

This final-form rulemaking will result in new paperwork requirements as follows:

- Increased personnel record requirements, including documentation of suitability for employment under § 201.19 (relating to personnel records)

- Written policies and procedures for admission under § 201.24 (relating to admission policy)
- Closure plan development, including plan for storage and retrieval of medical records under § 211.5 (relating to medical records)
- Posting of resident rights under § 201.29 (relating to resident rights)
- Written policies and procedures for disposition of medications under § 211.9 (relating to pharmacy services)
- Posting of meal plans under § 211.6 (relating to dietary services)

In addition, the three private pay facilities will have the following new paperwork requirements under this final-form rulemaking:

- Quality assurance and performance improvement documentation under 42 CFR 483.75 (relating to quality assurance and performance improvement)
- Posting if nursing staff data under 42 CFR 483.35(g) (relating to nursing services)
- Information provided to resident in a form and manner the resident can access and understand under 42 CFR 483.10(g)(3) (relating to resident rights)
- Written standards for infection control under 42 CFR 483.80(a) (relating to infection control)

(22a) Are forms required for implementation of the regulation?

Although there are no new forms required for implementation of this final-form rulemaking, the Department created a template of resident's rights, which sets forth a resident's rights in clear and easy to understand language. This template, which facilities may use as a tool to meet the posting and notice requirements in subsections (c.1) and (c.2) described below, is attached as Exhibit A, and will also be posted on the Department's website.

(22b) If forms are required for implementation of the regulation, **attach copies of the forms here.** If your agency uses electronic forms, provide links to each form or a detailed description of the information required to be reported. **Failure to attach forms, provide links, or provide a detailed description of the information to be reported will constitute a faulty delivery of the regulation.**

N/A

(23) In the table below, provide an estimate of the fiscal savings and costs associated with implementation and compliance for the regulated community, local government, and state government for the current year and five subsequent years.

	Current FY Year[4] 2022-2023	FY +1 Year 2023-2024	FY +2 Year 2024-2025	FY +3 Year 2025-2026	FY +4 Year 2026-2027	FY +5 Year 2027-2028
SAVINGS:	$	$	$	$	$	$

[4] The Department estimates there will be no costs for fiscal year 2022-2023. The effective date of the regulations is July 1, 2023, which is the first day of fiscal year 2023-2024.

Regulated Community	0	0	0	0	0	0
Local Government	0	0	0	0	0	0
State Government	0	0	0	0	0	0
Total Savings	0	0	0	0	0	0
COSTS:						
Regulated Community[5]	0	63,131,478	93,219,012	97,879,963	102,773,961	107,912,659
Local Government[6]	0	1,725,962	3,170,327	3,328,844	3,495,286	3,670,050
State Government[7]	0	25,912,618	58,753,710	61,691,395	64,775,965	68,014,763
Total Costs[8]	0	88,960,184	151,884,614	159,478,845	167,452,787	175,825,426
REVENUE LOSSES:						
Regulated Community	0	0	0	0	0	0
Local Government	0	0	0	0	0	0
State Government	0	0	0	0	0	0
Total Revenue Losses	0	0	0	0	0	0

(23a) Provide the past three-year expenditure history for programs affected by the regulation.

Program	FY -3 2019-2020	FY -2 2020-2021	FY -1 2021-2022	Current FY 2022-2023
DOH Quality Assurance	22,513,000	23,093,000	24,393,000	25,349,000

[5] The cost to the regulated community includes the costs to all facility types to comply with the new training requirements ($4,827,048 in FY 2023-24; $5,118,229 in FY 2024-25), plus the cost to hire social workers, LPNs and nurse aides ($112,114,234 in FY 2023-34; $210,320,787 in FY 2024-25), minus the portion of the staffing costs the Department estimates will be covered by Medicaid ($53,809,804 in FY 2024-25; $122,220,004 in FY 2024-25).

[6] The cost to local government includes the cost to county-owned facilities to comply with the new training requirements ($276,824 in FY 2023-24; $290,665 in FY 2024-25), plus the cost to hire LPNs and nurse aides ($5,993,128 in FY 2023-24; $11,909,273 in FY 2024-25), minus the portion of the staffing costs the Department estimates will be covered by Medicaid ($4,543,990 in FY 2023-24; $9,029,611 in FY 2024-25). There is no cost to the county-owned facilities to hire social workers.

[7] The cost to state government includes the costs to DMVA facilities to implement the new training requirements ($83,912 in FY 2023-24; $88,108 in FY 2024-25), plus the state portion of the cost to the MA program for private and county-owned Medicaid facilities to hire social workers, LPNs and nurse aides ($25,828,706 in FY 2023-24; $58,665,602 in FY 2024-25). There is no cost to the DMVA facilities to hire social workers, LPNs or nurse aides.

[8] The total cost is not a simple sum of the costs to the regulated community, local government and state government. This is because there are facilities owned by counties that are included in both the regulated community row and the local government row. Likewise, costs to the DMVA facilities are included in both the regulated community row and the state government row. So, the total cost is a sum of the cost to the regulated community ($63,131,478 in FY 2023-24; $93,219,012 in FY 2024-25) plus the state portion of the costs to the Medicaid program ($25,828,706 in FY 2023-24; $58,665,602 in FY 2024-25).

MA – Long-Term Care	470,244,000	208,841,000	121,346,000	165,981,000
MA – Community Health Choices	2,328,939,000	3,165,550,000	4,251,550,000	5,061,602,000
DMVA (actual expenditures)	80,108,213	80,386,733	77,671,425	82,903,586

(24) For any regulation that may have an adverse impact on small businesses (as defined in Section 3 of the Regulatory Review Act, Act 76 of 2012), provide an economic impact statement that includes the following:

(a) An identification and estimate of the number of small businesses subject to the regulation.

This final-form rulemaking applies to all 682 licensed long-term care nursing facilities in the Commonwealth. At least 91% of nursing facilities meet the definition of a small business. These facilities provide health services to approximately 72,000 residents. This total includes 19 county-owned and operated facilities, 6 veterans' homes that are operated by DMVA, 654 privately-owned facilities that participate in Medicare and/or MA, and 3 private-pay facilities that do not participate in either Medicare or MA.

Under section 3 of the Regulatory Review Act, 71 P.S. § 745.3, a small business is "defined in accordance with the size standards described by the United States Small Business Administration's Small Business Size Regulations under 13 CFR Ch. 1 Part 121 (relating to Small Business Size Regulations) or its successor regulation." Under 13 CFR 121.101 (relating to what are SBA size standards), the Small Business Administration's (SBA) "size standards determine whether a business entity is small." Size standards are developed under the North America Industry Classification System (NAICS). The Department applied the NAICS standards to determine how many long-term care nursing facilities, licensed by the Department, are small businesses. Based on these federal standards, the Department determined that a long-term care nursing facility is a small business if it has $30 million or less in annual receipts.

Based on the analysis of the latest long-term care nursing facility cost reports from the Centers for Medicare & Medicaid Services (CMS), the Department determined that 623 facilities that participate in Medicare and/or MA have $30 million or less in annual receipts. In making this determination, the Department applied current Federal Standards of Accounting to this data to determine each facility's annual receipts. The latest cost report data from CMS is 2018. Data.CMS.gov. Skilled Nursing Facility Cost Report. Retrieved from https://data.cms.gov/provider-compliance/cost-report/skilled-nursing-facility-cost-report/data. Although the data from CMS is from 2018, the Department expects a consistent number of facilities to meet the definition of a small business.

The Department also asked stakeholders during the meetings held in 2021 and 2022 for assistance in determining the impact to small businesses. The stakeholders were not able to provide the Department with specific information regarding how the Department's proposed

regulations would impact small businesses. However, during the stakeholder meeting for Rulemakings 1 and 2, a stakeholder suggested that the Department search GuideStar, which provides financial information regarding nonprofit entities, to determine whether the three private-pay facilities are small businesses. The Department searched the GuideStar website at https://www.guidestar.org/ for the three private-pay facilities that are licensed by the Department.

Based on this data, one of the private-pay facilities, Friends Home in Kennett/Linden Hall meets the definition of a small business under NAICS standards. Another private-pay facility, Foulkeways at Gwynedd does not meet the definition of a small business under NAICS standards because its gross receipts exceed $30 million. Data for the third private-pay facility, Dallastown Nursing Center, is not available on GuideStar, but for the purposes of this analysis, the Department assumes that Dallastown, similar to other nursing facilities, is a small business.

As provided above, at least 91% of nursing facilities meet the definition of a small business. Consistent with the HCFA and function of licensure, the purpose of these regulatory amendments is to ensure the health, safety, and welfare of all residents of long-term care nursing facilities in this Commonwealth by providing the minimum health and safety standards. Given that most facilities are a small business and the need for surveying for the health and safety of residents, the Department did not establish differing criteria for nursing facilities that are small business compared to the minority of facilities that are not small businesses. Further, in determining the minimum health and safety requirements, the department considered the myriad of received comments, feedback from meetings and stakeholder groups and attempted to balance the interests between consumers and the stakeholder industry. The Department's responsibility to ensure that residents receive safe, quality care applies to all residents of long-term care nursing facilities in this Commonwealth, and it is critical that all residents of long-term care nursing facilities receive the same level of high-quality care, regardless of whether the facility they reside in is a small business under NAICS standards.

(b) The projected reporting, recordkeeping and other administrative costs required for compliance with the proposed regulation, including the type of professional skills necessary for preparation of the report or record.

The Department's amendment to § 201.19 requires a facility to maintain certain employee personnel records, including a criminal background check and documentation of a determination of suitability for employment in the position to which the employee is assigned. The Department is not requiring any particular format for this determination and does not believe this requirement will be overburdensome to facilities.

The Department's amendment to § 201.24(e) requires the governing body of a facility to establish written policies and procedures for the admission process for residents, and through the administrator, to develop and adhere to procedures implementing those policies. These policies and procedures include introductions and orientation for residents to the facility and key staff, discussion and documentation of resident routines and preferences to be included in their care plan, and assistance to residents in creating a homelike environment. The Department is not requiring any particular format for these policies and procedures and believes that many facilities may already have such policies and procedures in place or may only need to review and update their existing policies and procedures to ensure compliance.

The Department's amendment to § 211.5(e) requires a long-term care nursing facility to provide to the Department a plan for the storage and retrieval of medical records. A specific form will not be required for this plan, and thus, should not be overburdensome for facilities. In addition, this requirement will only affect a facility in the event of a closure. When a facility closes, it is often difficult to determine where medical records have been stored as there is no longer a point of contact for the facility. Requiring a facility to have a plan for storage and retrieval, and to provide the Department with that plan, will ensure that residents will be able to access their medical records after a facility closes.

The Department's addition of § 211.9(k) requires a facility to have written policies and procedures for the disposition of medications. This should not impose any burden on those facilities that participate in Medicare or MA as they are already following this guidance. In addition, existing §§ 211.9(i) and (j) already requires all facilities licensed by the Department, including those that do not participate in Medicare or MA, to have policies in place regarding the disposition of medications that are similar to those in § 211.9(j.2). Therefore, only a minor update to existing policies and procedures should be required for the three facilities that do not participate in Medicare or MA.

The Department's amendment to §§ 201.29 (relating to resident rights) and 211.6 (relating to dietary services) requires the posting of resident rights and meal plans. Posting these existing documents is a nominal burden.

(c) A statement of probable effect on impacted small businesses.

See Question 15. Small businesses will be affected by these regulations in the same manner as other facilities that are not small businesses. Further, the Department anticipates that only two of the three private-pay facilities meet the definition of a small business, with gross receipts under $30 million.

(d) A description of any less intrusive or less costly alternative methods of achieving the purpose of the proposed regulation.

See answer to Question 26. Based on the comments received, the Department adjusted the minimum number of hours of direct resident care and adjusted the ratios for nurse aides and LPNs and RNs. Further, the Department adjusted the social worker requirements based on the size of the facility. In addition, in response to public comments, the effective date of this rulemaking is now July 1, 2023, with a graduated implementation beginning year 2, which will provide the regulated community time to prepare to comply with the new requirements.

(25) List any special provisions which have been developed to meet the particular needs of affected groups or persons including, but not limited to, minorities, the elderly, small businesses, and farmers.

No special provisions have been developed as this final-form rulemaking applies to long-term care nursing facilities. Specifically, the regulations apply to all 682 long-term care nursing facilities in the Commonwealth, which serve approximately 72,000 nursing facility residents.

(26) Include a description of any alternative regulatory provisions which have been considered and rejected and a statement that the least burdensome acceptable alternative has been selected.

As described above, the Department adjusted the minimum number of hours of direct resident care and adjusted the per-shift requirements for nurse aides and LPNs. The Department received numerous and varying comments in support of and in opposition to the increase in direct resident care hours, as well as the per-shift minimums for nurse aides, LPNs and RNs included on proposed form. The Department considered comments in support of maintaining the proposed staffing requirements on final form. The Department also considered comments suggesting that there be no increase to the staffing minimums and that facilities should instead be required to base staffing levels on resident acuity. Ultimately, the staffing requirements set forth in § 211.12 represent the least burdensome acceptable alternative to ensure that resident health, safety and wellbeing are protected.

The increase in direct care hours from the current minimum of 2.7 to 2.87 represents a small increase, which should be achievable for facilities. In fact, 622 facilities are already meeting or exceeding this requirement. The increase from 2.87 to 3.2 in year 2 represents a small increase as well. Currently, 523 nursing facilities (or 77%) already meet a 3.0 standard, with 374 nursing facilities (or 55%) meeting or exceeding the 3.2 requirement. The delayed implementation date until July 1, 2023 for year 1, with a graduated implementation beginning year 2, coupled with a reduced rate in combination with increased funding for nursing facilities generally and increased MA payments provides ample time and funding to fill positions.

The amendments on final-form to the per-shift staffing requirements are also achievable. There is no increase to the RN staffing requirements, although RNs may be used in place of LPNs to meet the per-shift requirements for LPNs. As explained in response to question 19, most of the staff that will need to be hired to comply with the per-shift staffing minimums are nurse aides. The requirement for new staff is therefore achievable for the regulated community because nurse aides are the least costly nursing personnel to employ, followed by LPNs.

In addition, the Department is requiring a full-time social worker generally; however, a facility with 26 to 59 beds may employ a part-time qualified social worker if the facility assessment indicates that a full-time qualified social worker is not needed. Further, facilities with 25 beds or less may either employ a part-time qualified social worker or share the services of a qualified social worker with another facility. The Department received varying comments in support of and in opposition to the proposed requirement for all facilities to have a full-time social worker. The Department considered comments in support of maintaining the proposed social worker requirement on final form. The Department also considered comments suggesting that there be no change to the social worker requirements. Ultimately, the social worker requirements set forth in § 211.16 represent the least burdensome acceptable alternative to ensure that resident health, safety and wellbeing are protected.

(27) In conducting a regulatory flexibility analysis, explain whether regulatory methods were considered that will minimize any adverse impact on small businesses (as defined in Section 3 of the Regulatory Review Act, Act 76 of 2012), including:

a) The establishment of less stringent compliance or reporting requirements for small businesses;

b) The establishment of less stringent schedules or deadlines for compliance or reporting requirements for small businesses;
c) The consolidation or simplification of compliance or reporting requirements for small businesses;
d) The establishment of performance standards for small businesses to replace design or operational standards required in the regulation; and
e) The exemption of small businesses from all or any part of the requirements contained in the regulation.

(a) As provided above, the purpose of these amendments is to ensure the health, safety, and welfare of all residents of long-term care nursing facilities in this Commonwealth. Further, at least 91% of nursing facilities meet the definition of a small business with gross receipts under $30 million. Given the need for minimum health and safety requirements, coupled with the overwhelming majority of facilities meeting the definition of a small business, the Department did not establish less stringent compliance or reporting requirements.

(b) This final-form rulemaking does not have any less stringent or alternative schedules or deadlines for small businesses, which as defined, include at least 91% of nursing facilities.

(c) This final-form rulemaking does not have any consolidated or alternative reporting requirements for small business, which as defined, include at least 91% of nursing facilities.

(d) This final-form rulemaking does not have alternative design or operational standards for small businesses, which as defined, include at least 91% of nursing facilities.

(e) This final-form rulemaking does not have specific exemptions for small businesses since, as defined, this includes as least 91% of nursing facilities.

(28) If data is the basis for this regulation, please provide a description of the data, explain in detail how the data was obtained, and how it meets the acceptability standard for empirical, replicable and testable data that is supported by documentation, statistics, reports, studies or research. Please submit data or supporting materials with the regulatory package. If the material exceeds 50 pages, please provide it in a searchable electronic format or provide a list of citations and internet links that, where possible, can be accessed in a searchable format in lieu of the actual material. If other data was considered but not used, please explain why that data was determined not to be acceptable.

The Department relied on data obtained from the following sources:

Penn State Harrisburg, Pennsylvania State Data Center. (July 2018). *Population Characteristics and Change: 2010 to 2017 (Research Brief)*. https://pasdc.hbg.psu.edu/data/research-briefs/pa-population-estimates (report compiled based on US census data).

Penn State Harrisburg, Pennsylvania State Data Center. (June 2022). Population in Pennsylvania's Population by Age. (Research Brief). Retrieved from https://pasdc.hbg.psu.edu/sdc/pasdc_files/researchbriefs/June_2022.pdf.

Administration for Community Living. (February 2020). How Much Care Will You Need? Retrieved from https://acl.gov/ltc/basic-needs/how-much-care-will-you-need.

Demographic Trends of COVID-19 Cases and Deaths in the US Reported to CDC. Retrieved from https://covid.cdc.gov/covid-data-tracker/#demographics.

The COVID Tracking Project. (March 2021). Long-Term-Care COVID Tracker. Retrieved from https://covidtracking.com/nursing-homes-long-term-care-facilities.

Kaiser Family Foundation. *Nursing Facilities, Staffing, Residents and Facility Deficiencies: 2009 through 2016*. (2018). https://www.kff.org/medicaid/report/nursing-facilities-staffing-residents-and-facility-deficiencies-2009-through-2016 (last visited: November 25, 2020) (study of long-term care facilities conducted in 2018).

AARP Nursing Home COVID-19 Dashboard Fact Sheets. Retrieved from https://www.aarp.org/ppi/issues/caregiving/info-2020/nursing-home-covid-states.html.

The Adverse Effects of the COVID-19 Pandemic on Nursing Home Resident Well-Being." *Journal of the American Medical Directors Association*, 22(5), 948-954.e2. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7980137/.

"Front-line Nursing Home Staff Experiences During the COVID-19 Pandemic." *Journal of the American Medical Directors Association*, 22(1), 199-203. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7685055/.

Department of Health. (2021). *Nursing Home Reports*. Retrieved from: https://www.health.pa.gov/topics/HealthStatistics/HealthFacilities/NursingHomeReports/Pages/nursing-home-reports.aspx.

State Policies Related to Nursing Facility Staffing. Retrieved from: https://www.macpac.gov/publication/state-policies-related-to-nursing-facility-staffing/

Gross Receipt Information -GuideStar Website - https://www.guidestar.org/

John F. Schnelle PhD, L. Dale Schroyer MMS, Avantika A. Saraf MPH, Sandra F. Simmons PhD, *Determining Nurse Aide Staffing Requirements to Provide Care Based on Resident Workload: A Discrete Event Simulation Model*, JAMDA 17 (2016) 970-977

Charlene Harrington1, Susan Chapman, Elizabeth Halifax, Mary Ellen Dellefield, and Anne Montgomery, *Time to Ensure Sufficient Nursing Home Staffing and Eliminate Inequities in Care*, HSOA Journal of Gerontology and Geriatric Medicine, Geriatr Med 2021, 7:099.

(29) Include a schedule for review of the regulation including:

A. The length of the public comment period:

30 days after notice or publication in the *Pennsylvania Bulletin*

B. The date or dates on which any public meetings or hearings will be held:

- The proposed regulations were presented to the Health Policy Board on October 29, 2020.
- On September 15, 2021, a public hearing was held before the Senate Aging & Youth Committee and the Senate Health & Human Services Committee, during which advocates provided feedback on proposed Rulemaking 1.

- The Department held meetings on December 15, 2021, June 8, 2022, and August 3, 2022. The Department invited stakeholders and commentators to these meetings to discuss their comments on the proposed regulations.

- The final-form regulations were presented to the Health Policy Board on August 10, 2022.

- The Department held a meeting on August 17, 2022. At this meeting, the Department presented stakeholders with an overview of the amendments that were made from proposed to final-form in response to their comments, on all four rulemakings, and provided them with an additional opportunity to comment and provide feedback on the final-form regulations.

C. The expected date of delivery of the final-form regulation: September 2022

D. The expected effective date of the final-form regulation: July 1, 2023, with the exception of § 211.12(f.1)(3) and (i)(2) (relating to nursing services). Section 211.12(f.1)(3) and (i)(2) will take effective July 1, 2024.

E. The expected date by which compliance with the final-form regulation will be required:

July 1, 2023, with the exception of § 211.12(f.1)(3) and (i)(2) (relating to nursing services). Section 211.12(f.1)(3) and (i)(2) will take effective July 1, 2024.

F. The expected date by which required permits, licenses or other approvals must be obtained:

Long-term care nursing facilities are already required to be licensed in the Commonwealth. This final-form rulemaking will not alter that requirement and all statutory timeframes for licensure will remain in effect.

(30) Describe the plan developed for evaluating the continuing effectiveness of the regulations after its implementation.

The Department regularly reviews the validity and efficacy of its regulations and will continue to do so in the future and as needs arise. In addition, the Department will be providing technical assistance and outreach to the regulated community to assist with implementation of this final-form regulation.

DEPARTMENT OF HEALTH, FINAL-FORM REGULATION # 10-224

RULEMAKING 4 — QUALIFICATIONS, TRAINING, JOB DUTIES, RECORDKEEPING, PROGRAM STANDARDS, AND RESIDENT RIGHTS AND SERVICES

EXHIBIT "A"

Resident Rights

A resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility.	42 CFR § 483.10(a)
A resident has the right to exercise their rights as a resident of the facility and as a citizen or resident of the United States.	42 CFR § 483.10(b)
A resident has the right to be free of interference, coercion, discrimination, and reprisal from a facility in exercising their rights and to be supported by the facility in the exercise of their rights.	42 CFR § 483.10 (b)(2)
A resident has the right to care without discrimination based upon race, color, familial status, religious creed, ancestry, age, sex, gender, sexual orientation, gender identity or expression, national origin, ability to pay, handicap or disability, use of guide or support animals because of blindness, deafness or physical handicap of the resident or because the resident is a handler or trainer of support or guide animals.	28 Pa. Code § 201.29(c.2)(4)
A resident, who has not been adjudged incompetent, has the right to designate a representative and the representative may exercise the resident's rights to the extent provided by law. Same-sex spouses must be afforded equal treatment.	42 CFR § 483.10(b)(3)
A resident retains the right to exercise the rights not delegated to a resident representative, including the right to revoke the delegation of rights, to the extent permitted by law.	42 CFR § 483.10(b)(3)(ii)
A resident has the right to be informed of, and participate in, their treatment, including the right to be fully informed of their health status in a language the resident understands.	42 CFR § 483.10(c)(1)
A resident has the right to participate in the planning, development and implementation of the resident's person-centered plan of care.	42 CFR § 483.10(c)(2)

A resident has the right to: identify individuals or roles to be included in the planning process; to request meetings; and to request revisions to the resident's plan of care.	42 CFR § 483.10(c)(2)(i)
A resident has the right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, including other factors related to the effectiveness of the resident's plan of care.	42 CFR § 483.10(c)(2)(ii)
A resident has the right to be informed, in advance, of changes to the resident's plan of care.	42 CFR § 483.10(c)(2)(iii)
A resident has the right to receive the services and items included in the resident's plan of care	42 CFR § 483.10(c)(2)(iv)
A resident has the right to see their care plan, including the right to sign after significant changes to the plan of care.	42 CFR § 483.10(c)(2)(v)
A resident has the right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care.	42 CFR § 483.10(c)(4)
A resident has the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option they prefer.	42 CFR § 483.10(c)(5)
A resident has the right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.	42 CFR § 483.10(c)(6)
Experimental research or treatment in a facility may not occur without the approval of the Pennsylvania Department of Health, including the Department's Institutional Review Board, and without the written approval and informed consent of a resident, or resident representative prior to participation, in accordance with law.	28 Pa. Code § 201.29(c.2)(3)

A resident has the right to self-administer medications, when clinically appropriate.	42 CFR § 483.10(c)(7)
A resident has the right to choose their attending physician in accordance with law.	42 CFR § 483.10(d)
A resident has a right to be treated with respect and dignity.	42 CFR § 483.10(e)
A resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with law.	42 CFR § 483.10(e)(1)
A resident has the right to retain and use personal possessions, including furnishings, and clothing, as space and health and safety permits.	42 CFR § 483.10(e)(2)
A resident has the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences, except when to do so would endanger the health or safety of the resident or other residents.	42 CFR § 483.10(e)(3)
A resident has the right to share a room with their spouse when married residents live in the same facility and both spouses consent to the arrangement.	42 CFR § 483.10(e)(4)
A resident has the right to share a room with their roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement.	42 CFR § 483.10(e)(5)
A resident has the right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed.	42 CFR § 483.10(e)(6)
A resident has the right to refuse to transfer to another room in the facility, if the purpose of the transfer is:	42 CFR § 483.10(e)(7)

(1)To relocate a resident of a nursing facility from the distinct part of the institution that is a nursing facility to a part of the institution that is not a nursing facility, or (2) solely for the convenience of staff.	
Prior to a transfer to another facility, the facility shall inform the resident, or the resident representative, whether the new facility is certified to participate in the Medicare and Medical Assistance Programs.	28 Pa. Code § 201.29(c.3)(2)
A resident has the right to resident self-determination through support of resident choice.	42 CFR § 483.10(f)
A resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with their interests, assessments and plan of care.	42 CFR § 483.10(f)(1)
A resident has the right to make choices about aspects of their life in the facility that are significant to the resident.	42 CFR § 483.10(f)(2)
A resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.	42 CFR § 483.10(f)(3)
A resident has a right to receive visitors of their choosing at the time of their choosing. A resident may deny visitation, when applicable, and in a manner that does not impose on the rights of another resident.	42 CFR § 483.10(f)(4)
A resident has a right to organize and participate in resident groups in the facility.	42 CFR § 483.10(f)(5)
A resident has a right to participate in family groups.	42 CFR § 483.10(f)(6)
A resident has a right to have family members or other resident representatives meet in the facility with the families or resident representatives of other residents in the facility.	42 CFR § 483.10(f)(7)

A resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.	42 CFR § 483.10(f)(8)
A resident has a right to choose to or refuse to perform services for the facility and the facility must not require a resident to perform services for the facility. The resident may perform services for the facility, if the resident chooses, when— (i) The facility has documented the resident's need or desire for work in the plan of care; (ii) The plan specifies the nature of the services performed and whether the services are voluntary or paid; (iii) Compensation for paid services is at or above prevailing rates; and (iv) The resident agrees to the work arrangement described in the plan of care.	42 CFR § 483.10(f)(9)
A resident has a right to manage their financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds.	42 CFR § 483.10(f)(10)
If changes in charges occur during a resident's stay, the resident shall be advised verbally and in writing at least 30 days in the advance of the change, unless circumstances dictate otherwise.	28 Pa. Code § 201.29(c.3)(1)
If a security deposit is required, the facility's written procedure or the contract with the resident shall indicate how the deposit will be used and the terms for the return of the deposit. A security deposit is not permitted for residents receiving Medical Assistance.	28 Pa. Code § 201.29(c.3)(1)
A resident has the right to be informed of their rights and of all rules and regulations governing resident conduct and responsibilities during their stay in the facility.	42 CFR § 483.10(g)(1)
A resident has the right to access personal and medical records pertaining to the resident.	42 CFR § 483.10(g)(2)

A resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language the resident understands.	42 CFR § 483.10(g)(4)
A resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense.	42 CFR § 483.10(g)(6)
A resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense.	42 CFR § 483.10(g)(8)
A 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.	42 CFR § 483.10(g)(9)
A resident has the right to— (i) Examine the results of the most recent survey of the facility conducted by surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.	42 CFR § 483.10(g)(10)
A resident has a right to personal privacy and confidentiality of their personal and medical records.	42 CFR § 483.10(h)

A resident has a right to secure and confidential personal and medical records. The resident has the right to refuse the release of personal and medical records except as provided under law.	42 CFR § 483.10(h)(3)(i)
A resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.	42 CFR § 483.10(i)
A 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.	42 CFR § 483.10(j)(1)
A resident has the right to have grievances promptly resolved, in accordance with law.	42 CFR § 483.10(j)(2)

CDL-1

FACE SHEET
FOR FILING DOCUMENTS
WITH THE LEGISLATIVE REFERENCE BUREAU

(Pursuant to Commonwealth Documents Law)

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SEP 27 2022

Independent Regulatory
Review Commission

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Copy below is hereby approved as to form and legality. Attorney General	Copy below is here by certified to be a true and correct copy of a document issued, prescribed or promulgated by:	Copy below is hereby approved as to form and legality. Executive or Independent Agencies.
BY: _____ (DEPUTY ATTORNEY GENERAL)	Department of Health (AGENCY)	BY: _____
_____ DATE OF APPROVAL	DOCUMENT/FISCAL NOTE NO. 10-224	September 27, 2022 DATE OF APPROVAL
☐ Check if applicable Copy not approved. Objections attached.	DATE OF ADOPTION: _____	Deputy General Counsel (Chief Counsel, Independent Agency) (Strike inapplicable title)
	BY: Denise Johnson, M.D.	☐ Check if applicable. No Attorney General approval or objection within 30 days after submission.
	TITLE: Acting Secretary of Health (EXECUTIVE OFFICER, CHAIRMAN OR SECRETARY)	

NOTICE OF FINAL RULEMAKING

DEPARTMENT OF HEALTH

TITLE 28. HEALTH AND SAFETY

PART IV. HEALTH FACILITIES

SUBPART C. LONG-TERM CARE FACILITIES

28 PA. CODE §§ 201.18—201.21; 201.24—201.31; 207.2; 209.3; 211.2—211.17

RULEMAKING 4 — QUALIFICATIONS, TRAINING, JOB DUTIES, RECORDKEEPING, PROGRAM STANDARDS, AND RESIDENT RIGHTS AND SERVICES

The Department of Health (Department), after consultation with the Health Policy Board, amends 28 Pa. Code §§ 201.18—201.21, 201.24, 201.26, 201.29, 201.31, 209.3, 211.2—211.10, 211.12, 211.15— 211.17 and deletes §§ 201.25, 201.30, 207.2, and 211.11 to read as set forth in Annex A. This is the fourth of four final-form rulemaking packages for long-term care nursing facilities being promulgated by the Department.

The contents for the four final-form rulemaking packages are as follows:

Rulemaking 1 – General Applicability and Definitions

§ 201.1. Applicability.

§ 201.2. Requirements.

§ 201.3. Definitions.

Rulemaking 2 – General Operation and Physical Requirements

§ 201.23. Closure of facility.

Chapter 203. Application of Life Safety Code for Long-Term Care Nursing Facilities. (Reserved on final-form).

Chapter 204. Physical Environment and Equipment Standards for Construction, Alteration or Renovation of Long-Term Care Nursing Facilities After July 1, 2023.

Chapter 205. Physical Environment and Equipment Standards for Long-Term Care Nursing Facilities Construction, Alteration or Renovation Approved before July 1, 2023.

§ 207.4. Ice containers and storage. (Reserved on final-form).

Rulemaking 3 – Applications for Ownership, Management and Changes of Ownership; Health and Safety

§ 201.12. Application for license of a new facility or change in ownership.

§ 201.12a. Notice and opportunity to comment (New Section on final-form)

§ 201.12b. Evaluation of application for license of a new facility or change in ownership. (Section renumbered on final-form)

§ 201.13. Issuance of license for a new facility or change in ownership.

§ 201.13a. Regular license. (New Section on final-form)

§ 201.13b. Provisional license. (New Section on final-form)

§ 201.13c. License renewal. (Section renumbered on final-form)

§ 201.14. Responsibility of licensee.

§ 201.15. Restrictions on license.

§ 201.15a. Enforcement. (New Section on final-form)

§ 201.15b. Appeals. (New Section on final-form)

§ 201.17. Location.

§ 201.22. Prevention, control and surveillance of tuberculosis (TB).

§ 209.1. Fire department service. (Reserved on final-form).

§ 209.7. Disaster preparedness. (Reserved on final-form).

§ 209.8. Fire drills. (Reserved on final-form).

§ 211.1. Reportable diseases.

Rulemaking 4 – Qualifications, Training, Job Duties, Recordkeeping, Program Standards, and Resident Rights and Services

§ 201.18. Management.

§ 201.19. Personnel records.

§ 201.20. Staff development.

§ 201.21. Use of outside resources.

§ 201.24. Admission policy.

§ 201.25. Discharge policy. (Reserved on final-form).

§ 201.26. Resident representative.

§ 201.29. Resident rights.

§ 201.30. Access requirements. (Reserved on final-form).

§ 201.31. Transfer agreement.

§ 207.2. Administrator's responsibility. (Reserved on final-form).

§ 209.3. Smoking.

§ 211.2. Medical director.

§ 211.3. Verbal and telephone orders.

§ 211.4. Procedure in event of death.

§ 211.5. Medical records.

§ 211.6. Dietary services.

§ 211.7. Physician assistants and certified registered nurse practitioners.

§ 211.8. Use of restraints.

§ 211.9. Pharmacy services.

§ 211.10. Resident care policies.

§ 211.11. Resident care plan. (Reserved on final-form).

§ 211.12. Nursing services.

§ 211.15. Dental services.

§ 211.16. Social services.

§ 211.17. Pet therapy.

Comments on Multiple Packages; Stakeholder Engagement

The Department received comments during the public comment periods of all four proposed rulemaking packages expressing concern with the Department's decision to divide the long-term care nursing facility regulations into separate rulemakings. As provided above, the Department divided the regulatory packages as follows: Rulemaking 1 – *General Applicability and Definitions*; Rulemaking 2 – *General Operation and Physical Requirements*; Rulemaking 3 – *Applications for Ownership, Management and Changes of Ownership; Health and Safety*; and Rulemaking 4 – *Qualifications, Training, Job Duties, Recordkeeping, Program Standards, and Resident Rights and Services.*

Although the Department intended to provide succinct areas for review and comment, commentators expressed some difficulty in reviewing sections of the regulations without the context of the remaining regulatory chapters and concern that multiple regulatory packages may lead to a lack of clarity and confusion for the regulated community and the public. Commentators also requested that the Department consider comments on all four proposed rulemaking packages outside of the 30-day comment period for each proposed package, or that the Department withdraw or resubmit all four proposed rulemaking packages as one package with an additional 30-day comment period. The Department also received comments regarding concern related to recent engagement with stakeholders, given that the Long-term Care Work Group last formally met in 2018 and was disbanded during the start of the COVID-19 pandemic.

In commenting on proposed Rulemaking 1, the Independent Regulatory Review Commission (IRRC) acknowledged the Department's authority to promulgate regulations as it deems appropriate. However, IRRC requested the Department to consider the regulated community's comments and the requests regarding the separate rulemakings. IRRC specifically asked the Department to explain why its approach in dividing the amendments into multiple packages was reasonable. IRRC also asked that the Department ensure that amendments be consistent across the packages, and that the interrelation and any impacts between the packages be clearly presented for the regulated community.

In commenting on proposed Rulemaking 2, IRRC again echoed concerns that separate rulemakings have the potential consequence of inconsistencies and errors across the four packages. IRRC inquired whether having multiple regulatory packages is in the public interest, whether it protects the public health, safety, and welfare, and whether it is reasonable and lacks ambiguity. IRRC asked whether it was in the public interest or reasonable to expect the regulated community to hold multiple proposed regulations simultaneously in mind while reviewing a proposed regulation. IRRC also asked the Department to: (1) identify in the final-form preamble any provisions which assume approval of Rulemaking 1 as final-form; (2) cross-reference these provisions to the relevant provisions in Rulemaking 1; and (3) explain the impact if Rulemaking 1 is not approved before or at the same time as rulemaking 2. IRRC

recommended that the Department deliver each of the four individual packages as final-form regulations on the same day. In addition, IRRC, in its comment for proposed Rulemaking 3 and Rulemaking 4 expressed the same concerns as in the previous proposed rulemakings, but additionally suggested that the Department consider issuing an Advance Notice of Final Rulemaking (ANFR) to assist in reaching consensus.

Response

At the outset, the Department recognized that the changes to the long-term care nursing facility regulations would be numerous and complex, whether presented in one giant package or in multiple packages. A large single package would have been unwieldy and would likely have been presented around the date that the fourth regulatory package was completed and submitted (May 11, 2022). A later publication date would have resulted in less opportunity for comments, less time for the commentators to study the material and deliberate, and less time for necessary and valuable stakeholder engagement. Further, the regulated community's input throughout this process informed the administration and legislature's investment in this year's budget. As such, the decision was made to continue with the changes in smaller, separate more digestible packages. As provided above, the Department initially decided to divide the proposed amendments to the six regulatory chapters under Subpart C (relating to long-term care facilities) into multiple packages to allow the public and interested parties a greater opportunity to thoroughly examine and digest the distinct proposed regulatory amendments over a longer period. In dividing these six chapters over four rulemakings, the public and interested parties would be permitted to provide more detailed comments and allow the Department to focus more closely on comments, provide a thoroughly considered response to questions and comments, and tailor the remaining proposed packages based on additional public and stakeholder input.

Further, in response to these public comments, the Department has considered all public comments and IRRC's comments across all four proposed rulemakings before drafting the four final-form rulemakings. In addition, based on comments received, the Department is submitting all four final-form rulemakings to IRRC, the legislative standing committees and the public commentators together on the same day. The drafting and submitting of all four final-form rulemakings together at the end of the last public comment periods allows interested parties and the public to vet and comment on each package separately, as well as in relation to the other packages. Throughout this process, the Department has continued to accept and review comments and be available to meet with stakeholders. If a commentator believed that a proposed amendment in Rulemaking 4 did not align with a proposed amendment in Rulemaking 1, the commentator could submit a comment to that effect for consideration by the Department during the public comment period for the proposed Rulemaking 4.

The Department did, in fact, take into consideration comments received on proposed Rulemakings 1 and 2, when drafting proposed Rulemakings 3 and 4. This is as evidenced by the proposal to expressly include text from the Centers for Medicare & Medicaid (CMS), *State Operations Manual, Appendix PP* into the text of the regulation. *See e.g.*, Proposed Rulemaking 4, Proposed § 201.29(o) (relating to resident's rights). This inclusion of specific text was based on comments received by commentators and IRRC in proposed Rulemaking 1. The Department also consolidated the total number of proposed packages from five to four packages in response to both public and IRRC comments received in proposed Rulemaking 1.

In addition to considering comments on the four proposed packages during and outside of the four public comment periods, the Department met with stakeholders on four occasions following the receipt of public comments to discuss their concerns and to gain additional insight into comments that were received. The first of these meetings, for proposed Rulemakings 1 and 2, occurred on December 15, 2021. Representatives from AARP, Alzheimer's Association – Delaware Valley and Greater Pennsylvania Chapters, Center for Advocacy for the Rights & Interests of the Elderly (CARIE), Community Legal Services, LeadingAge, Pennsylvania Health Care Association (PHCA), Pennsylvania Coalition of Affiliated Healthcare & Living Communities (PACAH), and SEIU Healthcare Pennsylvania attended that meeting. The second meeting, for proposed Rulemaking 3 occurred on June 8, 2022. Representatives from AARP, Alzheimer's Association, CARIE, Community Legal Services, LeadingAge, PHCA, Pennsylvania Health Law Project (PHLP), and SEIU again attended that stakeholder meeting. The Department explicitly stressed to stakeholders during this June 8, 2022, meeting that it would be considering comments on all proposed rulemakings, and that it would welcome any additional comments or feedback that stakeholders might have after the meeting regarding proposed amendments to the various regulatory chapters. The Department also indicated in a press release on proposed Rulemaking 4, issued on June 3, 2022, that it would be considering comments on all four proposed rulemakings before submitting final-form regulations. The third meeting with stakeholders, for proposed Rulemaking 4, occurred on August 3, 2022. Present at that meeting were representatives from AARP, Alzheimer's Association, CARIE, PHCA, Pennsylvania Health Funders Collaborative (PHFC), and SEIU. The Department held the fourth meeting on August 17, 2022. At this meeting, the Department presented stakeholders with an overview of the changes that were made from proposed to final-form in response to their comments, on all four rulemakings, and provided them with an opportunity to comment and provide feedback on the final-form regulations. Present at that meeting were representatives from the Alzheimer's Association, CARIE, Community Legal Services, County Commissioners Association (CCAP), Disability Rights, LeadingAge, PHCA, PHFC, and SEIU.

After consideration of all comments received on the four proposed packages, the Department firmly supports its decision in splitting the six long-term care nursing facility chapters into multiple packages. While the Department appreciates the comments and suggestion for one consolidated package, one is not needed at this stage due to the public, the regulated community, and advocates full and continued opportunity to offer input on all the long-term care nursing facilities' regulations, throughout the four separate public comment periods, the first of which occurred over a year ago, as well as during the stakeholder meetings that occurred from 2021 through August 2022. In addition, as mentioned previously, at the meeting on August 17, 2022, the Department provided stakeholders an overview of the changes that were adopted on all four rulemakings, to ensure that stakeholders fully understand all amendments. At that meeting, the Department also permitted stakeholders the opportunity to further comment on the final-form amendments and incorporated this feedback into the final-form regulations. Finally, as noted above, splitting the regulations into multiple, separate packages benefited the public, regulated community, and advocates because it allowed the Department to incorporate their feedback as it moved forward with the drafting of subsequent packages, which promoted the public interest, health, safety, and welfare by improving the overall quality of the proposed regulations.

The Department has, in each of the four final-form preambles, discussed and responded to all comments received on the contents of the four proposed rulemakings, regardless of when the comment was received. The Department has added cross-references, as appropriate, where comments received on one package relate to another package to further aid in the review of the four packages together in their entirety. For example, in proposed Rulemaking 1, the Department received comments requesting that staff, other than nursing personnel, be considered when determining whether a facility has met the minimum number of direct resident care hours in § 211.12(a)(i) (relating to nursing services). In response to this comment, the types of individuals required for the minimum number of direct resident care hours was intentionally addressed in proposed Rulemaking 4 and generated additional comments during that proposed rulemaking's public comment period. The Department has, therefore, indicated in § 211.12(i) of the preamble for final-form Rulemaking 1, that it received comments on this topic and provided a cross-reference to the more in-depth discussion of this topic in this preamble. Further, to provide additional clarity and readability, the Department moved the proposed language relating to direct resident care hours from proposed Rulemaking 1 to this proposed rulemaking, as discussed in further detail below. Finally, the Department has noted where one rulemaking assumes approval of another rulemaking. Through this extended review and public comment process, the Department has been transparent in its proposals and has responded to these comments throughout each rulemaking.

Background and Need for Amendments

The percentage of adults 65 years of age or older in this Commonwealth is increasing. In 2010, approximately 15% of Pennsylvanians were aged 65 or older. In 2017, this number increased to 17.8%. In 2020, just under 20 percent of the population in Pennsylvania was 65 years of age or older. For every 10 individuals under 25 years of age lost in Pennsylvania since 2010, the state gained 21 persons aged 65 or older. This Commonwealth also has a higher percentage of older adults when compared to other states. In 2017, this Commonwealth ranked fifth in the Nation in the number (2.2 million) of older adults and seventh in percentage (17.8%). The increase in older Pennsylvanians is expected to continue. It has been estimated that by 2030, there will be 38 older Pennsylvanians (65 years of age or older) for every 100-working age Pennsylvanians (15 years of age to 64 years of age). Penn State Harrisburg, Pennsylvania State Data Center. (July 2018). Population Characteristics and Change: 2010 to 2017 (Research Brief). Retrieved from https://pasdc.hbg.psu.edu/data/research-briefs/pa-population-estimates; Penn State Harrisburg, Pennsylvania State Data Center. (July 2018). (June 2022). Trends in Pennsylvania's Population by Age. (Research Brief). Retrieved from https://pasdc.hbg.psu.edu/sdc/pasdc_files/researchbriefs/June_2022.pdf.

As the number of older Pennsylvanians increases, the number of those needing long-term care nursing will also increase. It has been estimated that an individual turning 65 years of age today has an almost 70% chance of needing some type of long-term services or support during the remainder of their lifetime; 20% will need long-term care support for longer than 5 years. More people use long-term care services at home and for longer; however, approximately 35% utilize nursing facilities for this type of care. Administration for Community Living. (February 2020). How Much Care Will You Need? Retrieved from https://acl.gov/ltc/basic-needs/how-

much-care-will-you-need. Approximately 72,000 individuals reside in the 682 long-term care nursing facilities currently licensed by the Department.

The COVID-19 pandemic highlighted the vulnerability of older adults, with a larger percentage of deaths occurring in individuals 65 years of age and older. Centers for Disease Control and Prevention (CDC). Demographic Trends of COVID-19 Cases and Deaths in the US Reported to CDC. Retrieved from https://covid.cdc.gov/covid-data-tracker/#demographics. *See also*, CDC. COVID-19 Weekly Cases and Deaths per 100,000 Population by Age, Race/Ethnicity and Sex, United States, March 1, 2020—June 25, 2022. Retrieved from https://covid.cdc.gov/covid-data-tracker/#demographicsovertime. Further, it is estimated that at least a quarter of COVID-19 deaths occurred in long-term care nursing facilities. The COVID Tracking Project. (March 2021). Long-Term-Care COVID Tracker. Retrieved from https://covidtracking.com/nursing-homes-long-term-care-facilities. In this Commonwealth alone, there have been approximately 11,443 confirmed deaths of residents in long-term care nursing facilities since January 2020. AARP. (September 15, 2022). AARP Nursing Home COVID-19 Dashboard Fact Sheets. Retrieved from https://www.aarp.org/ppi/issues/caregiving/info-2020/nursing-home-covid-states.html.

The repercussions of the pandemic have reached far beyond the direct, physical effects of contracting the COVID-19 virus. Lockdowns intended to protect vulnerable residents at the beginning of the pandemic led to social isolation and loneliness because residents were prevented from having in-person contact with their loved ones. This led to an increase in depression and anxiety, cognitive decline and in some cases, physical deterioration, among residents who were already fearful of contracting the virus. Levere, M., Rowan, P., & Wysocki, A. (2021). "The Adverse Effects of the COVID-19 Pandemic on Nursing Home Resident Well-Being." *Journal of the American Medical Directors Association*, 22(5), 948-954.e2. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7980137/. Nursing services personnel, who were already stressed before the pandemic, incurred additional stress from, among other things, shortages in personal protective equipment (PPE), limited access to COVID-19 testing supplies, fear of contracting COVID-19 while at work and spreading it to others, concern for residents under their care, lack of public support and recognition, and an increase in workloads due to the additional protective measures needed to prevent spread of COVID-19 and other nursing services personnel leaving the workforce. White, E.M., Wetle, T.F., Reddy, A. & Baier, R.R. (2021). "Front-line Nursing Home Staff Experiences During the COVID-19 Pandemic." *Journal of the American Medical Directors Association*, 22(1), 199-203. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7685055/.

The Department's long-term care nursing facilities regulations have not been updated since 1999, with the last significant update occurring in 1997 after the 1996 amendment to the Health Care Facilities Act (the HCFA or act) (35 P.S. §§ 448.101—448.904b). Since that time, there have been substantial changes in the means of delivering care and providing a safe environment for residents in long-term care nursing facilities, with the pandemic further highlighting the need for change. The Department has been attempting to complete this much needed reform since before the pandemic, in late 2017. At that time, the Department sought assistance and advice from members of a long-term care work group (LTC Work Group). The Department worked with the LTC Work Group regularly in 2018. The members of the LTC Work Group were drawn from a diverse background and included representatives from urban

and rural long-term care facilities and various stakeholder organizations and consumer groups that work in the area of resident care and delivery of services. The LTC Work Group members consisted of representatives from the following organizations: American Institute of Financial Gerontology; Baker Tilly Virchow Krause, LLP; Berks Heim and Rehabilitation; Fulton County Medical Center; Garden Spot Community; HCR ManorCare; Inglis House; Landis Communities; Leading Age; Legg Consulting Services; LIFE Pittsburgh; Luzerne County Community College; The Meadows at Blue Ridge; Mennonite Home, Lutheran Senior Life Passavant Community; PA Coalition of Affiliated Healthcare and Living Communities; Pennsylvania Home Care Association; University of Pittsburgh; and Valley View Nursing Home. The following State agencies participated: Department of Aging; the Department of Human Services (DHS); and the Department of Military and Veteran's Affairs (DMVA).

The members of the LTC Work Group met regularly during 2018 with the LTC Work Group's primary focus being the simplification and modernization of the existing long-term care regulations. After these discussions were complete, the Department reviewed the recommendations of the LTC Work Group and consulted with other potentially impacted agencies, such as the Departments of Aging and Military and Veterans Affairs, in 2019 and 2020. In 2020, 2021 and 2022, the Department continued its efforts to draft amendments to the long-term care nursing facility regulations while also handling the day-to-day challenges of protecting the residents of those facilities, who were being hit the hardest by the COVID-19 pandemic.

As discussed previously, in response to concerns raised by IRRC and commentators, the Department ramped up its communications with stakeholders by holding the first of four stakeholder meetings, beginning in December 2021, to address comments received on proposed Rulemakings 1 and 2. The Department held a second meeting with stakeholders in June 2022 after the public comment and IRRC comment periods ended for proposed Rulemaking 3, and a third stakeholder meeting in August 2022 after the public and IRRC comment periods ended for proposed Rulemaking 4. The Department held a fourth stakeholder meeting on August 17, 2022, to provide an overview of changes from proposed to final-form and permitted stakeholders to provide additional feedback and comments on amendments during this meeting.

The discussions with stakeholders and the comments received on the four proposed rulemakings have made it abundantly clear that amendments to the current long-term care nursing facility regulations are desperately needed and must not be delayed any longer. Commentators expressed in comments to all four groups that they were pleased to see the Department updating these regulations. The comments in support of amending the regulations can generally be summarized as follows:

- Amendments are long overdue.
- Revisions to existing regulations are urgently needed.
- COVID-19 had a devastating impact on facilities and highlighted the need for revisions.
- Regulations need to be updated to provide additional protections to residents.

Unfortunately, while commentators agree for the most part that an update to the regulations is needed, they do not agree on the extent of the update needed. Some commentators strongly argued that the Department's proposed amendments do not go far enough in protecting

residents, while other commentators strongly argued that the Department's proposed amendments go too far and result in a fiscal impact. The Department has considered all comments it received both in favor of and against the proposed amendments and has responded to those comments. In considering those comments and balancing the competing interest of the parties in this regulatory review process, the Department has made revisions from the proposed rulemakings to the final-form rulemakings. The Department has also provided explanations to comments received in the preambles for each of the four final rulemakings, as explained more fully above.

Public Comments

In response to proposed Rulemaking 4, the Department received comments from 37 public commentators, two form letters, and comments from IRRC. These comments are discussed in further detail below. IRRC requested that the Department address any provisions that currently expand upon the Federal requirements and which the Department deletes at final, as to why the change is reasonable, protects the public health, safety, and welfare of residents, and is in the public interest. In addition, IRRC requested cross references to Federal regulations for provisions that are deleted. These provisions, including the applicable Federal cross references, are addressed in each section below.

Description of Amendments / Summary of Comments and Responses

§ 201.18. Management

Subsection (a)

Subsection (a) remains deleted on final-form. As explained on proposed, the Department deletes this subsection to eliminate duplication and avoid conflict with the Federal requirements for long-term care nursing facilities. Under 42 CFR 483.70(d)(1), a facility is required to have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of a facility. All facilities, including the three private-pay facilities, are already required to comply with 42 CFR 483.70(d)(1) under existing § 201.2, and will continue to be required to comply with this requirement under amended § 201.2.

One commentator argued that the requirement for a governing body should not be deleted and should be retained in case the Federal requirements change. After careful consideration, the Department declines to retain this subsection in response to this comment. As noted in final-form *Rulemaking 1 – General Applicability and Definitions*, the Department has chosen to incorporate the Federal requirements at 42 CFR Part 483, Subpart B as the baseline standards for the minimum health and safety requirements for long-term care nursing facilities. The Department, where necessary, has retained and added requirements to State regulation that exceed the Federal health and safety requirements. However, the Department declines to retain or copy and paste the verbatim Federal requirements into State regulation as some commentators suggested. Pursuant to 45 Pa. C.S. § 727 (relating to matter not required to be published), the Department shall omit the text of the *Code of Federal Regulations* when incorporated by reference in documents that are published in the *Pennsylvania Code*. This is similarly prohibited under § 2.14(b) of the *Pennsylvania Code & Bulletin Style Manual* (*Style Manual*), as well,

which the Department follows in drafting regulations. The Department, therefore, declines, on final-form, to add the requirement in subsection (a) back into regulation. If a future update to the Federal requirements results in provisions being deleted that the Department determines is necessary to be codified in State regulation to ensure the health, safety and welfare of residents, the Department will update its regulations.

Other commentators requested that subsection (a) be retained and strengthened by expanding on and clarifying the duties of the governing body. These commentators seek to have the Department add several requirements to subsection (a). First, they seek to have the Department add a requirement that the facility maintain written documentation to evidence how the governing body was created and by whom and maintain a list of all current and past board members. After careful consideration, the Department declines to make this amendment. In *Rulemaking 3 – Applications for Ownership, Management and Changes of Ownership; Health and Safety*, the Department is requiring a facility to submit the names and contact information of any persons who have or will have an interest in the management of the facility as part of the application for licensure under § 201.12(b)(5)(relating to application for license of a new facility or change in ownership). Management includes members of the governing body. In § 201.18(c), as described below, the facility will be required to report to the Department changes to this information within 30 days, so the Department will have a record of current and previous members of the governing body. Also, in final-form Rulemaking 3, in § 201.12(e)(1), a prospective licensee is required to submit a proposed staffing and hiring plan, which shall include the structure of the facility's governing body and its participants. This assumes approval of Rulemaking 3.

The commentators also requested that the Department add a requirement that the governing body be legally responsible for establishing and implementing policies regarding the management and operation of the facility. After careful consideration, the Department declines to make this amendment because it is already required under the Federal requirements at 42 CFR 483.70(d)(1), which provide that the governing body is "legally responsible for establishing and implementing policies regarding the management and operation of the facility." As noted previously, all facilities, including the three private-pay facilities, are already required to comply with 42 CFR 483.70(d)(1) under existing § 201.2, and will continue to be required to comply with this requirement under amended § 201.2.

The commentators requested that the Department add a requirement that the governing body report monthly to the licensee on operational activities including, at a minimum, the items identified in § 201.18(b). After careful consideration, the Department declines to make this amendment because it would be overly prescriptive to instruct the governing body to communicate with the licensee at specific intervals. This is a business decision, and the licensee has an existing responsibility to be aware of issues related to the operation of the facility. It is, therefore, not necessary to mandate monthly reporting by the governing body to the licensee.

The commentators also requested that the Department add a requirement that the governing body appoint the administrator of the facility. After careful consideration, the Department declines to make this amendment because it is already required under the Federal requirements at 42 CFR 483.70(d)(2), which assign responsibility for appointing the

administrator to the governing body. All facilities, including the three private-pay facilities, are already required to comply with 42 CFR 483.70(d)(1) under existing § 201.2, and will continue to be required to comply with this requirement under amended § 201.2.

The commentators requested that the Department add a requirement that the governing body actively engage in the establishment of all policies and procedures governing the facility and oversee the quality assurance and performance improvement (QAPI) process. After careful consideration, the Department declines to make this amendment because, as noted above, the Federal requirements at 42 CFR 483.70(d)(1) already require that the governing body be legally responsible for policies regarding the management and operation of the facility. With regards to the governing body overseeing the QAPI program, that is also required by the Federal requirements at 42 CFR 483.70(d)(3) and 42 CFR 483.75(f). The commentator also recommended that the governing body be required to review the projects, provide oversight and analyze outcomes to ensure that the QAPI program is performing effectively. This is also generally covered by the Federal requirements at 42 CFR 483.75(f), which among other things, requires the governing body to be responsible and accountable for ensuring that the QAPI program identifies and prioritizes problems and opportunities based on performance indicator data and that corrective actions address gaps in systems and are evaluated for effectiveness. The Department notes that all facilities that participate in Medicare or Medical Assistance (MA) are required to comply with 42 CFR 483.70(d)(3) and 42 CFR 483.75(f), but this will be a new requirement for the three private-pay facilities. This response, therefore, assumes approval of final-form Rulemaking 1– *General Applicability and Definitions*, in which the Department expands the incorporation of the Federal requirements in § 201.2.

In addition, the commentators requested that the Department add a requirement that the administrator present, at least quarterly, a detailed description of the QAPI projects being performed by facility staff and the results of QAPI projects completed. After careful consideration, the Department declines to make this amendment. The administrator is already required to maintain an ongoing relationship with the governing body under existing § 201.18(e)(3), which would necessarily involve communicating with the governing body. In addition, as described below, the Department adds language to § 201.18(e)(3) on final-form to require that the administrator maintain a relationship with the governing body through meetings and reports, which shall occur as often as necessary but at least monthly. Because the governing body is ultimately responsible for the QAPI program, the governing body could request that information about the QAPI program be included in some or all of those regular reports, depending on the current activities of the QAPI program. In addition, this amendment requires meetings and reports with medical and nursing staff and other professional and supervisory staff as often as necessary, but at least on a monthly basis.

Subsection (b)

Subsection (b) is amended from proposed to final-form. As explained on proposed, the Department adds language at the beginning of this subsection to clarify that the requirements in this subsection are in addition to the Federal requirements at 42 CFR 483.70(d). The Department also adds the words "of a facility" after "governing body" to make it clear that the governing body of a long-term care nursing facility shall perform the tasks delineated in paragraphs (1)

through (3) of subsection (b). Some commentators recommended that the Department add a requirement to this subsection for the return of any resident property remaining at the facility within 10 business days after the resident's discharge or death. Another commentator simply suggested that the Department establish a deadline for the return of personal property. Commentators indicated that they were requesting this amendment because some facilities delay or do not return property at all. Under the Federal requirements at 42 CFR 483.10(f)(10)(v), a facility is required to return resident funds within 30 days, but there is no requirement related to the return of personal property. The Department agrees that the addition of a requirement related to the return of personal property into regulation is appropriate, and therefore, on final-form, adds a requirement to the end of subsection (b)(2) for the return of personal property. The Department, however, aligns the timeframe with the Federal requirement related to resident funds, by requiring the return of personal property within 30 days after discharge or death.

Subsection (c)

Subsection (c) is amended from proposed to final-form. The Department proposed to replace the words "provide the information required in § 201.12 and prompt reports of changes which would affect the accuracy of the information required" with the words "report to the Department within 30 days changes to the information that was submitted with the facilities application for licensure under § 202.12 (relating to application for licensure of a new facility or change in ownership)" to clarify the governing body's responsibility with respect to the information submitted under § 201.12. It is a prospective licensee's responsibility to submit the information required under § 201.12 with the application for licensure. Once an application for licensure is approved, the governing body becomes responsible for reporting to the Department any change to the information that was submitted with the application for licensure. The Department proposed to require that changes be reported within 30 days to align with § 51.4 (relating to change in ownership; change in management), which requires notification to the Department at least 30 days prior to a transfer involving 5% or more of stock or equity, a change in ownership and a change in management.

Commentators generally supported the Department's proposal to require that facilities report changes to the information included in a facility's application for licensure within 30 days of the change. One commentator requested that the Department clarify exactly what information must be reported to the Department to reduce the risk of accidental violations due to an oversight or misinterpretation of the regulation. The Department made various amendments on final-form to § 201.12, in Rulemaking 3 – *Applications for Ownership, Management and Changes of Ownership; Health and Safety*. After finalizing these amendments, the Department reviewed the complete list of information that must be submitted with an application for licensure and determined that only changes to the information required under §§ 201.12(b)(1) through 201.12(b)(6) must be reported to the Department within 30 days. The Department, on final-form, therefore, amends this subsection to require only changes to the information under these subsections be reported to the Department within 30 days. The information in §§ 201.12(b)(1) through 201.12(b)(6) include the names and contact information for the facility's owners,

nonprofit officers and directors, partners, the administrator, those who have a management interest in the facility, and the facility's officers and board of directors, and represents the information that correlates most directly to the ownership and management of a facility. This assumes approval of Rulemaking 3.

Other items that must be submitted with the application, but which do not have to be reported to the Department within 30 days of a change, are the requirements set forth in §§ 201.12(b)(7) through 201.12(b)(13) and § 201.12(e). The items listed in those subsections are required to be submitted with the application for licensure so the Department can determine whether a prospective licensee is a responsible person under the act in order to own and operate a long-term care nursing facility. Once the prospective licensee becomes licensed, the Department uses surveys to measure compliance with the regulations and does not need this background information to be updated. For example, the Department does not need for the licensee to continuously update their regulatory history in other jurisdictions, which is required in § 201.12(b)(10). The Department also decided not to require that the information in § 201.12(b)(8) be updated within 30 days because the Department decided in final-form Rulemaking 3 – *Applications for Ownership, Management and Changes of Ownership; Health and Safety* to make the financial report an annual requirement, which will be submitted with a facility's application for renewal in § 201.13c (relating to license renewal). This assumes approval of Rulemaking 3.

Another commentator urged the Department to establish a policy of conducting visits to facilities after each report of a change in the information included in the application for licensure to ensure that the new owners are providing residents with appropriate care. After careful consideration and balancing the frequency of existing surveys, the Department declines to add this amendment. For new facilities, the Department conducts an occupancy survey before a facility opens, a survey after the facility opens, and a survey for certification once the facility has a few residents. The Department also conducts surveys of all facilities on an annual basis. Further, the Department conducts a survey of a facility when a complaint is received, including subsequent unannounced examinations. Lastly, to the extent any deficiencies were previously identified by a prior owner of a facility, a new owner is required to correct these deficiencies to retain a facility license.

Subsection (d)

Subsection (d) is amended from proposed to final-form. The Department had proposed to delete the first sentence in subsection (d), which requires the governing body to adopt effective administrative and resident care policies and bylaws governing the operation of the facility, to eliminate duplication and avoid conflict with the Federal requirements. In the second sentence of subsection (d), the Department had proposed to add a cross-reference to 42 CFR 483.70(d)(1) for clarity. The Department also deletes the phrase "shall be made available to the members of the governing body, which shall ensure that they are operational", because it is unnecessary and redundant. Finally, the Department replaces the term "responsible persons" with the term

"resident representatives" in the third sentence for consistency in the use of the term "resident representatives" throughout the regulations.

Some commentators objected to the deletion of the first sentence, urging the Department to retain the requirement that the governing body adopt administrative and resident care policies and bylaws. In response to these comments, the Department further examined the requirement in 42 CFR 483.70(d)(1) and agrees that it does not rise to this level of specificity. The Department, therefore, on final-form, retains the first sentence of existing subsection (d) and deletes the cross-reference to 42 CFR 483.70(d)(1) in the second sentence.

A commentator also suggested that the policies and bylaws required in this subsection be reviewed on an annual basis. The Department agrees with this suggested amendment, and on final-form, amends the second sentence in this subsection to require that the policies and bylaws be reviewed and revised "as often as necessary but at least annually."

Subsection (d.1)

Subsection (d.1) is amended from proposed to final-form. As explained on proposed, the Department moves the requirement in existing subsection (e) into subsection (d.1) with minor amendments. The Department replaces language requiring the governing body to appoint an administrator with a cross-reference to that requirement in 42 CFR 483.70(d)(2) of the Federal requirements. The Department retains the requirement that the administrator be currently licensed and registered in this Commonwealth and that the administrator be full-time. The Department removes the requirement in existing subsection (e) that a facility, with 25 beds or less, seek an exception to share an administrator with another facility. The Department adds language, in subsection (d.1), to permit a facility with 25 beds or less to share an administrator provided they meet certain conditions, set forth in paragraphs (1) through (5).

Some commentators expressed support for the addition of the requirements in this subsection that allow a facility with fewer than 25 beds to share an administrator. Commentators stated that the requirements are reasonable and eliminate the need for a facility to request an exception to the regulations to share an administrator, as was previously required in subsection (e). On final-form, the Department amends paragraph (3) to include the words "and resident representatives" after the word "resident." This amendment is in response to a comment recommending that there be a readily available method for resident representatives as well as residents to contact the administrator should they find it necessary.

One commentator and IRRC asked about the requirement in paragraph (4) that requires facilities that share an administrator to have a director of nursing with "adequate knowledge and experience to compensate for the time the administrator is not in the building." The commentator asked what is meant by "adequate knowledge and experience" and how that determination would be made. IRRC further asked what standards will determine "adequate knowledge and experience" and asked the Department to clarify this provision to establish enforceable standards that can be predicted by the regulated community. On final-form, the Department amends paragraph (4) by replacing the phrase "adequate knowledge and experience"

with "at a minimum, knowledge and experience of the facility, its policies and procedures and resident needs" to clarify the type of knowledge and experience that the director of nursing needs to have in order to fulfill the role of the shared administrator when they are not in the building. Specifically, administrators are knowledgeable with the details of a facility, including its policies and procedures and needs of the residents. This type of knowledge needs to be available in an administrator's absence to ensure that there is always someone on site who is equipped to respond to issues or emergencies that may arise, when that role is shared between two facilities with 25 beds or less.

Subsection (d.2)

This subsection is amended from proposed to final-form. As explained on proposed, the Department moves the requirement in the fourth sentence of subsection (e) into this subsection. The Department moves this requirement to its own subsection for clarity and ease of readability. One commentator requested that the Department amend this subsection to require that the administrator's "normal work schedule" be posted so that it does not have to be adjusted if the administrator needs to be absent without much notice. Other commentators requested that the Department add language requiring that the schedule include the days and times the administrator will be physically present in the building. IRRC also asked the Department to clarify the standards for implementation of this provision and what the expectations are for updating the accuracy of the schedule, and how often it is to be posted. IRRC specifically asked whether the schedule is to be posted daily or weekly, and whether the schedule can be a "normal" or "anticipated" schedule. IRRC also asked whether the schedule must be updated if the administrator gets sick. In response to these comments, on final-form, the words "anticipated biweekly work" are added before the word "schedule" to clarify the frequency and time when the administrator will be working. Further, the Department added the requirement that the administrator's "anticipated work schedule shall be updated within 24 hours of a change." This biweekly work schedule is required to be posted and kept up-to-date to, at a minimum, inform residents, resident representatives, staff and other visitors of the times the administrator is generally available and onsite.

Some commentators recommended that, in addition to the administrator's schedule being posted in the facility, it also be posted on a facility's public website. After careful consideration, the Department declines to make this amendment due to potential personal security concerns, access by others unrelated to the facility and the unintended consequence of requiring facilities to maintain a public website.

The same commentators suggested that the staffing numbers for all types of staff also be posted in the facility and on the facility's website. The Department notes that, under 42 CFR 483.35(g), a facility is already required to post, on a daily basis, the total number of hours worked by nursing personnel. That section also requires the information to be posted "in a prominent place readily accessible to visitors" as well as requiring that the facility "make nurse staffing data available to the public for review at a cost not to exceed the community standard." All facilities that participate in Medicare or MA are already required to comply with 42 CFR

483.35(g). This will be a new requirement for the three private-pay facilities under amended § 201.2 in final-form Rulemaking 1 - *General Applicability and Definitions*. This assumes approval of Rulemaking 1. The Department, however, declines to require staffing numbers for all staff types to be posted on a facility's website due to unintended consequence of requiring facilities to maintain a public website.

Subsection (e)

The main body of subsection (e) is amended from proposed to final-form. A commentator suggested that the Department add a requirement for the administrator to engage in an analysis of all financial information relevant to the operation of the facility and participate in the development of the facility's budget in conjunction with the governing body and licensee. The Department, in response to this comment, adds a cross-reference to the beginning of this subsection, to 49 Pa. Code § 39.91 (relating to standards of professional practice and professional conduct for nursing home administrators). Under 49 Pa. Code § 39.91, an administrator of a facility is required to provide or recommend the development of a budget, among other items related to financial management.

As explained on proposed, the Department also deletes the requirement in the first sentence of this subsection and moves it to subsection (d.1), with amendments. The Department also deletes the next two sentences. The ability of a facility to share an administrator is contemplated through the addition of the language in subsection (d.1), above, which will permit facilities with 25 beds or less to have a part-time administrator if the requirements in subsections (d.1)(1)—(4) are met. As noted previously, the Department also deletes the requirement in the fourth sentence and moves it, with amended language discussed above, into subsection (d.2). Amendments to paragraphs (1) through (7) are described more fully below.

Paragraph (1)

Paragraph (1) is unchanged from proposed to final-form. The Department did not propose any amendments to paragraph (1).

Paragraph (2)

Paragraph (2) is unchanged from proposed to final-form. The Department did not propose any amendments to paragraph (2).

Paragraph (2.1)

Paragraph (2.1) is amended from proposed to final-form. The Department had proposed to move into paragraph (2.1) existing language from § 207.2(a) (relating to administrator's responsibility), requiring an administrator to ensure satisfactory housekeeping and maintenance of the building and grounds. The Department proposed this amendment so that the administrator's responsibilities are all together in one place in the regulations. Although this was existing language and, therefore, already required by the regulated community, a commentator questioned the meaning of the word "satisfactory" before the word "housekeeping," commenting that this qualifier is vague and could be widely interpreted based on an individual's personal

standards. IRRC also asked what standards will determine "satisfactory housekeeping" and asked the Department to clarify this provision to establish enforceable standards that can be predicted by the regulated community.

In response to these comments, the Department amends § 201.18(e)(2.1), on final-form, to add the words "that a sanitary, orderly and comfortable environment is provided for residents through" before the word "satisfactory." The addition of this language clarifies these standards and aligns with a resident's right to a safe, clean, comfortable, and homelike environment in 42 CFR 483.10(i), and the requirement in 42 CFR 483.10(i)(2) that a facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Although the Federal requirement does not express who within the facility is responsible for this task, existing § 207.2(a) assigned this responsibility to the administrator. The Department is maintaining this requirement in State regulation, but moving it to § 201.18(e)(2.1) with the above amendment. All facilities, including the three private-pay facilities, are currently required to comply with 42 CFR 483.10(i) under existing § 201.2.

Paragraph (3)

Paragraph (3) is amended from proposed to final-form. The Department did not propose any amendments to paragraph (3). However, some commentators recommended that there be a requirement that the administrator report to the governing body at least monthly regarding the operation of the facility, including survey results, allegations of abuse or neglect, complaints or other information related to the safety of the facility's residents. They also suggested that the regulations require the governing body to respond in writing to the report within thirty days with a plan to address noncompliant conduct.

In response to these comments, the Department amends paragraph (3), on final-form, to require the administrator to report as often as necessary, but at least monthly to the governing body. . In addition, this amendment requires meetings and reports with medical and nursing staff and other professional and supervisory staff as often as necessary, but at least on a monthly basis. Further, the word "periodic" is deleted before the word "reports." The Department, however, declines to add a requirement that the administrator prepare and submit a report that meets specific criteria and that the governing body respond to the report in writing within a certain period. Under this paragraph, the administrator is already required to maintain an "ongoing relationship with the governing body." Additionally, under 42 CFR 483.70(d)(2)(iii), the administrator reports to and is accountable to the governing body. If the governing body, which is responsible for implementation of the policies related to the management and operation of the facility, wishes to require additional or more specific reporting of certain information from the administrator, it may do so. Facilities that participate in Medicare or MA are already required to comply with 42 CFR 483.70(d)(2)(iii). This will be a new requirement for the private-pay facilities under the expansion of the Federal requirements in amended § 201.2, in final-form Rulemaking 1– *General Applicability and Definitions*. This assumes approval of Rulemaking 1.

Some commentators suggested that the facility assessment process also include a detailed review of operations by the governing body. After careful consideration, the Department declines to make this amendment. As further discussed in final-form Rulemaking 3 –

Applications for Ownership, Management and Changes of Ownership; Health and Safety, under § 201.14 (relating to responsibility of licensee), facility assessments are focused on residents' needs and the resources needed to care for them, including staffing and training needs. In order to emphasize this focus and maintain congruency with Federal requirements under 42 CFR 483.70(e), the Department declines to make this change.

Paragraph (4)

Paragraph (4) is unchanged from proposed to final-form. The Department did not propose any amendments to paragraph (4).

Paragraph (5)

Paragraph (5) is unchanged from proposed to final-form. As explained on proposed, the Department replaces the term "employe" with the term "employee" for correct usage and spelling of that term.

Paragraph (6)

Paragraph (6) is unchanged from proposed to final-form. The Department did not propose any amendments to paragraph (6).

Paragraph (7)

Paragraph (7) is unchanged from proposed to final-form. The Department did not propose any amendments to paragraph (7).

In addition to the comments received to paragraphs (1) through (7) above, some commentators recommended that the administrator also be responsible for clearly and openly communicating to residents and resident representatives any updates about the composition of or decisions made by the governing body. After careful consideration, the Department declines to make this amendment on final-form. It may not be necessary for residents to be informed of every decision made by the governing body. Decisions that impact residents, such as changes to policies, should be communicated by the facility to residents. This is required communication under various notice provisions of the Federal regulations. *See e.g.*, 42 CFR 483.10(c), (f)(v) and (vi), (g)(1) and (12), (16), (18), (j)(4) (relating to resident rights). With regards to communicating "clearly and openly," this is also addressed under the Federal requirements. Under 42 CFR 483.10(g)(3), the facility is required to provide information to each resident in a form and manner the resident can access and understand. Facilities that participate in Medicare or MA are already required to comply with 42 CFR 483.10(g)(1) and (3). Further, the three private-pay facilities are already required to comply with 42 CFR 483.10(g)(1) under existing § 201.2. However, the requirement in 42 CFR 483.10(g)(3) (regarding clear communications) will technically be a new requirement for the three private-pay facilities under amended § 201.2 in final-form Rulemaking 1– *General Applicability and Definitions*. This assumes approval of Rulemaking 1.

Subsection (f)

Subsection (f) is unchanged from proposed to final-form. As explained on proposed, the Department replaces the term "responsible person" with the term "resident representative" for consistency in the use of that term throughout the regulations. The Department also deletes the words "and funds" and the phrase "and for expenditures and disbursements made on behalf of the resident" to eliminate duplication and avoid conflict with the Federal requirements at 42 CFR 483.10(f)(10) and (11) (relating to resident rights), which address the facility's responsibility for resident funds.

Some commentators disagreed with the deletion of the language related to funds and expenditures and disbursements made on behalf of a resident, asserting it is important that a facility maintain a complete record regarding use of resident funds. Commentators asserted that the existing provision is more protective than the Federal requirements, with one commentator noting that the existing language requires the record of use of funds be always available, while the Federal requirements provide for financial records to be available to residents through quarterly statements. IRRC asked that the Department explain the need for and reasonableness of residents only receiving quarterly statements.

Contrary to these comments, a complete record is required under 42 CFR 483.10(f)(10)(iii)(A), which states that the facility must "establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf." In addition, under 42 CFR 483.10(f)(10)(iii)(C), an individual financial record must be available to the resident "through quarterly statements *and upon request*" (emphasis added). This means that a written record must be maintained and may be requested by a resident at any time. The Department, therefore, declines to amend subsection (f) in response to comments. Facilities that participate in Medicare or MA are already required to comply with 42 CFR 483.10(f)(10(iii) (C). This will be a new requirement for the three private-pay facilities under the expansion of the Federal requirements in amended § 201.2, in final-form Rulemaking 1– *General Applicability and Definitions*. This assumes approval of Rulemaking 1.IRRC also asked the Department to explain how the final regulation protects the public health, safety, and welfare related to records of residents' personal possessions. The Department did not propose any changes in this subsection related to what the facility must do related to residents' personal possessions, and that standard remains the same on final-form. Under these provisions, a facility is required to maintain a written record on a current basis for each resident with written receipts for personal possessions received or deposited with the facility. This record is also available upon request. In addition, the Department has added on final-form, a requirement related to the return of personal property in § 201.18(b)(2) in response to comments, as explained further in that section.

Subsection (g)

Subsection (g) remains unchanged from proposed to final-form. The Department did not propose any amendments to this subsection.

Subsection (h)

Subsection (h) is amended from proposed to final-form. As explained on proposed, the Department replaces the term "resident's responsible person" with "resident representative" for consistency in the use of that term throughout the regulations. The Department also deletes the last sentence requiring a facility to provide resident with access to their money, either cash or check, within 3 business days when requested by the resident. The Department updates this provision with a requirement that a facility provide the resident with cash, if requested, within 1 day of the request, or with a check, if requested, within 3 days of the request. The requirement that a facility provide a resident with cash, if requested within 1 day was new, on proposed. As explained by the Department, on proposed, based on the discussions with the LTC Work Group, facilities typically have enough cash on hand, or can obtain cash quickly, and therefore, should be able to provide a resident with cash, if requested, within 1 day. The Department is requiring that a check be provided, if requested, within 3 days because specific personnel are often needed to process a check and these personnel may not be onsite every day.

Some commentators opposed the amendments to this subsection, arguing that allowing a facility three days to provide a check to a resident is unnecessary, and that residents should have access to their funds almost immediately after a request is made. Some commentators suggested that all requests be processed within one day of the request, including requests for checks. Other commentators opposed the requirements in this section because of the challenges facilities could encounter fulfilling requests for funds. One commentator suggested that a facility only be required to provide cash within one day if the amount requested is $100 or less, while greater amounts be provided within one bank business day. Another commentator recommended that the section be amended to require the requests for cash and checks to be provided within one and three business days, respectively. This commentator asserted that most facilities do not have ATM cards for residents. In balancing the competing interest between consumer advocates and industry stakeholders, the Department will maintain the number of days required to respond to resident requests for funds via cash or check, as provided on proposed. IRRC noted that the Department on proposed removed the words "bank business" from the regulation and asked the Department to clarify how days are to be counted for implementation of the final-form regulation. In accordance with the Rules of Statutory Construction, the language "day" is interpreted as calendar days. 1 Pa.C.S. § 1991 (relating to definitions); 1 Pa.Code § 1.7 (relating to Statutory Construction Act of 1972 applicable). Given the increased accessibility of funds since the original promulgation of this provision, and in balancing residents' access to their funds with a facility's business practices, the Department is maintaining the time period as provided on proposed.

Some commentators pointed out that there is no recognition in this subsection of the possibility of electronic transfer of funds. These commentators recommend that there be an acknowledgement of this option and a corresponding requirement that electronic transfer of funds be processed within one day. The Department agrees. In response to this comment, subsection (h) is amended on final-form to include a requirement that, if a facility utilizes electronic transfers, the facility shall initiate an electronic transfer of funds, if requested, within one day of the request.

§ 201.19. Personnel records

The title and main body of this section is unchanged from proposed to final-form. As explained on proposed, the Department amends the name of this section from "personnel policies and procedures" to "personnel records," as this title more accurately describes the requirements of this section. The Department also replaces the term "employe" with the term "employee" to reflect the current usage and spelling of that term. The Department also adds the word "facility" before the word "employee" to clarify that this section applies to employees of the facility. The Department replaces the word "sufficient" with the words "the following" and to delete "to support placement in the position to which assigned" after the word "information." As explained on proposed, these amendments reflect the addition of several new requirements in paragraphs (1) through (9) of this section, as further explained below.

Paragraph (1)

Paragraph (1) is unchanged from proposed to final-form. As explained on proposed, the Department is codifying that the personnel records for each facility employee contain the employee's job description, educational background and employment history. This requirement is currently part of the Department's interpretive guidelines for § 201.19 (relating to personnel records). The Department is codifying this requirement in this section for clarity. Department of Health Interpretive Guidelines. Retrieved from: https://www.health.pa.gov/topics/Documents/Laws%20and%20Regulations/interpretive_guidelines_for_state_regs.pdf.

Paragraph (2)

Paragraph (2) is amended from proposed to final-form. As explained on proposed, the Department is codifying the current requirement that the personnel records for each facility employee contain employee performance evaluations. The Department is codifying this requirement for clarity. Some commentators recommended that an employee's personnel record include documentation of any monitoring, performance, or disciplinary action related to the employee. The Department agrees that information related to an employee's past performance is important to retain on file and is relevant to protecting the health, safety, and welfare of residents. The Department, therefore, amends this paragraph on final-form to add "including documentation of any monitoring, performance, or disciplinary action related to the employee" after the word "evaluations."

Paragraph (3)

Paragraph (3) is amended from proposed to final-form. As explained on proposed, the Department is codifying the current requirement that the personnel records for each facility employee contain documentation of current certification, registration or licensure, if applicable, for the position to which the employee is assigned. The Department is including this requirement in regulation to make it clear that facilities are expected to include this item in employee personnel records. Some commentators suggested that all the employee's credentials be included in the employee's personnel record. One commentator recommended that this paragraph be

amended to include the words "all credentials including but not limited to" before the words "current certification." The Department agrees that a requirement for credentials is reasonable, as the employee could have other relevant credentials that are not contemplated by the Department's requirement for "current certification, registration or licensure." The Department, therefore, on final-form, adds the words "credentials, which shall include, at a minimum" before the words "current certification, registration or licensure."

Paragraph (4)

Paragraph (4) is unchanged from proposed to final-form. As explained on proposed, the Department is codifying the current requirement that the personnel records for each facility employee contain a determination by a health care practitioner that the employee, as of the employee's start date, is free from the communicable diseases or conditions listed in § 27.155 (relating to restrictions on health care practitioners). The Department is codifying this requirement for clarity.

Paragraph (5)

Paragraph (5) is amended from proposed to final-form. As proposed, paragraph (5) mirrored an existing requirement for hospitals under §103.36 (relating to personnel records). Although the Department did not receive any comments on this paragraph, based on comments to § 201.21(e)(relating to use of outside resources), the Department has removed the "physically able" language to clarify that it is not the intent of this provision to have any impact on an individual's disability, if any, or to impact a facility's reasonable accommodation under the Americans with Disability Act (42 U.S.C.A. §§ 12101 - 12213). On final-form, this section was clarified to require that an employee personnel file contain records relating to a medical exam, if required by a facility, or attestation that the employee is able to perform the employee's job duties.

Paragraph (6)

Paragraph (6) is unchanged from proposed to final-form. As explained on proposed, the Department is requiring that the personnel records for each facility employee contain documentation of the employee's orientation to the facility and the employee's assigned position prior to or within 1 week of the employee's start date. This requirement is currently part of the Department's interpretive guidelines for § 201.19. The Department is including this requirement in regulation to make it clear that facilities are expected to include this item in employee personnel records.

Paragraph (7)

Paragraph (7) is amended from proposed to final-form. As explained on proposed, the Department is requiring that the personnel records for each facility employee contain documentation of the employee's completion of required trainings. This requirement is currently part of the Department's interpretive guidelines for § 201.19. The Department is including this requirement in regulation to make it clear that facilities are expected to include this item in

employee personnel records. Some commentators suggested that an employee's personnel record include a record of all training the employee receives. One commentator recommended that this paragraph be amended to include the words "initial, annual, and ongoing" before the word "training." In response to this comment, the Department adds "under this Chapter, including documentation of orientation and other trainings" to clarify that documentation of completed trainings must include all trainings required under this Chapter.

Paragraph (8)

Paragraph (8) is amended from proposed to final-form. On proposed, this paragraph provided for the recordkeeping of an employee's criminal history record. In consideration of public comments and comments received from IRRC, the Department is clarifying the language on final-form that a copy of the final report from the Pennsylvania State Police and the Federal Bureau of Investigation be maintained in accordance with the Older Adult Protective Services Act (OAPSA) (35 P.S. § 10225.502), the Adult Protective Services Act (35 P.S. §§ 10210.101-10210.704) and applicable regulations. Under these statutory and regulatory provisions, there is an existing requirement for the submission of a criminal history background check for individuals applying for employment in a long-term care nursing facility. Further, the Commonwealth Court's decision in *Peake v. Commonwealth*, 132 A.3d 506 (Pa. Cmwlth. 2015) (holding statutory lifetime employment bans to be facially unconstitutional with consideration of relevant factors) does not impact the statutory requirement to submit a criminal background check, as further detailed below.

One commentator recommended that the Department require comprehensive national background checks for all long-term care facility employees. The commentator asserted that background checks protect consumers. The Department appreciates this comment and agrees that criminal background checks are a consumer protection and must be obtained in accordance with law. As provided above, applicants for employment are required to obtain a criminal background check in accordance with section 502 of OAPSA, the Adult Protective Services Act and the applicable agency's regulations. Further, the Department is supportive of legislative updates to the criminal background and employment provisions under OAPSA through the legislative process in order to provide further protections to consumers and address the employment ban provision decided in *Peake*. In addition, another commentator recommended this section be amended to require that other background checks be maintained as part of the personnel file. However, it is unclear what is intended with the suggested "other background checks" language. As provided above, the Department is clarifying this language on final-form to specify that a personnel record include a copy of the final report from the Pennsylvania State Police and the Federal Bureau of Investigation in accordance with the Older Adult Protective Services Act, the Adult Protective Services Act, and the applicable regulations.

Paragraph (9)

Paragraph (9) is amended from proposed to final-form. On proposed, the Department added this paragraph to require, in the event that an employee has a conviction, that a facility

include in the employee's personnel record a determination of the employee's suitability for employment in the position to which the employee is assigned. The Department recognizes that hiring decisions should be made on a case-by-case basis, and are dependent upon individual circumstances. For resident safety, this provision requires a facility document that the facility determine an applicant or employee's suitability for employment when the applicant or employee has been convicted of a criminal offense. This language is in response to the Commonwealth Court's decision in *Peake v. Commonwealth*, 132 A.3d 506 (Pa. Cmwlth. 2015), which determined statutory lifetime bans to be unconstitutional without the consideration of various factors. IRRC also inquired regarding the type of information to be included and the reasonableness of this requirement. Further, IRRC inquired whether this provision is consistent with the Commonwealth Court's decision in *Peake v. Commonwealth*, 132 A.3d 506 (Pa. Cmwlth. 2015). In addition, a commentator asserted there may be attorney-client privilege concerns related to suitability for employment determination in a personnel file.

After careful consideration of the comments received, the Department clarified this language to provide that documentation of a determination of suitability for employment be maintained in a personnel file. The Department added a definition of "suitability for employment" to further clarify this provision. As defined, "suitability for employment" includes a review of the offense; the length of time since the individual's conviction; the length of time since incarceration, if any; evidence of rehabilitation; work history; and the employee's job duties. These factors are consistent with the factors to be considered as articulated in *Peake*. Specifically, the Department is not requiring an employment ban, but instead is requiring documentation that a facility considered these enumerated factors as a consumer protection. In addition to this provision, the Department continues to support legislative amendments to the Older Adults Protective Services Act to update consumer protections and address the court's decision in *Peake* regarding statutory lifetime employment bans. In response to comments regarding attorney-client privilege, the Department is clarifying that it does not intend to have privileged documents between the facility and its counsel as part of an employee's personnel record. Instead, this requirement is to provide documentation that the facility considered the enumerated factors when hiring or maintaining an employee when that person is convicted of a criminal offense.

Paragraph (10)

This paragraph is new on final-form and is added at the request of commentators to require that the personnel records for each facility employee contain the employee's completed employment application. This requirement is reasonable and likely a common business practice. The Department, therefore, adds this requirement on final-form.

Other comments

A commentator stated generally that personnel records should not be limited to what is listed in this section of the regulations. The Department agrees that other information may be kept on file, in conformance with the law, to meet the needs of the facility. The requirements under Subpart C (relating to long-term care facilities) are minimum health and safety

requirements for licensure in the Commonwealth. The Department notes there is nothing in this section that should be construed as limiting the contents of personnel record files. Rather, this section is intended only to set forth the minimum requirements for a facility. Facilities are encouraged to go beyond the minimum standards to set forth additional requirements to meet the needs of the facility and the residents.

Some commentators recommended that, in addition to the requirements in paragraphs (1) through (9), an employee's personnel record include a record of the employee's receipt of required vaccinations. The only vaccine that is currently required is the COVID-19 vaccine. Current Federal requirements related to COVID-19 vaccinations are found at 42 CFR 483.80(i) (relating to infection control), which requires a facility to develop and implement policies and procedures to ensure staff is vaccinated for COVID-19. All facilities that participate in Medicare or MA are required to comply with 42 CFR 483.80(i). This will be a new requirement for the private-pay facilities by virtue of the expansion of the incorporation of the Federal requirements in § 201.2 in Rulemaking 1 – *General Applicability and Definitions*. This assumes approval of Rulemaking 1. Currently, when demonstrating compliance with 42 CFR 483.80(i), facilities usually maintain such information in the aggregate and in one place, along with all necessary documentation related to the facility's compliance with vaccination-related policies and procedures. For example, under 42 CFR 483.80(i)(3)(iii), a facility is required to have a process for ensuring the implementation of additional precautions for staff who are not fully vaccinated, and under 42 CFR 483.80(i)(3)(iv), a facility is required to have a process for tracking exemptions. The most streamlined approach for ensuring compliance with vaccination requirements at this time is to permit a facility to use a centralized process, rather than requiring that they separately maintain information related to the employee's vaccination status in the personnel record for each employee. Therefore, the Department declines to add a requirement that vaccination status be maintained in each employee's personnel record.

One commentator disagreed with the Department's proposal to rename this section to "personnel records" and instead recommended that the Department rename this section to broaden its contents to cover all facility policies and procedures. In addition, the commentator recommended that the Department require, under this section, that a facility have written policies and procedures related to several specific topics, described below. The Department declines to make this amendment on final-form for the reasons identified below.

First, the commentator recommended language requiring facilities to have policies and procedures related to "hygiene, infection control and tracking resident interactions (for contract tracing)." This requirement is not added on final-form because this would be duplicative of Federal requirements at 42 CFR 483.80(a) (relating to infection control), which provide that the facility's infection prevention and control program must include written standards, policies and procedures for the program. The requirement for written standards, policies and procedures for infection control will technically be a new requirement for the three private-pay facilities under the expansion of the incorporation of the Federal requirements in § 201.2 in Rulemaking 1 – *General Applicability and Definitions*. This assumes approval of Rulemaking 1.

Next, the commentator recommended that the regulations include a requirement that facilities have written policies and procedures related to "hiring, staffing, staff sick time and sick pay and other family leave policies." While in practice a facility should have such policies, the Department declines to prescribe a facility's internal employment policies, such as policies related to the accrual of leave and other employment and human relations matters. The purpose of the Department's authority under the act is to provide minimum licensure standards to protect the health, safety and welfare of residents of long term care nursing facilities. Further, employment and labor related policies and procedures are outside of the Department's grant of statutory authority. Therefore, the Department declines to make this amendment on final-form.

Next, the commentator recommended that the regulations include a requirement that facilities have written policies and procedures related to cultural non-discrimination. The Department has included in § 201.29 (relating to resident rights), as amended on final-form, protections from discrimination on the basis of race, color, familial status, religious creed, ancestry, age, sex, gender, sexual orientation, gender identity or expression, national origin, ability to pay, handicap or disability, use of guide or support animals because of the blindness, deafness or physical handicap of the resident or because the resident is a handler or trainer of support or guide animals. In addition, specific Federal requirements also address the protection of a resident's cultural preferences. For example, under 42 CFR 483.10(c)(3)(iii) (relating to resident rights), in the development and implementation of a resident's person-centered plan of care, the planning process must incorporate a resident's personal and cultural preferences in developing goals of care. Similarly, when preparing foods and meals, a facility must take into consideration residents' religious, cultural and ethnic needs and preferences and the overall cultural and religious make-up of the facility's population. 42 CFR 483.10(f)(2); 483.60(c) (relating to food and nutrition services). All facilities will be required to comply with these regulatory requirements, by virtue of § 201.2, as amended in Rulemaking 1– *General Applicability and Definitions*. This assumes approval of Rulemaking 1. The Department therefore declines to make this amendment.

Next, the commentator recommended that the regulations include a requirement that facilities have written policies and procedures related to "guaranteed access to the facility (for LTC Ombudsman, Protective Services, surveyors, etc.)." The right to receive visitors is set forth in the Federal requirements at 42 CFR 483.10(f)(4)(i) (relating to resident rights), which require that the facility provide immediate access to any resident by any representative of the State, and any representative of the Office of the State Long-Term Care Ombudsman, among others. All facilities, including the three private-pay facilities, are required to comply with 42 CFR 483.10(f)(4)(i) under existing § 201.2, and will continue to be required to do so under amended § 201.2, in Rulemaking 1– *General Applicability and Definitions*. In addition, section 813(a) of the act (35 P.S. § 448.813(a)) provides the Department with authority to enter and inspect facilities for the purpose of determining the adequacy of the care and treatment provided to residents. The act also defines "survey" as an announced or unannounced examination which may include an onsite visit, for the purpose of determining a facility's compliance with licensure requirements. 35 P.S. § 448.802a. Therefore, the Department may conduct an announced or

unannounced survey of a facility regardless of whether a facility permits this through written policies and procedures. The Department, therefore, declines to make this amendment.

Next, the commentator recommended that the regulations include a requirement that facilities have written policies and procedures related to "conducting person-centered service planning and providing person-centered care." The Department appreciates this comment and supports person-centered care. Section 211.10 (relating to resident care policies), as amended in this final-form rulemaking, includes requirements related to resident care policies that address the total medical, nursing, and mental and psychosocial needs of residents. Further, as explained in further detail under § 211.2 (relating to medical director), medical directors are required to support and promote person-directed care, including choice regarding medical care options. Under the minimum Federal health and safety requirements, comprehensive person-centered care planning is required. 42 CFR 483.21 (relating to comprehensive person-centered care planning). Specifically, a facility is required to develop and implement care plans that provide comprehensive, effective and person-centered care. Under the Federal definitions, person-centered care means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives. 42 CFR 483.5 (relating to definitions).

The commentator also recommended that the regulations include a requirement that facilities have written policies and procedures related to "mandatory reporting of abuse, neglect, and exploitation and reporting of critical/adverse incidents or sentinel events." Under 42 CFR 483.12(b) (relating to freedom from abuse, neglect, and exploitation), a facility is required to develop and implement policies and procedures related to abuse, neglect and exploitation, which includes: the prohibition and prevention of abuse, neglect and exploitation; investigation of any such allegations; trainings; establishing coordination with the Quality Assurance and Performance Improvement (QAPI) program; and reporting requirements. In addition, State law also addresses the requirement to report abuse, neglect and exploitation under the Older Adults Protective Service Act (35 P.S. §§ 10225.101 – 10225.5102) and the Adult Protective Services Act (35 P.S. §§ 10210.101 – 10210.704). In addition, under 28 Pa. Code § 51.3 (relating to notification), a facility is required to notify the Department of events that seriously compromise quality assurance or resident safety. The Department, therefore, declines to make this amendment. The requirement for a facility to develop and implement policies and procedures related to abuse and neglect are not new for the private-pay facilities. However, the notification and written policy requirements under 42 CFR 483.12(b) will technically be new for the private-pay facilities under amended § 201.2 in final-form Rulemaking 1– *General Applicability and Definitions*. This assumes approval of Rulemaking 1.

The same commentator also recommended that the regulations require that facilities submit all written policies to the Department and that facilities notify the Department, residents, resident representatives, and the Office of the Long-Term Care Ombudsman 30 days in advance of changes to any policies. The commentator also recommended requiring all policies and procedures always be available to the Department.

After careful consideration, the Department declines to make this amendment on final-form. While the Department appreciates this comment, it would be logistically impossible for the Department to manage and maintain a record of every policy and procedure for the 682 licensed long-term care nursing facilities on an ongoing basis. Under § 201.12(e), as amended in final-form Rulemaking 3 – *Applications for Ownership, Management and Changes of Ownership; Health and Safety*, the Department is requiring prospective licensees to submit specific documentation when applying for licensure to demonstrate preparedness to operate a facility. That documentation includes a proposed staffing and hiring plan, a proposed training plan for staff, a proposed emergency preparedness plan, a proposed standard admissions agreement, and a 3-year budget. Once licensed, the facility is responsible for compliance with all regulatory requirements, including requirements for policies and procedures, such as those in § 201.18(d)(relating to management), which requires that the governing body adopt effective administrative and resident care policies.

In addition, it is important that facilities have the ability to update policies and procedures as needed in response to resident and business needs without prior approval. As to accessibility of written policies and procedures, section 813(a) of the act (35 P.S. § 448.813(a)) provides the Department with authority to enter and inspect facilities for the purpose of determining the adequacy of the care and treatment provided to residents and compliance with departmental requirements. Specifically, the Department is granted the authority to review policies and procedures of the facility while conducting such a survey. As defined by the act, the term "survey" is "an announced or unannounced examination by the Department of Health or its representatives, which may include an onsite visit, interviews with employees, patients and other individuals and review of medical and facility records." 35 P.S. § 448.802a. As such, it is not necessary for the Department to add this suggested amendment.

The same commentator also recommended that policies and procedures be reviewed and updated at least annually in accordance with best practices in resident care and service delivery. The Department agrees with this recommendation. Under § 201.18(d) (relating to management), as further detailed above, the Department has added a requirement that administrative and resident care policies be reviewed and revised by the governing body at least annually. Although the Department encourages facilities to consider best practices when establishing, reviewing and implementing policies and procedures, the Department does not require best practices in regulation since licensure of facilities is governed by the minimum health and safety standards for protection of the health, safety and welfare of residents. As such, the Department declines to make this amendment.

§ 201.20. Staff development

Subsection (a)

Subsection (a) is amended from proposed to final-form. As explained on proposed, the Department moves the requirement that a facility provide, at a minimum, annual in-service training from subsection (c) to this subsection, to add a cross-reference to the Federal training requirements in 42 CFR 483.95 (relating to training requirements), and to include from existing

subsection (c) accident prevention, restorative nursing techniques, emergency preparedness and fire prevention and safety as additional training topics. The Department deletes from subsection (c) those requirements that are duplicative of the Federal requirements in 42 CFR 483.95 and moves from subsection (c) those topics that are not covered under 42 CFR 483.95. For additional clarity and ease of readability, the Department places these training topics into an enumerated list.

The topics deleted from subsection (c) include infection prevention and control, residents' confidential information, residents' psychosocial needs and resident rights, as these are required as part of the training requirements in 42 CFR 483.95. The Department retains and moves into subsection (a), accident prevention and restorative nursing techniques, as these two topics are not covered within the training requirements in 42 CFR 483.95. The Department retains these two training requirements to ensure the health and safety of residents. The Department also retains and moves into subsection (a), emergency preparedness and fire prevention and safety as training topics, as they are not covered within 42 CFR 483.95. These topics are covered elsewhere in the Federal requirements, but because they are not covered specifically in 42 CFR 483.95, the Department retains them in this subsection with cross-references for clarity. Disaster preparedness is covered under 42 CFR 483.73(d) (relating to emergency preparedness), which requires facilities to develop and maintain an emergency preparedness training and testing program that is based on their emergency plan. Fire prevention and safety training is required by the National Fire Protection Association's *Life Safety Code* (*Life Safety Code*), which has been adopted in the Federal requirements in 42 CFR 483.90(a) (relating to physical environment). Under sections 18.7.2.3.1 and 19.7.2.3.1 of the *Life Safety Code*, all facility personnel are to be instructed in their role in the use of and response to fire alarms.

Also, as explained in further detail below, the Department adds training requirements for resident rights, including nondiscrimination and cultural competency, and a general requirement for annual training based on needs identified through a facility assessment. The training requirements in 42 CFR 483.95, except for certain training requirements for nurse aides in 42 CFR 483.95(g)(2) and (3), will be new for the three private-pay facilities by virtue of § 201.2, as amended in Rulemaking 1 – *General Applicability and Definitions*. This assumes approval of Rulemaking 1.

Commentators requested the addition of various training requirements, including the following: disability competency; physical, intellectual, and mental health disabilities; assistive technology; physical accessibility; disability rights; available accommodations when voting; understanding dementia, Alzheimer's disease and effective communication skills; best care practices, including person-centered care, restraint-free care and social engagement, and communication with people with dementia; dementia training with a competency requirement; gerontology; nondiscrimination; racial equity and implicit bias; LGBTQ cultural competency; cultural sensitivity/competency trainings; person-centered care; assessment and care planning; activities of daily living; medical management information education; support, staffing, supportive and therapeutic environments; transitions and coordination of services; detection and the reporting of resident abuse, neglect and exploitation; best practices for infection prevention,

detection and control; cleaning and disinfecting processes and procedures; fire prevention and resident safety; accident prevention; confidentiality on information; resident psychological needs; restorative nursing techniques; understanding brain injury; incident reporting; and donning and doffing of personal protective equipment. A commentator also requested specific training topics for administrative staff related to dementia care and treatment, person-centered care, assessment and care planning, activities of daily living, medical management information education and support, staffing, supportive and therapeutic environments, transitions and coordination of services. In addition, commentators also requested the Department require demonstration of competency through a combination of observation and competency testing. Commentators also suggested specifying the hours of each type of training, ranging from 4 to 16 hours of annual training, and providing the portability of training.

The Department appreciates the myriad of suggested training topics. However, instead of enumerating a long list of training requirements, the Department, on final-form, adds a requirement for annual in-service training on resident rights, including nondiscrimination and cultural competency, and any other training needs identified through a facility assessment. The Department is enumerating annual resident rights' training to emphasize the importance of these rights and resident health and safety. In addition, instead of listing a wide array of required annual training topics with minimum training hours, the Department adds the provision for training based on needs identified through a facility assessment. The purpose of a facility assessment is to evaluate resident acuity, ensure adequate and appropriately-trained staff, and assess the needs of a facility's specific resident population. Specifically, by identifying these specific resident needs, a facility can tailor its training of its staff to meet these needs, both in topics covered and duration. Similarly, training that results from facility-specific assessments is not necessarily portable. As such, the Department declines the recommendation of portability of training due to the preference that tailored training be provided annually at each facility. This reinforces training content, recognizes evolving standards, resident needs and best practices.

In addition, the Department declines to add annual training requirements on subjects that are already enumerated under Federal training requirements in 42 CFR 483.95 (relating to training requirements). The federally-required training includes, but is not limited to, resident abuse prevention and reporting, dementia management, infection control, resident rights and quality assurance and performance improvement.

Subsection (b)

Subsection (b) is amended from proposed to final-form. As explained on proposed, the Department replaces the term "employe" with the term "employee" for current usage and spelling of that term. On proposed, the Department deleted the second sentence of this subsection because training on the prevention of resident abuse and reporting of abuse is covered under the Federal training requirements. A commentator objected to deletion stating that although the Federal training requirements include this topic, the Federal requirements do not require the topic at orientation. IRRC also requested the Department to explain how the final regulation protects the public health, safety, and welfare related to training on the prevention and reporting of abuse.

After careful consideration, the Department agrees with this recommendation. Based on the comments received, on final-form, the Department clarifies that orientation shall include training on the prevention, detection and reporting of resident abuse and dementia management and communication skills.

A commentator also suggested language be added to this subsection to clarify that training be provided in a manner that effectively conveys information and results in the learning of material. The commentator clarified that adding this language would alleviate concerns related to the potential for merely picking up literature and signing in that training was provided. The Department agrees that merely distributing literature is not training. Under the dictionary definition, "to train" means "to teach so as to make fit, qualified, or proficient." https://www.merriam-webster.com/dictionary/train. Although the Department agrees that mere distribution of literature is not training, the Department declines to add this language since training is an understood term. Further, Federal training requirements require that a facility develop, implement and maintain an effective training program. 42 CFR 483.95.

Other commentators suggested orientation be expanded to include infection prevention, detection, and control procedures; emergency, pandemic, and disaster preparedness planning and preparedness, fire prevention and resident safety procedures, incident reporting and accident prevention procedures, person-centered service planning and care, understanding dementia and effective communication skills with people living with dementia and how to apply that to residents of the facility; transfer techniques; assistance with feeding; and management of aggressive behaviors. A commentator also suggested facility-specific and resident-specific orientation be added.

As provided previously, the Department adds dementia management and communication skills, in addition to resident abuse prevention, detection and reporting, as orientation topics to emphasize their importance and resident health and safety. The Department declines, however, to enumerate a vast array of required orientation subjects due to concerns related to length and breadth of orientation. As provided previously, certain training topics are required under Federal regulations or listed under subsection (a), such as accident prevention, emergency preparedness, and fire prevention and safety. Based on a facility's assessment, a facility shall tailor its orientation and training to meet its facility, staffing and resident needs. Specifically, a facility is required to develop, implement and maintain an effective training program based on the needs of residents and staff. 42 CFR 483.95. As previously noted, the training requirements in 42 CFR 483.95, except for certain training requirements for nurse aides in 42 CFR 483.95(g)(2) and (3), will be new for the three private-pay facilities by virtue of § 201.2, as amended in Rulemaking 1 – *General Applicability and Definitions*. This assumes approval of Rulemaking 1.

Subsection (c)

Subsection (c) remains deleted on final-form. As explained on proposed, the Department deletes this subsection in light of the proposed amendments to subsection (a), as described previously. A commentator requested this subsection remain on final-form and additional training topics be required. As explained above, training requirements are not being removed

and this subsection has been folded into subsection (a). Further, training topics have been expanded on final-form. However, the Department declines to add the myriad of topics requested by commentators. In addition to the training required under subsection (a), a facility shall tailor its orientation and training to meet its facility, staffing and resident needs based on its facility assessment.

Subsection (d)

Subsection (d) is unchanged from proposed to final-form. As explained on proposed, the Department deletes the word "the" between the words "at" and "staff development programs." A commentator requested adding a requirement for the method and format of the training records. The commentator also suggested a competency requirement be added. After careful consideration, the Department declines this recommendation since the existing regulation requires written records for training programs, including the content of the training and attendance. Further, based on a facility's assessment, training should be provided that is tailored to its employees and resident needs. This includes the method and format for meeting these training needs and requirements. In addition, as provided in further detail above, the Department declines to add competency requirements.

Other Comments

A commentator stated that it is critical that training requirements be increased, including participating in quality improvement efforts. Two other commentators requested that training requirements be clarified to provide that training be provided by appropriately knowledgeable trainers. Another commentator restated its support of portability of training. A commentator also requested training on understanding dementia and effective communication skills.

To clarify, the Department is not reducing or eliminating any training requirements. As explained previously, the Department is cross-referencing the minimum training requirements in 42 CFR 483.95 (relating to training requirements) and condensing existing subsections by adding accident prevention, restorative nursing techniques, emergency preparedness and fire prevention and safety under subsection (a). In order to not be duplicative, the Department is not restating the Federal requirements in 42 CFR 483.95. Based on comments received, however, the Department adds the following training and orientation requirements: resident rights, including nondiscrimination and cultural competency; training needs identified through a facility assessment; resident abuse prevention detection and reporting; dementia management and communication skills. Due to the requirement for training to be based on needs identified in a facility's assessment, the Department declines to add portability of training. The Department also agrees that training should be provided by appropriately knowledgeable trainers. However, the Department declines to add this language due to vagueness. Further, as previously provided, a facility is already required to develop, implement and maintain an *effective* training program based on the needs of residents and staff. 42 CFR 483.95. This includes the provision of training by trainers with appropriate knowledge and expertise.

§ 201.21. Use of outside resources

Subsection (a)

Subsection (a) remains deleted on final-form. As explained on proposed, the Department deletes this subsection to eliminate duplication and to avoid conflict with the Federal requirements. Under 42 CFR 483.70(g)(2)(i), an arrangement or agreement for the use of outside resources must specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in the facility. A commentator suggested subsection (a) be retained since the Federal requirement at § 483.70(g)(2)(i) only applies to qualified professional persons and not all personnel. Specifically, the commentator asserted that subsection (a) is needed to require personnel meet all necessary licensure and certification requirements. IRRC also inquired how the deletion of this subsection protects the public health, safety and welfare.

The Department declines to make this amendment for the following reasons. When the Federal requirement under 42 CFR 483.70(g)(1) is read in *pari materia* with subsection 483.70(f) (relating to staff qualifications), a qualified professional person includes "those professionals necessary to carry out the provisions [of services]." Further, subsection (f) applies not only to full-time and part-time professional employees, but also to consultation who provide professional services. Paragraph (2) of that provision specifically requires that professional staff "must be licensed, certified or registered in accordance with applicable State law." 42 CFR 483.70(f)(1) and (2). As such, no further amendments are needed.

Subsection (b)

Subsection (b) remains deleted on final-form. As explained on proposed, the Department deletes this subsection to eliminate duplication and to avoid conflict with the Federal requirements. Under 42 CFR 483.70(g)(1), a facility is required to have services furnished to residents by a person or agency outside the facility if the facility does not employ a qualified professional person to furnish that service.

A commentator suggested this requirement be retained since facilities must use contracted services if it cannot provide the needed services. To clarify, the Department is not deleting the requirement for services to be furnished by a person or agency outside the facility if the facility does not employ such a person. This requirement is already required under 42 CFR 483.70(g) and incorporated under § 201.2. However, the requirement for contracted services will technically be new for the private-pay facilities under amended § 201.2 in final-form Rulemaking 1– *General Applicability and Definitions*. This assumes approval of Rulemaking 1.

Subsection (c)

Subsection (c) is amended from proposed to final-form. On proposed, the Department deleted this subsection. However, based on comments received from commentators and IRRC to maintain this language and require written agreements between facilities and outside resources, the Department adds the following language: "In addition to the requirements under 42 CFR

483.70(g) (relating to administration), the responsibilities, functions, objections and terms of agreements related to outside resources shall be delineated in writing and signed and dated by the parties."

Subsection (d)

Subsection (d) remains deleted on final-form. The Department deletes this subsection and replaces it with subsection (e), described below.

Subsection (e)

Subsection (e) is amended from proposed to final-form. As explained on proposed, subsection (e) replaces the requirement in existing subsection (d) regarding outside resources that supply temporary employees to a facility. Under this new subsection, if a facility acquires employees from outside resources, the facility is required to obtain confirmation from the outside resource that the employees are free from the communicable diseases and conditions listed in § 27.155 (relating to restrictions on health care practitioners) and that the employees are able to perform their assigned job duties.

Based on comments received from a commentator and IRRC, the Department removes the word "physically" from "physically able." The Department removes this language to clarify that it is not intent of the provision to have any impact on an individual's disability, if any, or to impact a facility's reasonable accommodation under the Americans with Disability Act (42 U.S.C.A. §§ 12101 - 12213). The Department is not concerned with what specific conditions an employee may have but is only checking to see if the facility has obtained confirmation from an outside resource that the individual is able to work with residents and is free from communicable diseases and conditions. In addition, the Department adds the word "job" before "duties" to be consistent with language under § 201.19(5) (relating to personnel records).

§ 201.24. Admission policy

Subsection (a)

This subsection is retained but amended on final-form. The Department had proposed to delete this subsection in its entirety to eliminate duplication with the Federal requirements at 42 CFR 483.10(b)(3), which address the ability of a resident representative to act on behalf of a resident.

Some commentators opposed the deletion of this subsection and argued that a facility should be prohibited from requiring a resident to designate a resident representative. They explained that designating a resident representative is a choice and the regulations should maintain that choice. One commentator indicated that many residents have full capacity to make all or many of their own decisions, and the regulations should reflect the fact that residents can remain free to maintain autonomy and independence if they can and wish to manage their own affairs. A commentator also pointed out that a prohibition on requiring a resident to designate a resident representative does not explicitly appear in the Federal requirements at 42 CFR 483.10(b). IRRC also asked the Department to explain the need for deleting this provision from

regulation, and how the final regulation protects the public health, safety and welfare or resident capable of managing their own affairs.

After careful consideration, the Department agrees that the Federal requirements do not explicitly include language indicating that a resident is not required to name a resident representative. Therefore, the Department retains but amends this subsection on final-form, in response to these comments. On final-form, the Department deletes the first sentence of subsection (a) as the ability to appoint a resident representative is explicitly covered by the Federal requirements, but retains the second sentence with one amendment. The Department replaces the term "responsible person" with "resident representative" to reflect current terminology. The term "responsible person," as used in existing subsection (a), is an outdated term that is no longer used and has been replaced with the term "resident representative" to describe the types of individuals who may act on behalf of a resident. The term "resident representative" is defined in the Federal requirements at 42 CFR 483.5 (relating to definitions) and encompasses not only individuals who are authorized by law to act on behalf of a resident, but also other individuals who may be chosen by residents to act on their behalf.

Under 42 CFR 483.10(b)(3)(i), a resident representative has the right to exercise a resident's rights to the extent those rights are delegated to the resident representative, either by the resident or by law. Given the broad definition of "resident representative" this provision will technically be partially new for the three private-pay facilities under amended § 201.12, assuming approval of that section in final-form Rulemaking 1– *General Applicability and Definitions*.

Some commentators also recommended that there be a prohibition on a facility requiring a resident representative or other third party to sign an admissions agreement or to otherwise financially bind the resident representative for a resident's care. Some commentators recommended language prohibiting a facility from requesting or requiring a resident representative or any other third party to sign an admissions contract unless the resident lacks decisional capacity and the resident representative or other third party has legal authority to act on the resident's behalf. The Federal requirements at 42 CFR 483.15(a)(3) prohibit a facility from requesting or requiring a third-party guarantee of payment to the facility as a condition of admission or expedited admission or continued stay in the facility. However, a resident representative who is legally authorized to make financial decision and access a resident's income or resources may sign a contract and provide payment from the resident's income or resources. Therefore, the recommended language is duplicative of Federal requirements and unnecessary. As such, the Department declines to make this amendment.

A commentator also recommends language in this subsection prohibiting a facility employee from serving as a resident representative. As further detailed in § 201.26 (relating to resident representative) only a resident's family member who is employed in the facility may serve as resident representatives, so long as there is no conflict of interest. In addition, as further detailed below, the Department adds a paragraph (2) that clarifies a facility may be designated as a representative payee for Social Security as determined by the Social Security Administration in accordance with the Social Security Act and application regulations.

Subsection (b)

Subsection (b) is amended from proposed to final-form. On proposed, the Department deleted this subsection. However, based on comments received from commentators and IRRC, the Department retains this language on final-form. Some commentators objected to the deletion of this subsection on proposed because they believe it removes protections against a resident. They assert that the language in subsection (b) is needed because it prohibits a facility from forcing residents to release the facility from liability for failure to fulfill its duties, which is distinct from the Federal requirements at 42 CFR 483.15(a)(2)(iii) (relating to admission, transfer and discharge rights). IRRC also asked whether facilities would be able to obtain a release from other types of liabilities and how removing this provision is reasonable and protects the public health, safety and welfare of residents related to liabilities other than liability for loss of personal property. The Department agrees with these concerns and is retaining this subsection.

Subsection (c)

This subsection is unchanged from proposed to final-form. The Department did not propose any amendments to this subsection, which requires that a facility only admit residents whose nursing care and physical needs can be provided by the staff and facility. Some commentators commented that this subsection gives too much discretion to facilities to deny admission. Commentators assert that additional protections are necessary to ensure that facilities do not deny admission for arbitrary, discriminatory, payment or payor source reasons. Commentators recommended that the Department require facilities to have a written policy that outlines what nursing care and physical needs a facility can and cannot provide and that the policy be approved by the Department and be compliant with the Americans with Disabilities Act and all other non-discrimination laws and regulations. Further, commentators suggest that the policy be publicly posted in the facility, on the facility website, and be uniformly applied. Commentators suggest that facilities should only be permitted to deny admission to a potential resident if the potential resident's care needs exceed the level of care a facility has stated it can provide, or if a facility is at capacity with available beds.

After careful consideration, the Department declines to adopt these recommendations. As an initial matter, a facility has to be compliant with all applicable Federal and State laws, including the American with Disabilities Act, and other non-discrimination laws. Further, as mentioned previously, the Department declines to manage, review and approve policies for the 682 licensed long-term care nursing facilities on an ongoing basis due to logistical concerns. Further, it would be impractical to require a facility to have a policy that states what care and physical needs the facility can and cannot provide when a facility's capacity to provide a certain level of care may fluctuate depending on the availability of staff with specific training and skillsets. Further, although a facility is not specifically required to have a policy that comprehensively states the services it can and will provide, a facility is required under 42 CFR 483.15(a)(6) (relating to admission, transfer and discharge rights) to disclose and provide to a resident or potential resident, prior to the time of admission, notice of special characteristics or service limitations of the facility. Thus, a facility is required to inform a potential resident if the facility cannot serve the resident's needs. This will be a new requirement for the three private-

pay facilities under amended § 201.2 in Rulemaking 1– *General Applicability and Definitions*, assuming approval of that rulemaking.

Additionally, to the extent that the decision not to admit residents based on payment source has a disparate impact on a protected class of persons, there is case law that establishes precedent for complainants to seek injunctive relief to force facilities to remedy practices that have a discriminatory impact. *Linton v. Carney*, 779 F. Supp. 925 (M.D. Tenn. 1990).

In addition, there are protections to ensure that a resident is not subject to different treatment due to the source of payment for their care. For example, under 42 CFR 483.10(a)(2) (relating to resident rights) a facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source, and a facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. The requirement in 42 CFR 483.10(a)(2) will be a new requirement for the three private-pay facilities under amended § 201.2 in final-form Rulemaking 1 - *General Applicability and Definitions*, assuming approval of that rulemaking.

Commentators also recommended that this subsection include language requiring a facility to provide the level of care residents require with a cross-reference to a new section that they propose requiring a facility to provide "all medical, social, nursing, pharmacy, dementia care, activities, protective supervision, cueing, and other services to meet the physical health, behavioral health, skilled nursing, nursing, psychosocial, emotional, cognitive, social, personal care, nutritional, rehabilitative, technological, equipment, transportation, [MA] eligibility, and other needs and preferences of each individual resident and as may be required of a person who meets the nursing facility level of care." They also suggest language requiring a facility to "assist residents with activities of daily living and instrumental activities of daily living and in preparing for transition out of the nursing facility." After careful consideration, the Department declines to add this language because these various health services topics are addressed in the entirety of 42 CFR Part 483, Subpart B (relating to requirements for States and Long Term Care Facilities). The purpose of these Federal health and safety standards is to provide the minimum standards relating to all aspects of a resident's care. As such, the suggested language would be duplicative of Federal requirements at 42 CFR 483.21 (relating to comprehensive person-centered care planning), which requires that a resident's comprehensive care plan outline the care and services the resident needs and that the facility provide the services outlined in the care plan.

Subsection (d)

This subsection is unchanged from proposed to final-form. The Department did not propose any changes to this section.

Subsection (e)

This subsection is amended from proposed to final-form. The Department proposed to add this subsection, which exceeds the Federal requirements at 42 CFR 483.15(a) by requiring that the governing body of a facility establish written policies and procedures for the admissions

process for residents, and through the administrator, develop and adhere to procedures implementing those policies. The Department proposed to require that the facility's admissions policies and procedures include the requirements in paragraphs (1) through (5), which set forth requirements for orienting residents to the facility and introducing them to the basic information they need to reside in the facility.

Some commentators were supportive of the new requirements in this subsection and believed these requirements will help ensure that residents quickly become acclimated to the facility, its procedures, and staff. A commentator stated that the timely review of immediate care orders and discussion of the resident's customary routines and preferences are important for a good start to the resident's stay, as are orientation to the facility and help settling into the resident's room.

Commentators to proposed Rulemaking 2 requested that the Department require education to residents about the right to have a locked drawer or cabinet. Commentators requested that this occur during the resident's first care plan meeting, and that the resident be specifically informed of the right to have a locked drawer or cabinet, and the need to inform staff when the key is lost, the drawer is broken, or when something is stolen. The Department notes that there is not an existing right to have a locked drawer; however, the Federal requirements at 42 CFR 483.10(i)(1)(ii)(relating to resident rights) establish that a facility must exercise reasonable care for the protection of the resident's property from loss or theft. To the extent that a facility provides a mechanism for residents to secure their possessions, the Department agrees that residents should be instructed on how to use that mechanism. Therefore, the Department amends paragraph (5) by removing the words "if needed" and adding the words "and securing" after the word "settling" and before the words "personal possessions," to ensure that facilities have policies and procedures in place to assist residents in securing their personal possessions.

Some commentators commented that, although requiring written admissions policies is a good start, the Department fell short in what must be included in those policies. These commentators recommended that facilities be required to include anti-discrimination provisions in their admissions policies. A commentator on proposed Rulemaking 1 and commentators in this rulemaking specifically recommended that Department require facilities to include in their admissions policy prohibitions on discrimination against potential residents on the basis of sexual orientation, gender identity or gender expression. Some commentators also recommended that non-discrimination admission policies be submitted to and approved by the Department. Some commentators on this subsection also recommended that the Department require facilities' admissions policies to prohibit discrimination on the basis of payment source.

For the reasons described in further detail above in response to similar comments in subsection (c), the Department declines to add these recommendations. As discussed above, a facility has to be compliant with all applicable Federal and State laws, including the American with Disabilities Act and other non-discrimination laws.

Some commentators recommended that facilities be required to use a standard admissions agreement. One commentator recommended that the standard agreement be created by the

Department for all facilities, because uniformity would benefit both the resident and the facility. Another commentator suggested that facilities submit their standard agreement to the Department for approval, and that facilities should be required to include in the agreement sections related to consent to treatment, resident rights, non-discrimination, financial arrangements, transfer and discharge, personal property and funds, photographs, confidentiality of medical information, and facility rules and grievance procedures. After careful consideration, the Department declines to adopt these recommendations. With regards to creating a standard admissions agreement, the Department declines to address and approve all contractual agreements between 682 nursing facilities and their approximate 72,000 residents on an ongoing basis due to feasibility and logistical concerns. In addition, it is important that facilities be able to update their admissions agreement in response to resident and business needs without having to wait for Department approval. Further, the Federal health and safety requirements and the Department's regulations address the myriad of topics suggested by commentators, including the provision of resident rights.

A commentator recommended that residents be advised that the admissions agreement can be reviewed by a legal representative or other advisor before signing. After careful consideration, the Department declines to make this amendment. Residents and resident representatives have the autonomy to seek legal or other counsel as the resident, or resident representative, deem appropriate.

Subsection (f)

This subsection is amended from proposed to final-form. As explained on proposed, this subsection requires the coordination of introductions, orientation, and discussions required under proposed subsection (e) be the responsibility of the facility's social worker, or other delegee designated by the governing body. Social workers play a vital role in assisting residents with their psychosocial needs, and thus, are ideally suited for performing these types of tasks. Another individual, identified by the governing body, may be permitted to perform these tasks as the social worker may not always be available at the time of a resident's admission.

The Department proposed to require that the coordination of introductions, orientation and discussions occur within 2 hours of a resident's admission to further ensure that residents are not left on their own for too long after being admitted to a facility. A commentator, however, asserted that the 2-hour window of time proposed in § 201.24(f) for the facility to coordinate introductions, orientation and discussions for a new resident is unrealistic, since most admissions occur during the afternoon and evening shifts and on weekends. The commentator further asserted that facilities need at least 72 hours to complete all the requirements in § 201.24(f) unless the information can be provided in writing. Other commentators also argued that facilities need more time to comply with the requirements in § 201.24(f). The commentators commented that it is important not to overwhelm residents with too much information in such a short amount of time, especially if they are arriving after a period of hospitalization or arriving late in the day. They asserted that transitioning to living in a facility can be a difficult time for a resident, and the resident might prefer to receive information over a longer period after admission.

In contrast, another commentator recommended amending subsection (f) to require that within 2 hours of a resident's admission, the facility offer a basic welcome to the building and conduct a nursing assessment to determine the resident's care needs and preferences and begin the development of the resident's comprehensive care plan. The commentator pointed out that an assessment of the resident's needs and preferences should be the priority, and it can take up to 2 hours to complete. The commentator recommended that other provisions be completed within 24 hours of admission. Similarly, a commentator suggested that introduction to at least one member of the nursing staff can reasonably occur within 2 hours of admission but suggested that residents be allowed to conduct other portions of the orientation within 24 hours if that is the resident's preference. IRRC stated that they share commentators' concern with the need not to overwhelm a resident during this time of transition. IRRC asked if the 2-hour timeframe is reasonable considering that an individual might be coming directly from a hospital or have other serious health conditions. IRRC asked that the Department explain the reasonableness of the timeframe related to the coordination of introductions, orientation and discussion.

The Department amends subsection (f), on final-form, in response to these comments. Specifically, the Department amends this subsection to prioritize different activities. As amended, this subsection requires that the activities under subsections (e)(1) and (e)(2) regarding orientation and introduction occur within 2 hours of a resident's admission. These activities include reviewing the orders of the physician or other health care practitioner for the resident's immediate care, introduction of the resident to at least one member of the professional nursing staff and to direct care staff assigned to care for the resident, and orientation of the resident to the facility and location of essential services and key personnel, including the dining room, nurses' workstations and offices for the facility's social worker and grievance or complaint officer. The activities included under subsection (e)(3) and (e)(4) regarding routines and preferences shall occur within 24 hours of a resident's admission. These activities include providing a description of facility routines, including nursing shifts, mealtimes and posting of menus and discussion and documentation of the resident's customary routines and preferences, to be included in the resident's care plan. The activities included under subsection (e)(5) regarding adjustment to surroundings shall occur within 72 hours of a resident's admission. These include assisting the resident in creating a homelike environment and settling and securing personal possessions in the resident's room.

Other Comments

In addition to the comments on subsections (a) through (f), commentators recommended that a subsection be added to this section that requires facilities to retain a log of all referrals, verbal or written requests or applications for admission, and outcomes of any referrals, requests, or applications for admission. They also recommended that the log contain for each referral a patient identifier, and indicate the race, sex, color, national origin of the referral, the date of referral, the referring hospital or agency, and the date and the disposition of the referral by the facility. They recommended that the log be submitted to the Department annually with the Department's civil rights compliance questionnaire. After careful consideration, due to

administrative burden concerns the Department declines to add an additional paperwork requirement relating to the creation and submission of an admission and referral log.

Some commentators also recommended a new subsection, requiring that in the event a facility denies admission to a potential resident, the facility provide that potential resident a written notice of denial stating the basis for denying admission, a statement of the potential resident's right to appeal and the process for appealing, contact information for local legal services to assist with the appeal, and contact information for the appropriate agency that can help the potential resident find alternative services. After careful consideration, the Department declines to incorporate this recommendation. The Department is not in the position or granted the authority to adjudicate resident appeals generally. Under the MA program, appeals are governed by the Department of Human Services. Otherwise, litigation surrounding denials have jurisdiction in the Court of Common Pleas.

§ 201.25. Discharge policy

This section remains deleted on final-form. However, the Department is not deleting the requirement for discharge plans. As explained on proposed, the Department deletes this section to eliminate duplication and avoid confusion with the Federal requirements. Under 42 CFR 483.21(c), a facility is required to develop and implement a discharge plan and a post-discharge plan of care. The Department notes that this is a new requirement for private-pay facilities under amended § 201.2 in final-form Rulemaking 1– *General Applicability and Definitions*, assuming approval of that rulemaking.

A commentator asserted that the Department should retain and amend § 201.25, arguing that the Federal requirements address the discharge planning process, but not the discharge plan itself. The commentator asserted that the Federal requirements do not clearly state that the discharge plan must ensure that the resident has a program of continuing care after discharge from the facility and that the plan must be in accordance with each resident's needs. Other commentators suggested that § 201.25 be retained and that the Department add language to stress that the program of continuing care be person-centered. The commentators also suggested adding language requiring that the setting the resident is discharged or transferred to have the capability of meeting the resident's needs and preferences. The commentators suggested adding language to require that the discharge plan include transfer of current person-centered service plans and any advance planning documents, or orders related to the resident. IRRC asked whether the Federal requirements address a centralized coordinated discharge plan for each resident as required by existing § 201.25. IRRC asked the Department to explain how the final-form regulation protects the public health, safety, and welfare of residents regarding discharge plans.

After careful consideration, the Department declines to retain or amend § 201.25. Although the Federal requirements do not specifically use the terminology "centralized coordinated discharge plan," robust and comprehensive discharge planning and plans are required. Under 42 CFR 483.21(b)(1)(iv)(C) (relating to comprehensive person-centered care planning), a facility is required to include discharge plans in the comprehensive care plan that is developed for each resident. The Federal discharge plan requirements are more robust and

include specific elements that are not currently delineated in existing § 201.25, to ensure that the public health, safety, and welfare of residents are protected when discharge from a facility takes place. Under 42 CFR 483.21(c), a facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of the resident to be an active partner in the planning process and to effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The discharge planning process must be consistent with the discharge rights set forth in 42 CFR 483.15(b) (relating to admission, transfer and discharge rights) and must ensure that the discharge needs of the resident are identified and result in the development of a discharge plan. The resident, resident representative and interdisciplinary team must be involved in the development of the discharge plan. The discharge plan must be updated, as needed, based on regular reevaluation of the resident. Under 42 CFR 483.21(c)(iv), the discharge plan must take into consideration the availability of a caregiver or support person and the resident or caregiver's capacity and capability to perform the care identified in the resident's discharge needs. It must also address the resident's goals of care and treatment preferences and include documentation that a resident has been asked about their interest in receiving information regarding a return to the facility, as well as documentation of any referrals to local agencies or other appropriate entities. 42 CFR 483.21(c)(1)(vi) and (vii). The discharge plan must also contain all relevant information related to the resident to facilitate the plan's implementation and to avoid unnecessary delays in the resident's discharge and transfer. 42 CFR 483.21(c)(ix). When discharge occurs, the facility must provide a discharge summary under 42 CFR 483.21(c)(2), which includes a recapitulation of the resident's stay, a final summary of the resident's status, reconciliation of all pre-discharge medications with post-discharge medications, and a post-discharge plan of care. A facility must also meet the requirements for transfer or discharge in 42 CFR 483.15(c)(2), which require documentation in the resident's medical record and communication of information to the receiving healthcare facility or provider. The Department additionally notes this communication of information includes advance directive information, all special instructions or precautions for ongoing care as appropriate, comprehensive care plan goals, and all other necessary information, including the discharge summary and any other documentation to ensure a safe and effective transition of care. 42 CFR 483.15(c)(2)(iii)(C) through (F).

Some commentators requested that the Department retain and amend § 201.25 to require a facility to follow a discharge policy that is approved by the Department. After careful consideration, the Department declines to make this amendment. As explained above, the Federal requirements for a discharge policy are robust and serve as the minimum health and safety standards for facilities. In addition, as mentioned previously, it would be logistically impossible for the Department to approve every policy and procedure for the approximately 682 licensed long-term care nursing facilities on an ongoing basis.

A few commentators requested that the Department retain § 201.25 because residents lack adequate protections against unjust and unsafe discharges or transfers to other settings. After careful consideration, the Department declines to make this amendment. As further detailed above, existing Federal health and safety requirements are robust regarding discharge of

residents. Under 42 CFR 483.15(c), a facility must permit residents to remain in the facility and not transfer or discharge a resident unless: the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; the safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; the health of individuals in the facility would otherwise be endangered; the resident has failed after reasonable and appropriate notice to pay for a stay at the facility; or the facility ceases to operate. Under 42 CFR 483.15(c)(1)(ii), a facility may not transfer or discharge a resident while an appeal is pending under 42 CFR 431.220(a)(2), unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. Under 42 CFR 431.220(a)(2) under Subpart E (relating to appeals of discharges, transfers, and preadmission screening and annual resident review (Pasarr) determinations), the Department of Human Services must grant an opportunity for a hearing to any resident who requests it when the resident believes a facility has erroneously determined a transfer or discharge. This would be applicable only to those facilities that participate in MA, however, and not the three private-pay facilities. The Department does not have the authority to hear appeals from residents.

A few commentators requested that the Department retain and amend § 201.25 to require written notice to residents facing unwanted discharge with information on how to appeal the facility's decision before being unwillingly discharged or transferred from the facility. After careful consideration, the Department declines to make this amendment as this notice is already required under the Federal requirements. Under 42 CFR 483.15(c)(3), a facility must provide notice to the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they can understand. The facility must send a copy of this notice to the Office of the State Long-Term Care Ombudsman. Under 42 CFR 483.15(c)(4), the notice must be given at least 30 days before the resident is transferred or discharged, or as soon as practicable if the health and safety of individuals would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the resident's urgent medical needs, or the resident has not resided in the facility for 30 days. The notice must include, under 42 CFR 483.15(c)(5), the reason for the transfer or discharge, the effective date of the notice or discharge, the location to which the resident is being transferred or discharged, a statement of the resident's appeal rights, contact information for the Office of the State Long-Term Care Ombudsman, and for residents with intellectual, developmental, mental or related disabilities, contact information to the agencies responsible for the protection and advocacy of these individuals. As noted above, residents in facilities that participate in MA can appeal a facility's decision to transfer or discharge under 42 CFR 431.220(a)(2). The Department, however, does not have the authority to hear appeals from residents.

§ 201.26. Resident representative

This section is amended from proposed to final-form. As explained on proposed, the Department replaces the words "power of attorney" in the title and body of this section with

"resident representative." The term "resident representative" encompasses not only a power of attorney relationship, but also other types of individuals who are authorized to act on behalf of a resident. The Department deletes the slash mark and replace the word ''employe'' with ''employee'' for stylistic and current usage reasons.

The Department adds to the end of the prohibition an exception for family members of residents who are employed in the facility. This section permits family members who are employed in the facility to serve as resident representatives, so long as there is no conflict of interest. In addition, as further provided below, the Department adds a paragraph (2) that clarifies a facility may be designated as a representative payee for Social Security payments under certain circumstances. Paragraph (2) clarifies that this designation must be in accordance with the Social Security Act and application regulations.

One commentator supported this provision stating that facility staff should not serve in the position of a substitute decision-maker. Another commentator requested the Department not delete the prohibition of a facility serving as a power of attorney for a resident. Commentators also suggested this section be expanded or clarified to prohibit staff from serving as guardian, healthcare proxy or another surrogate.

As currently drafted, a staff member may not be a resident representative, unless the staff member is also a resident's family member and there is no conflict of interest. Although the Department agrees with the commentators' concerns regarding employees serving in an agent or fiduciary role, the suggested amendments are unnecessary given the broad and inclusive definition of "resident representative." Specifically, a resident representative includes: legal representatives; court-appointed guardians or conservators of a resident; or a person authorized by State or Federal law (including, but not limited to, agents under power of attorney, representative payees, and other fiduciaries) or an individual chosen by the resident to act on behalf of the resident, in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications. 42 CFR 483.5 (relating to definitions). To further clarify the definition of "resident representative," the Department added this term and the cross-reference to 42 CFR 483.5 to Rulemaking 1 – *General Applicability and Definitions*. This assumes approval of Rulemaking 1.

A commentator also suggested that a facility could be a representative payee for Social Security payments with the permission of the resident or the resident's representative. The Department agrees with the exception for a facility to serve as a representative payee, as designated by the Social Security Administration. However, since the Social Security Administration administers the Social Security Act and determines whether a facility should be designated as a representative payee, the Department declines to include the additional suggested provisions regarding conditions for serving as a representative payee.

Another commentator also commented that facilities will only communicate with an agent of the resident and not with other family members when the agent and family members are fighting. As discussed above, the definition of "resident representative" includes individuals chosen by a resident to act on the resident's behalf and also court-appointed representatives. Due to resident autonomy, the Department declines to add a designation for family members to access resident information when a family member is neither designated by the resident nor appointed by the courts.

§ 201.27. Advertisement of special services

The Department did not include this provision in the proposed rulemaking. Commentators, however, suggested that the Department add language on final-form to ensure that facilities comply with the requirements of the Unfair Trade Protection and Consumer Protection Law (UTPCPL) to prohibit facilities from advertising their services in a manner that misrepresents the facility's scope of services as being greater or lesser than their actual services, and to prohibit advertising that a facility provides services or specialties unless such services or specialties are defined specifically by the Commonwealth.

First, this comment is outside the scope of the proposed rulemaking. In addition, the Department declines to amend this section on final-form. Sections 201.14(a) and (b) are amended in final-form Rulemaking 3 – *Applications for Ownership, Management and Changes of Ownership; Health and Safety* to add language that facilities must comply "with all applicable Federal and State laws, and rules, regulations and orders issued by the Department and other Federal, State or local agencies." This language provides additional awareness that facilities must adhere to any applicable Federal and State laws, which would include the UTPCPL.

Commentators further cite to the recent Pennsylvania Supreme Court case *Shapiro v. Golden Gate National Senior Care, LLC,* 194 A.3d 1010, 1023 (Pa. 2018) to ensure compliance with the requirements of the UTPCPL. However, the decision in *Golden Gate* did not hold that the UTPCPL does not apply to nursing facilities; but instead, provided that the conduct in that matter was not actionable under the UTPCPL. To the extent that additional consumer protections are desired under the UTPCPL, a legislative amendment is needed.

§ 201.29. Resident rights

Commentators objected to the deletion of regulatory language in § 201.29 that is duplicative of residents' rights requirements in the Federal requirements at 42 CFR 483.10. Commentators indicated that it is necessary to specifically enumerate the Federal requirements in State regulation to provide a single point of reference for lay persons to understand a resident's rights. These commentators asserted that lay persons do not have the ability to understand the interplay between State and Federal requirements, and most people look to the State regulations to determine a resident's rights. Commentators requested that the Department either spell out all rights in § 201.29 or at a minimum, cross-reference the Federal requirements. IRRC further asked the Department to explain how the final-form regulation protects public health, safety and welfare in relation to making a resident's rights clear. In response to these comments, the Department has added an explicit cross-reference in § 201.29 to the Federal requirements for resident rights at 420 CFR 483.10 (relating to resident rights) to make it clear that the requirements for resident rights include both the requirements in § 201.29 and 42 CFR 483.10. The resident rights under this § 483.10 are readily accessible in various locations, including, for example, https://www.law.cornell.edu/cfr/text/42/483.10; https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483; https://www.govinfo.gov/content/pkg/CFR-2011-title42-vol5/pdf/CFR-2011-title42-vol5-sec483-10.pdf.

In addition, to further assist the regulated community, residents, and others in understanding resident's rights, the Department has also created a template of resident's rights, which sets forth a resident's rights in clear and easy to understand language. The creation of a template also addresses a comment that the Department received during the meeting with stakeholders on August 17, 2022, in which a stakeholder suggested that the Department create a comprehensive list of resident rights that can be shared with facilities. This template, which facilities may use as a tool to meet the posting and notice requirements in subsections (c.1) and (c.2) described below, is attached as Exhibit A, and will also be posted on the Department's website.

Subsection (a)

Subsection (a) is amended from proposed to final-form in response to public comments. The Department did not propose any changes to the first sentence of this subsection. On final-form, the first sentence is broken into two sentences, and a phrase is added to the end of the new first sentence to clarify that the rights and responsibilities of residents referenced in this subsection include both the rights and responsibilities set forth in 42 CFR 483.10 and this section. This amendment is in response to some commentators' suggestion that this section should be amended to require that the governing body of a facility establish written policies consistent with Federal and State regulations regarding the rights and responsibilities of residents. IRRC also commented regarding the proposed deletion of subsection (m) because existing subsection (a) addresses the requirement that a facility have policies and procedures related to resident rights. IRRC noted, however, that, unlike subsection (m), subsection (a) does not require that a facility's policies and procedures reflect the residents' rights provided for in this section; only that policies regarding rights be developed and adhered to. The amendment on final-form in this first sentence addresses this comment by adding the requirement that the policies and procedures specifically reflect the rights set forth in this section and in 42 CFR 483.10.

The new second sentence in this subsection is amended for grammar and clarity. The word "and" is deleted at the beginning of the sentence, and the word "through" is capitalized because it is now the first word of the sentence. The words "the governing body" are added following the words "through the administrator", since a subject would otherwise be missing from this sentence.

The last sentence in this subsection is amended from proposed to final-form also in response to public comment. The Department proposed to add this sentence, which requires that the written policies established by the governing body include a mechanism for the inclusion of residents in the development, implementation and review of the policies and procedures regarding the rights and responsibilities of residents. The Department proposed this requirement as part of its efforts to promote more resident-centered environments in long-term care nursing facilities. Several commentators supported the proposal to require that residents be included in the development, implementation and review of policies related to resident rights. A commentator noted that facilities should have the option to include a resident representative on behalf of a resident if a resident is not able or willing to be included. This recommendation is adopted on final-form, and the words "or a resident representative" are added after the words "inclusion of residents".

Subsection (b)

Subsection (b) is unchanged from proposed to final form. The Department did not propose any amendments to this section.

Subsection (c)

Subsection (c) is unchanged from proposed to final-form. The Department did not propose any amendments to this subsection.

Subsection (c.1)

Subsection (c.1) is added on final-form. The Department moves the requirement in existing subsection (n) that a facility post in a conspicuous place near the entrances and on each floor of the facility a notice which sets forth the list of resident's rights, into this subsection, with a cross-reference to subsection (c.3) and 42 CFR 483.10 to make it clear that the posting requirement includes both the Federal resident rights requirements and the resident rights requirements in subsection (c.3). The Department has moved the requirement in subsection (n) higher up in this section for organizational reasons to make the requirements clearer and easier to understand. As noted at the beginning of this section, the cross-reference to 42 CFR 483.10 is added in response to comments to make it clear that the requirements in § 201.29 include the Federal requirements at 42 CFR 483.10 (relating to resident rights). As noted at the beginning of this section, the Department has created a template of resident's rights, which sets forth a resident's rights in clear and easy to understand language. This template, which facilities may use as a tool to meet the posting and notice requirements in this subsection and subsection (c.2) described below, is attached as Exhibit A, and will also be posted on the Department's website.

Subsection (c.2)

Subsection (c.2) is added on final-form. This subsection requires a facility to provide personal notice of a resident's rights in accordance with 42 CFR 483.10(g)(16). The Department moves from existing subsection (n) the requirement that a certificate of the provision of personal notice be entered in the resident's medical record. The first sentence is added for clarity to cross-reference the requirement that personal notice of resident rights must be given to a resident, as such notice must be provided for it to be noted in the resident's medical record. For clarity, the Department has placed these requirements here in subsection (c.2) instead of adding or retaining them in subsection (n). Additionally, as noted at the beginning of this section, the Department has created a template of resident's rights, which sets forth a resident's rights in clear and easy to understand language. This template, which facilities may use as a tool to meet the posting and notice requirements in this subsection and subsection (c.1) described above, is attached as Exhibit A, and will also be posted on the Department's website.

Subsection (c.3)

This subsection is added on final-form in response to the previously discussed comments, which requested that all Federal and State regulatory requirements for resident rights be together or that a cross-reference be added into § 201.29 to the Federal requirements. The Department adds language in subsection (c.3) to clarify that the rights delineated in paragraphs (1) through (4), described below, are in addition to the rights set forth at 42 CFR 483.10.

Paragraph (1)

The Department moves into paragraph (1), current language from existing subsection (e), with amendments. Specifically, the Department moves all but the first sentence from subsection (e) into paragraph (1), with two grammatical amendments. As noted on proposed, the first sentence of subsection (e) is duplicative of the requirement in 42 CFR 483.10(g)(18) that a facility must inform each resident before or at the time of admission, and periodically during a resident's stay, of the availability of services and related charges. The Department deletes the word "the" before the word "charges" and replaces the word "money" with the word "deposit." The Department also replaces the term "responsible person" with "resident representative" for consistency in the use of that term in the regulations. The Department had proposed to delete subsection (e) to eliminate duplication and avoid conflict with the Federal requirements at 42 CFR 483.10(g)(18).

Commentators disagreed that the requirements in the second and third sentences of existing subsection (e) are duplicative of the Federal requirements and recommended that these sentences be retained. The Department had proposed to delete these two sentences because 42 CFR 483.10(g)(18)(i) and (ii) requires notice of changes in charges for items and services as soon as reasonably possible and changes for other items and services at least 60 days prior to implementation of the change. A commentator asserted that while 42 CFR 483.10(g)(18) requires facilities to inform a resident before changes are made to charges, the second sentence in existing subsection (e) requires the facility to inform the resident *verbally and in writing* of changes in charges. Commentators asserted that the words "verbally and in writing" offer greater protection than the Federal requirement and should be retained. Commentators also asserted that the deletion of the requirement for at least 30 days' advance notice regarding changes in charges from the second and third sentences is not appropriate, because the requirement in 42 CFR 483.10(g)(18)(ii) for 60 days' notice only applies to charges that are not covered by Medicare and MA, and therefore, the wholesale deletion of the requirement in subsection (e) for 30 days' notice is inappropriate. IRRC asked the Department to explain how the deletion of provisions related to notice for changes in charges are reasonable and protect the public health, safety, and welfare of residents.

The Department agrees. In response to these comments, the Department retains the requirement for 30 days' notice, unless circumstances dictate otherwise, and moves it from subsection (e) to this paragraph for clarity. As noted, the Federal requirements provide for two separate notices related to charges under 42 CFR 483.10(g)(10). Under 42 CFR 483.10(g)(i), a facility is required to provide notice "as soon as is reasonably possible" when changes in coverage are made to items and services covered by Medicare or MA. Under 42 CFR 483.10(g)(ii), a facility is required to inform the resident at least 60 days prior to implementation of a change when changes are made to charges for other items and services that the facility offers. The 60-day notice period under 42 CFR 483.10(g)(ii), therefore only applies to charges for items and services not covered by Medicare or MA. After careful consideration, the Department agrees that the term "as soon as reasonably possible" is vague and moves both the second and third sentences of subsection (e) to this paragraph, with amendments, as described previously, to alleviate the concerns raised by commentators regarding the timelines provided in the Federal requirements. As amended, if a change in charges occurs during the resident's stay, a resident, or resident representative, shall be advised *verbally and in writing* reasonably in

advance of the change. "Reasonably in advance of the change" is further defined as "30 days prior to the change unless circumstances dictate otherwise"

Commentators also objected to the deletion of the fourth and fifth sentences in subsection (e), which set forth requirements pertaining to security deposits, when required by a facility, and prohibit a facility from requiring a security deposit for an MA resident. A commentator asserted that these requirements, and the prohibition on security deposits for MA residents, should be retained because they are not explicitly covered by the Federal requirements. IRRC asked the Department to explain how the deletion of provisions related to security deposits are reasonable and protect the public health, safety, and welfare of residents. The Department agrees. After careful consideration, the Department moves the fourth and fifth sentences of subsection (e) to this paragraph, with amendments, as described previously.

Paragraph (2)

The Department moves into paragraph (2), the second sentence from existing subsection (g), which the Department had proposed to retain with amendment. The Department carries over amendments that were proposed to replace the term "resident's responsible person" with "resident representative" and "MA" with "Medical Assistance Programs."

Paragraph (3)

The Department moves into paragraph (3), the language that was proposed in subsection (o), with amendments on final-form. The Department had proposed amendments to subsection (o) to align with Federal guidance The Department adds "including the Department's Institutional Review Board" after "the approval of the Department' from proposed to final-form, in response to commentators who suggested that Department approval of experimental research or treatment should include approval by the Department's Institutional Review Board. The Department also makes minor adjustments to the proposed language on final-form, including breaking it down into subsections for clarity and ease of readability.

Some commentators commented that the language should more clearly state that it is a resident's choice to participate in experimental research or treatment, and that a resident is not required to participate in such research or treatment. After careful consideration, no amendments are made in response to this comment. Informed consent by the resident or resident representative is required under this paragraph prior to participation and initiation of the experimental research or treatment. Informed consent is a legal term of art that is defined by *Black's Law Dictionary* as, "a patient's *knowing choice* about a medical treatment or procedure, made after a physician or other healthcare provider discloses whatever information a reasonably prudent provider in the medical community would give to a patient regarding the risks involved in the proposed treatment or procedure" (emphasis added).

A commentator also commented that a resident representative should only be allowed to provide informed consent if the resident is unable to understand the situation and the risks and benefits of the proposed research. The commentator expressed that, if the resident has capacity, only the resident should be able to provide consent for experimental research or treatment. After careful consideration, the Department declines to make this amendment, as there are protections in place in the Federal requirements, that address the relationship between a resident and resident representative. Specifically, under 42 CFR 483.10(b)(3) (relating to resident rights), a resident

who has not been adjudged incompetent by a State court has the right to choose a resident representative to act on the resident's behalf. The resident, however, retains the right to exercise any rights that not delegated to a resident representative and also retains the right to revoke a delegation of rights, except as limited by State law. Therefore, if a resident has not been determined to be incompetent by a State court, they have the right, and autonomy, on whether to delegate, or not, decisions regarding experimental research and treatment to a resident representative.

The commentator also recommended the addition of language providing that facility staff have a responsibility, where a resident representative gives consent, to ensure that the consent is properly obtained and that essential measures are taken to protect the resident from harm or mistreatment. After careful consideration, the Department declines to make this amendment. The definition of "informed consent" extends to a resident representative under the plain language of this paragraph. In addition, there are other, existing protections in regulation to prevent residents from being harmed or mistreated, regardless of their participation in experimental research or treatment. For example, the Federal requirements at 42 CFR 483.12 (relating to freedom from abuse, neglect, and exploitation) specify that a resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation, including a prohibition on verbal, mental, sexual or physical abuse, corporal punishment or involuntary seclusion. 42 CFR 483.12(a)(1).

A commentator recommended that the definition of experimental research or treatment be expanded to add that experimental research and treatment could include nursing or social science exploration of new approaches to aiding with activities or daily living or addressing social isolation. After careful consideration, the Department declines to make this amendment because these items are encompassed under the definition of "experimental research" that has not yet been approved by the "medical community as effective" under paragraph (3)(iii).

Paragraph (4)

The Department moves into paragraph (4) the language that was proposed in subsection (p), without amendment. As explained in proposed subsection (p), the Department adds this language to make it clear that a resident has the right to care without discrimination based upon race, color, familial status, religious creed, ancestry, age, sex, gender, sexual orientation, gender identity or expression, national origin, ability to pay, handicap or disability, use of guide or support animals because of the blindness, deafness or physical handicap of the resident or because the resident is a handler or trainer of support or guide animals. As explained on proposed, this language mirrors existing protections under the Pennsylvania Human Relations Act (PHRA), as interpreted and applied by the Pennsylvania Human Relations Commission.

Some commentators in response to Rulemaking 2 – *General Operation and Physical Requirements* stated that stronger protections are needed to address discrimination and ill treatment. Some commentators were supportive of the language that was proposed in subsection (p) and commented that this provision was past due and represented an important step forward to ensure that residents are free from discrimination. A commentator stated that these protections will help ensure that older LGBTQ adults receive the services they need. Another commentator expressed that they are hopeful that this protection will come with robust enforcement to ensure compliance. Another commentator stated that the addition of the proposed language in

subsection (p) was unnecessary, since it is, with one exception, a duplication of the PHRA protections for all citizens in this Commonwealth, and federally-required for clients of health care entities that receive federal funding through Section 1557 of the Patient Protection and Affordable Care Act (42 U.S.C.A. § 18116).

The inclusion of this anti-discrimination language, that was proposed in this rulemaking and carried over to final-form, is responsive to those comments. As stated on proposed, the Department's inclusion of the language in this paragraph is consistent with section 102 of the act (35 P.S. § 448.102) to ensure that "all citizens receive humane, courteous, and dignified treatment", and the Pennsylvania Human Relations Commission's application of the PHRA. Further, 42 CFR 483.10 provides that a resident has the right to be free from interference, coercion, and discrimination in exercising the resident's rights.

Subsection (d)

This subsection remains deleted on final form. As explained on proposed, the Department deletes this subsection, which requires that staff of the facility be trained and involved in the implementation of resident rights' policies and procedures, to eliminate duplication and to avoid conflict with the Federal requirements. Under 42 CFR 483.95(b) (relating to training requirements), a facility must ensure that staff members are educated on the rights of residents and the responsibilities of the facility to properly care for residents, as further set forth in 42 CFR 483.10 (relating to resident rights)

Some commentators objected to the deletion of this subsection, arguing that, while the Federal requirements require staff to be trained on residents' rights, they do not require staff to be involved in the implementation of policies related to residents' rights. IRRC asked the Department to clarify whether the existing regulation requires more involvement of staff in policies and procedures than the Federal requirements, and, if so, explain how the final-form regulation protects the public health, safety, and welfare by lessening staff involvement. In response to these comments, the Department clarifies that existing subsection (d) does not require more involvement of staff in policies and procedures than the Federal requirements. "Implementation" refers to the process of putting a decision or plan into effect. Merriam-Webster. *Implementation*. Retrieved from https://www.merriam-webster.com/dictionary/implementation. Facility staff are necessarily involved in the implementation of all facility policies and procedures, including those pertaining to resident rights, because they are the ones who are required to put those policies and procedures into effect. For example, under 42 CFR 483.10(c), a resident has a right to be informed of, and participate in their treatment. The policies related to informing residents of and including them in their treatment are implemented by the staff who interact with residents during the development and implementation of their care plan. Further, surveys are conducted to ensure the implementation of both Federal and State requirements, including the implementation of resident rights requirements. As such, the Department declines to make this amendment.

Some commentators also recommended requiring annual training by outside entities. They assert that the Federal requirements neither require annual trainings nor require training by outside organizations. A commentator specifically recommended that there be annual training provided by the Long-Term Care Ombudsman and by State or local "Older Adult Protective Services personnel." The Department declines to make these amendments. Requirements for

annual training were proposed in, and are retained on final-form, in § 201.20 (relating to staff development), as further discussed above. The Department also does not have the authority to require that the State Long-Term Care Ombudsman or personnel from other agencies perform trainings.

Subsection (e)

This subsection is deleted on final-form, as explained in subsection (c.3)(1), above.

Subsection (f)

This subsection remains deleted on final form. As explained on proposed, the Department deletes this subsection to eliminate duplication and to avoid conflict with the Federal requirements. The requirements pertaining to the transfer and discharge of residents are in 42 CFR 483.15 (relating to admission, transfer, and discharge rights). The first sentence of existing subsection (f) is addressed in 42 CFR 483.15(c)(1). Under 42 CFR 483.15(c)(1), a facility must permit each resident to remain in the facility and not transfer or discharge the resident from the facility unless the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; the resident's health has improved sufficiently so that the resident no longer needs services provided by the facility; the health and safety of individuals is endangered; the resident has failed after reasonable and appropriate notice to pay for staying at the facility; or the facility ceases to operate. The notification requirements contained in the second, third and fourth sentences of existing subsection (f) are covered in 42 CFR 483.15(c)(3) and (4). Under 42 CFR 483.15(c)(3) and (4), a facility must notify a resident and the resident's representative of the transfer or discharge in writing and in a language and manner they understand, at least 30 days before the transfer or discharge, except where an immediate transfer or discharge is required, where the health and safety of individuals at the facility would be endangered, or when a resident has not resided in the facility for 30 days. Further, a facility's bed-hold policy is covered by 42 CFR 483.15(d), which requires written notice regarding the duration of its bed-hold policy to a resident, or the resident representative.

A commentator objected to the deletion of this subsection and recommended that the Department retain the existing language, with the addition of language and cross-references to conform with the Federal requirements at 42 CFR 483.15(c) cited above. The commentator made the same assertions as those addressed at the beginning of this section, regarding the need for a single, comprehensive statement of resident rights with the inclusion of Federal resident rights and State resident rights in one section. After careful consideration, the Department declines to make this amendment on final-form. The Department first notes that the requirements at 42 CFR 483.15(c) represent the minimum standards necessary to ensure the health and safety of residents during a discharge or transfer from the facility. In addition, with respect to the comment regarding the availability of resident rights, the Department has also created a template of resident's rights, which sets forth a resident's rights in clear and easy to understand language. This template, which facilities may use as a tool to meet the posting and notice requirements in this subsection and subsection (c.1) described above, is attached as Exhibit A, and will also be posted on the Department's website.

Subsection (g)

This subsection is deleted on final-form. The last sentence of existing subsection (g) is moved to subsection (c.)(2), as explained above. Additional comments are discussed below.

Some commentators objected to the deletion, on proposed, of the first sentence of subsection (g), which requires a facility to assure that appropriate arrangements are made for a safe and orderly transfer and that the resident is transferred to an appropriate place that is capable of meeting the resident's needs, unless the discharge is initiated by the resident or resident's responsible person. The commentators assert that the Federal requirement at 42 CFR 483.15(c)(7), which requires a facility to "provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility" is not sufficient to prompt facilities to engage in comprehensive discharge planning, and that discussion of alternative settings, including returning to home and community settings, is frequently skipped. After careful consideration, the Department declines to amend this subsection. As discussed above, Federal requirements require comprehensive discharge planning under 42 CFR 483.15(c) and 42 CFR 483.21(c) (relating to comprehensive person-centered care planning), which include a requirement that the facility develop and implement an effective discharge planning process that focuses on the resident's discharge goals and the preparation of residents to be active partners and effectively transition them to post-discharge care. There are detailed requirements under 42 CFR 483.21(c)(1)(vii) related to ensuring that a resident has been asked about their interest in returning to the community and ensuring that the resident receives appropriate referrals if the resident does express a desire to return to the community. If a determination is made that discharge to the community is not feasible, the facility must document this as well, and include in the documentation why the determination was made.

Some commentators also objected to the deletion of the requirement in the first sentence that a resident be transferred to an appropriate place that can meet the resident's needs. These commentators assert that facilities regularly attempt to transfer residents to homeless shelters, hotel rooms, boarding homes, and other settings where their needs cannot be met. They also assert that while the transfer and discharge requirements at 42 CFR 483.15(c) address transfer to another long-term care nursing facility, it does not address transfers to other settings. IRRC also asked how the final-form regulation will protect residents from transfers to settings where their needs cannot be met. IRRC further asked the Department to explain the reasonableness of removing this provision and how the final regulation protects the public health, safety, and welfare related to transfers.

After careful consideration, the Department declines to amend this language, but has in response to comments added to final-form Rulemaking 1– *General Applicability and Definitions*, definitions for "discharge" and "transfer" to provide this distinction. The Federal requirements define "discharge and transfer" together in 42 CFR 483.5, when in fact the two terms are separate and distinct concepts. This distinction is reflected in *Appendix PP* of the State Operations Manual, which defines the term "discharge" as "the movement of a resident from a bed in one certified facility to a bed in another certified facility or other location in the community, when return to the original facility is not expected" and the term "transfer" as "the movement of a resident from a bed in one certified facility to a bed in another certified facility when the resident expects to return to the original facility." The Department adds these

definitions in § 201.3 in final-form Rulemaking 1 – *General Applicability and Definitions* for clarity. The circumstances to which the commentators refer, *i.e.*, residents moving to homeless shelters, hotel rooms and other settings, are a discharge, not a transfer. Specifically, there are protections for residents who are being discharged from a facility, which include notice requirements at 42 CFR 483.15(c)(3) as well as a requirement at 42 CFR 483.15(c)(7) that the facility "provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility." There are also extensive discharge planning requirements as well at 42 CFR 483.21(c) (relating to comprehensive person-centered care planning) that ensure that a resident is effectively transferred to post-discharge care and to reduce the chances of the resident having to be readmitted.

Subsection (h)

This subsection remains deleted on final-form. As explained on proposed, the Department deletes this subsection to eliminate duplication and to avoid conflict with the Federal requirements. The Federal requirements pertaining to the transfer of residents are in 42 CFR 483.15 (relating to admission, transfer, and discharge rights). Under 42 CFR 483.15(c), a facility is only permitted to transfer a resident under certain circumstances. These circumstances do not contemplate the ability to transfer a resident where the transfer would be harmful to the physical or mental health of the resident being transferred. Because the Department is proposing to adopt the Federal requirements, and a facility would be prohibited under 42 CFR 483.15(c) from transferring a resident where the transfer would be harmful to that resident, there is no need to include this requirement in State regulation.

Subsection (i)

This subsection remains deleted on final-form. As explained on proposed, the Department deletes this subsection to eliminate duplication and to avoid conflict with the Federal requirements. Under 42 CFR 483.10(b) (relating to resident rights), a resident has the right to exercise their rights as a resident of the facility and as a citizen or resident of the United States. Under 42 CFR 483.10(g)(4) and 42 CFR 483.10(g)(5), a resident has the right to receive notices orally and in writing in a format and a language that they understand. The notices required under 42 CFR 483.10(g)(4) include contact information for all pertinent State regulatory and informational agencies, advocacy groups, the State Long-Term Care Ombudsman, and others. A facility is also required to provide information for filing grievances or complaints. Under 42 CFR 483.10(g)(5), a facility is required to post this information, in a form and manner that is accessible and understandable to residents and resident representatives. In addition, under 42 CFR 483.10(j), a resident has the right to voice grievances to the facility or to an agency or entity that hears grievances without discrimination or reprisal or fear of discrimination or reprisal. A facility is also required under 42 CFR 483.10(j)(4) to establish a grievance policy which meets certain minimum requirements, and under 42 CFR 483.10(j)(3), make available information on how to file a grievance or complaint.

Some commentators objected to the deletion of this subsection because they feel it is important to clearly include this requirement in State regulation, even though it is covered by the Federal requirements. The Department declines to make this amendment for the reasons stated at the beginning of this section. Commentators and IRRC commented that the requirement for a facility to "encourage and assist" residents in the exercise of their rights as a resident and a

citizen is not present in the Federal requirements. However, the requirements at 42 CFR 483.10(b)(1) provide clear language that a facility must ensure that residents can exercise their rights. Commentators and IRRC also commented that the Department's hotline, which is included in this subsection is not included in the Federal requirements. The number of the hotline may be subject to change, so the broader requirement under 42 CFR 483.10(g)(4)(i)(C) that the phone number, names, addresses (mailing and email) be provided will ensure that up-to-date information is provided to residents. In addition, the Department's website provides contact information for a concern or a complaint. https://www.health.pa.gov/topics/facilities/nursing%20homes/Pages/Nursing%20Homes.aspx. As provided on the website, if a resident, resident representative or family member has a concern or complaint, the Department may be contacted at 1-800-254-5164; c-ncomplai@pa.gov; via the online complaint form http://apps.health.pa.gov/dohforms/FacilityComplaint.aspx; fax 717-772-2163, or via mail at: Division of Nursing Care Facilities Director, Pennsylvania Department of Health, Division of Nursing Care Facilities, 625 Forster Street, Room 526, Health and Welfare Building, Harrisburg, PA 17120-0701.

Commentators and IRRC also commented that the requirement that a facility include the telephone number of the local legal services program is not expressly listed in the Federal requirements. However, the Federal requirements at 42 CFR 483.10(g)(4)(i)(c) do require that the facility provide contact information for State and local advocacy organizations, including, but not limited, to the State Long-Term Care Ombudsman program. If a resident is not provided with the information for legal advocacy organizations, the Ombudsman program would be able to provide an appropriate referral. Commentators and IRRC also commented that the Federal requirements do not include a requirement that the information be physically posted in a prominent location and in large print. However, under 42 CFR 483.10(g)(5), the facility must post the information in a form and manner accessible and understandable to residents, and resident representatives.

Subsection (j)

This subsection remains deleted on final-form. As explained on proposed, the Department deletes this subsection to eliminate duplication and to avoid conflict with the Federal requirements. Under 42 CFR 483.10(a)(1), a facility is required to treat each resident with respect and dignity and to care for each resident in a manner and in an environment that promotes maintenance or enhancement of quality of life, while recognizing each resident's individuality. Under 42 CFR 483.10(h), a resident has a right to personal privacy and confidentiality of personal and medical records. Some commentators opposed the deletion of this subsection in order to keep a statement regarding treating each resident with respect and dignity in the regulations. Based on the Federal requirements that expressly require respectful and dignified treatment, the Department declines to make this requested change.

Subsection (k)

This subsection remains deleted on final-form. As explained on proposed, the Department deletes this subsection to eliminate duplication and to avoid conflict with the Federal requirements. Under 42 CFR 483.10(e)(2), a resident has the right to retain and use personal possessions, including clothing and furnishings, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. Under 42 CFR 483.10(i), a facility must

provide residents with a safe, clean, comfortable, and homelike environment, and allow residents to use their personal belongings to the extent possible. This includes the provision of private closet space in each resident's room. Although commentators opposed the deletion of this subsection, they did not provide an explanation of why this provision should be retained. In order to maintain consistency and eliminate duplication, the Department declines to make this requested change.

Subsection (l)

Subsection (l) remains deleted on final-form. As explained on proposed, the Department deletes this subsection to eliminate duplication and to avoid conflict with the Federal requirements. The ability of a resident representative to exercise the rights of a resident are addressed in 42 CFR 483.10(b). Under that subsection, a resident representative has the right to exercise a resident's rights to the extent those rights are delegated to the resident representative, either by the resident or by law. Some commentators objected to the deletion of subsection (l), with one commentator stating that the section should be retained and improved upon with an explicit statement that, regardless of any delegation of decision-making authority to third parties, facilities must ascertain the resident's wishes and preferences and allow the resident to participate in the care planning process. A commentator also recommended that the rights and authority of resident representatives be detailed in this subsection, and recommended language that mirrors the Federal requirements at 42 CFR 483.10(b)(7). The Department declines to make these requested changes because the rights and authority of a resident representative are clearly articulated in 42 CFR 483.10(b), including a statement that to the extent practicable, the resident must be provided with opportunities to participate in the care planning process, and a statement that resident representatives acting on behalf of a resident must consider the resident's wishes and preferences.

A commentator also recommended that language be added to this subsection codifying a resident's right to visitors and an essential caregiver. The commentator recommended language stating that a resident has a right to their choice of visitors, except where a court order restricts this right. The Department declines to make this requested change because visitation rights are already protected by the Federal requirements at 42 CFR 483.10(f)(4). When visitation is restricted by a court order, a facility is already required by law to comply with that order. The commentator also suggests that a statement be included that ensures that during periods when visitation is restricted, the resident retains the right to identify at least one essential caregiver to visit in-person, and that the facility may not prohibit entry of a caregiver who is following the facility's safety protocols. The Department declines to make this change because the allowance for an essential caregiver is set forth in and governed by statute under the Access to Congregate Care Facilities Act (35 P.S. § 10281—10289).

Subsection (m)

This subsection remains deleted on final-form. Comments received on this subsection are addressed in subsection (a), above.

Subsection (n)

This subsection is deleted on final-form. The first and last sentence of existing subsection (n) are moved to subsection (c.2), as explained above. Additional comments are discussed below.

Commentators opposed the deletion of the second sentence in this subsection, which currently requires rights to be provided on admission and requires the facility to ensure that this policy is fully communicated to residents who cannot read, write or understand English. Commentators noted that this provision helps ensure that that limited English proficiency (LEP) residents and residents with disabilities understand their rights. IRRC noted these comments and asked the Department to explain how deleting this provision protects the public, health, safety, and welfare related to providing notice of resident rights to a resident, particularly to a resident who cannot understand English. After careful consideration, the Department declines to make this change and retain this provision as it is covered by the Federal requirements. As the Department explained on proposed, under 42 CFR 483.10(g)(16)(relating to resident rights), a facility must provide a notice of rights and services to residents prior to or upon admission and during the residents' stay. Specifically, a facility must inform a resident of their rights and all rules and regulations governing resident conduct and responsibilities during their stay in the facility, both orally and in writing, in a language that the resident understands. 42 CFR 483.10(g)(16)(i). Additionally, the Federal requirements at 42 CFR 483.10(g)(3) require that a facility provide information 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.

Subsection (o)

This subsection is deleted on final-form. Resident rights with respect to experimental treatment are moved to new subsection (c.3)(3), with amendments, as described above.

Subsection (p)

This subsection is deleted on final-form. The language that was proposed in subsection (p) is moved to new subsection (c.3)(4), without amendment, as described above.

Other Comments

A commentator stated that it is critical that the regulations include requirements that aid residents and their representatives in understanding their rights. The commentator also stated the importance of communicating what recourses are available to residents if their rights are violated.

As previously provided, clear communication of resident rights is already detailed at 42 CFR 483.10(g)(3), which requires that the facility provide information 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. The Federal requirements establish that facilities must furnish to each resident a written description of legal rights, which includes the names and contact information of all pertinent State regulatory and informational agencies, resident advocacy groups, the State licensure office, the State Long-Term Care Ombudsman program, and adult protective services, among others. In addition, facilities must provide residents a statement that the resident may file a complaint with the State Survey Agency concerning any

suspected violation of State or Federal long-term care nursing facility regulations. 42 CFR 483.10(g)(4)(i)(C) — (D). Since these comments are addressed by adoption of the Federal requirements, the Department declines to make these requested changes.

A commentator recommended that each place where a resident right is set forth begin with the words "residents have a right to..." The Department recognizes the importance of communicating information to residents in a manner that residents can understand, but declines to make this amendment on final-form. Under 42 CFR 483.10(g)(3), a facility is required to provide information to each resident in a form and manner the resident can access and understand. In addition, as noted at the beginning of this section, the Department has created a template of resident's rights, which sets forth a resident's rights in clear and easy to understand language, which facilities may utilize. This template is attached as Exhibit A and will also be posted on the Department's website.

A commentator highlighted the need for residents to be respected and treated as responsible adults and not be treated as though they are living in prisons. The Department agrees that it is important that residents be treated with respect, and this right is provided for in the Federal requirements at 42 CFR 483.10(a)(1) (relating to resident rights), which provides that a facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of their quality of life. The commentator also stated that, when possible, a variety of enriching experiences outside of the facility and inside the facility should be made available to residents. Enriching experiences are also provided for in the Federal requirements at 42 CFR 483.24(c) (relating to quality of life), which requires that a facility provide an ongoing program to support residents in their choice of activities designed to meet the interests of residents and encouraging both independence and interaction in the community. Therefore, the Department declines to make this requested amendment.

A commentator, in comment to proposed Rulemaking 2, recommended that, when a facility plans to conduct construction, alteration or renovation, they first present the written plan, architectural renderings and a plain language description of their plans to the resident and family council and the Long-Term Care Ombudsman. The Department considered this comment in its review of comments on § 201.29 (relating to resident rights), because the commentator's recommendation would afford residents a right to review the above-mentioned documents. After careful consideration, the Department determined that, while it may be a best practice to share information regarding plans for construction, alteration or renovation with the resident council, it does not constitute a minimum health and safety requirement that must be included in the regulations in order to protect the health, safety and welfare of residents. Therefore, the Department declines to make this requested amendment.

Another commentator, in comment to proposed Rulemaking 2, suggested that a doorbell be installed outside of each resident room and that staff be required to knock prior to entering a resident's room. The Department declines to include a requirement that a doorbell be installed outside each room. The Department considers knocking and requesting permission to enter to fall within a resident's preferences, subject to an emergency, which is covered by 42 CFR 483.10(e)(3) (relating to resident rights), which provides that a resident has the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other

residents. If a resident prefers that staff knock before entering the resident's room, then the resident has the right to that accommodation, as long as it does not endanger their health or safety or the health or safety of others. Therefore, the Department declines to make the requested amendment.

A commentator recommended adding language that establishes a resident's right to visitors and essential caregivers. The Department declines to make this requested amendment because the Federal requirements at 42 CFR 483.10(f)(4) provide that a resident has the right to receive visitors of the resident's choosing. In addition, the Department declines to make this change because the allowance for an essential caregiver is set forth in and governed by statute under the Access to Congregate Care Facilities Act (35 P.S. § 10281—10289) as discussed above.

A commentator also requested the Department to add protections for residents related to a resident's ability to appeal an "involuntary discharge" from the facility due to concerns related to Medical Assistance (MA) appeals regarding the discharge of residents who are MA beneficiaries. The commentator specifically asserts concerns regarding burden of proof and the ability for a resident to prepare an effective case. The Department notes that a notice of discharge is required and Federal requirements at 42 CFR 483.15(c)(3) (relating to admission, transfer and discharge rights) require the notice to include the reasons for the discharge. The reason must also be noted in the medical record, which the resident has a right to access under 42 CFR 483.10(g)(2). Furthermore, this comment, which relates to the hearing and appeals process under 55 Pa.Code Chapter 1181 (relating to nursing facility care) for providers participating in the MA program is outside the scope of this rulemaking and the Department's authority. As such, the Department declines to make this suggested amendment.

A commentator suggested that the Department add a requirement that residents have the right to receive care in accordance with the resident's care plan. The Department declines to make this suggested amendment because it would be duplicative of 42 CFR 483.10(c)(2), which provides that a resident has the right to participate in the development and implementation of their person-centered plan of care, including the right to receive the services or items included in the plan of care.

A commentator also recommended that the Department add a requirement that residents have the right to recognition of their families of choice and domestic partnerships the same as traditional family units and marriages. The Department declines to make this additional amendment to this section because under amended subsection (c.3)(4), described above, a resident has the right to care without discrimination on the basis of sexual orientation. Residents also have the right to dignity, self-determination, and communication with and access to persons inside and outside the facility under 42 CFR 483.10(a). Also, in the case of visitation, under 42 CFR 483.10(f)(4)(vi), residents have a right to receive visitors designated by the resident, including a spouse, a domestic partner, another family member, or a friend. The right to visitation shall not be restricted on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation or disability.

Next, the commentator recommended that the Department add a requirement that residents have the right to go to their hospital of choice even if the facility has a transfer agreement with other hospitals and to also require that facilities inform residents of the facility's

transfer agreements upon admission. The Department declines to add this requirement because there are protections in place to ensure that a resident's preferences regarding medical care are honored. For example, the Federal requirements at 42 CFR 483.10(f) provide that a resident has the right to, and the facility must promote and facilitate resident self-determination through support of resident choice. Under 42 CFR 483.10(c), residents have the right to be informed of, and to participate in, their treatment, which includes the right to be fully informed in language that they can understand of their total health status, including but not limited to, their medical condition. Residents also have the right to participate in the development and implementation of their person-centered plan of care, which includes but is not limited, the right to participate in the planning process and in establishing goals and the right to be informed in advance of changes to the plan of care. In addition, the facility is required to inform residents of the right to participate in their treatment and are required to support residents in this right. Residents also have the right to be informed, in advance, of the care to be furnished and the type for caregiver or professional that will furnish care. Residents have the right to be informed in advance of risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option they prefer. Finally, residents also have the right to request, refuse or discontinue treatment. 42 CFR 483.10(c). The Department expects facilities to comply with these rights, which would extend to a resident's right to make choices regarding their care including the ability to choose a hospital, in a non-emergency situation. However, the Department also notes that while a facility should strive to honor a resident's choice in hospitals, it may not always be feasible to transfer residents to their hospital of choice in an emergent situation, due to the location of the preferred hospital or the type or level of care needed.

The commentator also recommended that the Department add a requirement that residents be provided with annual resident rights training by the Long-Term Care Ombudsman. As provided above, the Department declines to make this amendment since the Department does not have the authority to require that the State Long-Term Care Ombudsman or personnel from other agencies conduct trainings.

Next, the commentator recommended that the Department add a statement that residents have the right to bring a private right of action and establish a prohibition on facilities asking residents to waive that right. Generally, residents have a right, under 42 CFR 483.10(b), to exercise their rights as a resident of the facility and as a citizen or resident of the United States. Where a private right of action is available by law, that right applies to residents in a facility. Further, based on comments received, the Department is maintaining the provision that a facility may not obtain from or on behalf of residents a release of liabilities or duties imposed by law or Subpart C (relating to long-term care facilities) in § 201.24(b) (relating to admission policy).

Next, the commentator recommended that there be a requirement that residents be provided with a written notice of resident rights and responsibilities and payment policies, including filial responsibility and estate recovery rules that may apply as well as information about the right to choose whether to have the facility serve as the resident's representative payee for Social Security. After careful consideration, the Department declines to make this amendment. Under 42 CFR 483.10(g)(16), a facility must inform the resident both orally and in writing of their rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. In addition, under amended § 201.29(b), policies and procedures regarding rights and responsibilities of residents must be available to residents.

Further, under amended § 201.29(c.1), a facility must post a notice in the facility which sets forth the list of resident rights. A facility must also provide residents with personal notice of resident rights. *See* § 201.29(c.2).

Regarding payment policies, the Federal requirements under 42 CFR 483.10(g)(18) provide that the facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services. Further, the designation of the facility as a representative payee by the Social Security Administration is governed by the Social Security Act and accompanying regulations. Similarly, the Medical Assistance Estate Recovery program is only applicable to MA beneficiaries and governed by the Department of Human Services regulations under 55 Pa.Code Chapter 258 (relating to Medical Assistance estate recovery). In addition, filial support is governed by the statutory provisions under 23 Pa.C.S. Chapter 46 (relating to support of the indigent). The Department declines to make this amendment to require nursing facilities to provide notice regarding these other Federal and State programs as they are outside of the Department's purview.

Next, the commentator recommended that the Department add a requirement that residents be informed about bed hold policies prior to a transfer to a hospital and provide information on how the facility tracks the period in which the resident is absent from the facility. After careful consideration, the Department declines to add this requirement. Under the Federal requirements at 42 CFR 483.15(d) (relating to admission, transfer and discharge rights), when a resident is transferred, the facility must provide written information about the facility's policies regarding bed-hold periods, as well as written notice that specifies the duration of the bed-hold policy. For MA beneficiaries, beds may be held for a maximum of 15 days per hospitalization. 55 Pa. Code 1187.104 (relating to limitations on payment for reserved bed).

Next, the commentator recommended that language be added establishing that a resident has a right to privacy, and that LGBT residents have the right to decide who knows about their sexual orientation and gender identity, and if, when or how they choose to come out. They suggest that outing a resident or disclosing their gender history, sexual orientation or HIV status without their consent should be prohibited. After careful consideration, the Department declines to make this suggested amendment. Residents have a right, under 42 CFR 483.10(a)(1), to respect and dignity and care in a manner that promotes maintenance or enhancement of their quality of life, recognizing each resident's individuality. In addition, under 42 CFR 483.10(e)(3), a resident has a right to be treated with respect and dignity, including reasonable accommodation of resident needs and preferences. In some cases, sharing of information such as gender history or HIV status could constitute sharing of medical information, which is prohibited under 42 CFR 483.10(h), which states that a resident has a right to personal privacy and confidentiality of their personal and medical records. Finally, under § 201.29(c.3)(4) a resident has the right to care without discrimination based upon sexual orientation or gender identity or expression.

Lastly, the commentator suggested that language be added stating that residents have the right to be free from restraints except where medically ordered and where restraints provide the least restrictive alternative, as outlined in the resident's care plan. After careful consideration, the Department declines to make this amendment. Restraints are addressed in § 211.8, described below, and a medical order is required for restraints in accordance with § 211.8(d). In addition, the Federal requirements at 42 CFR 483.12(a)(2) establish that when the use of restraints is

indicated, a facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This is reiterated in § 211.8(c.1), which provides that when utilized, a facility must use the least restrictive method for the least amount of time to safely and adequately response to individual resident needs in accordance with the resident's comprehensive assessment and comprehensive care plan.

§ 201.30. Access requirements

This section remains deleted on final-form. As explained on proposed, the Department deletes this section to eliminate duplication and avoid conflict with the Federal requirements at 42 CFR 483.10(f) (relating to resident rights). Under 42 CFR 483.10(f)(4) (relating to resident rights), a resident has a right to receive visitors of their choosing at the time of their choosing. A facility must provide immediate access to certain individuals, subject to the resident's right to deny visitation. The Federal requirements further require that a facility must provide reasonable access to any entity or individual that provides health, social, legal or other services to the resident, subject to the resident's right to deny visitation. A facility must also have written policies and procedures regarding visitation rights, including any clinically necessary or reasonable restriction or limitation or safety restriction or limitation the facility may need to place on such rights. These policies and procedures must include the reasons for such restriction or limitation. 42 CFR 483.10(f)(4).

Subsection (a)

Commentators requested that the Department retain the language in subsection (a) with amendments. Specifically, commentators requested that the Department add language that facilities may not limit forms of access (telephonic, videographic, and electronic) to residents, except in accordance with State and Federal public health mandates or court orders. After careful consideration, the Department declines to retain this subsection or add any additional language on final-form. The Federal requirements at 42 CFR 483.10(g)(7) provide that a facility must protect and facilitate a resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to telephone, internet, stationery, postage, writing implements, and the ability to send mail. Under 42 CFR 483.10(g)(8), a resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service.

A commentator also requested that the Department retain the language in subsection (a) prohibiting a facility from questioning an attorney, ombudsman staff or agency representatives about the reason for their visit to a resident, as similar language is not included in the Federal requirements. After careful consideration, the Department declines to retain this language. The intent behind the language in subsection (a) that the Department deleted was to prevent a facility from retaliating against a resident that has complained about the facility by dissuading the resident from meeting with the Ombudsman or an attorney. However, the Federal requirements at 42 CFR 483.10(b)(1) provide that a facility must ensure that a resident can exercise their rights without interference, coercion, discrimination, or reprisal from the facility. Further, 42 CFR 483.10(b)(2) states: "The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising their rights and to be supported by the facility in the exercise of their rights as required under this subpart." Therefore, the language

noted by the commentator in subsection (a) is covered under the Federal requirements and the Department declines to make this change.

Subsection (b)

A commentator requested that the Department retain language in subsection (b) that requires that a person not enter the living area of a resident without identifying themselves to the resident and receiving permission to enter as this provision is not included in the Federal requirements. After careful consideration, the Department declines to retain this language. As stated above, 42 CFR 483.10(f)(4) provides that "[t]he resident has a right to receive visitors of their choosing at the time of their choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident." This covers the language that the Department deleted in subsection (b). Specifically, 42 CFR 483.10(f)(4) provides that the resident has the ability and right to receive visitors of their choosing. As applied, this regulation requires that the resident would need to be aware of the identity of the visitor and the time for visitation prior to consenting to visitation. To the extent that the potential visitor does not identify themselves to the resident, the resident has the right to deny visitation.

Other Comments

IRRC noted the several comments above and requested the Department explain the reasonableness of not providing in the final regulation for the protection of a resident's right to visitors and control over who enters the living area, and how the final regulation protects the public health, safety, and welfare related to a resident's right to visitors and control over who enters the living area. As explained above, the Department is not removing the protections related to the rights of visitors and control of who enters the living area. The Federal regulations at 42 CFR 483.10(b)(2), (f)(4), (g)(7) and (g)(8) address the Federal health and safety requirements related to consenting to and denying visitation, communication, and freedom from interference and coercion. As such, as stated above, the Department declines to make the suggested change.

A commentator suggested that the Department add a subsection prohibiting facilities from limiting access to the facility by State and local officials, including the Department, the Department of Human Services, the Long-Term Care Ombudsman Program, Protective Services, Protection and Advocacy, Law Enforcement, and others with legal authority to enter. Another commentator requested that the Department make facilities' obligations to allow visitors and representatives from government agencies and other entities, such as those similar to and including the ones listed above, more explicit. After careful consideration, the Department declines to add this language. Under 42 CFR 483.10(f)(4)(i), representatives of the State and representatives of the Office of the State Long-Term Care Ombudsman are to be provided immediate access to any resident of the facility. Furthermore, other parties with the legal authority to enter the facility would already be granted such authority by operation of law, and the Department need not include duplicative language in this subsection. Finally, the Federal requirements at 42 CFR 483.10(f)(4) provide explicit requirements for facilities to follow in allowing residents to have visitors. The Federal requirements at 42 CFR 483.10(f)(4)(iv) specifically state that "[t]he facility must 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."

§ 201.31. Transfer agreement

The Department retains this section on final-form. The Department had proposed to delete this section to eliminate duplication and avoid conflict with the Federal requirements at 42 CFR 483.70(j), which require a facility to have in effect a written transfer agreement with one or more hospitals that are approved for participation under Medicare or MA. Commentators opposed the deletion of this section, asserting that the Federal requirements are less stringent and that it is unacceptable for a facility to lack an agreement for the transfer of residents, even if the facility has tried in good faith to obtain one but has failed. IRRC asked, if the provisions in this section were removed on final-form, that the Department address how the regulation would protect the public health, safety, and welfare in the event of a need to transfer a resident to a hospital if no transfer agreement is in effect. Upon further review of the Federal requirements at 42 CFR 483.70(j) and in consideration of public comments, the Department has decided to retain the existing language in § 201.31 which requires a facility to have a transfer agreement with one or more hospitals, without exception.

Some commentators requested that the Department add language to this section to allow for a resident to have a choice of hospitals in non-emergency situations. One commentator also indicated that a facility should be required to counsel residents on the implications of receiving care at different local hospitals, which would include providing residents with information on whether the hospital participates in their health insurance plan. Other commentators echoed that the Department should add language requiring a facility to assist residents in determining which providers are considered in-network providers for insurance coverage.

After carefully considering these comments, the Department declines to make these amendments, as these considerations are contemplated and discussed under Resident Rights. As discussed previously, under 42 CFR 483.10(f), a resident has the right to, and the facility must promote and facilitate resident self-determination through support of resident choice. Under 42 CFR 483.10(c), residents have the right to be informed of, and to participate in, their treatment, which includes the right to be fully informed in language that they can understand of their total health status, including but not limited to, their medical condition. Residents also have the right to participate in the development and implementation of their person-centered plan of care, which includes but is not limited, the right to participate in the planning process and in establishing goals and the right to be informed in advance of changes to the plan of care. In addition, the facility is required to inform residents of the right to participate in their treatment and are required to support residents in this right. Residents also have the right to be informed, in advance, of the care to be furnished and the type for caregiver or professional that will furnish care. Residents have the right to be informed in advance of risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option they prefer. Finally, residents also have the right to request, refuse or discontinue treatment. The Department expects facilities to comply with these rights, which would extend to a resident's right to make choices regarding their care including the ability to choose a hospital, in a non-emergency situation. However, the Department also notes that while a facility should strive to honor a resident's choice in hospitals, it may not always be feasible to transfer residents to their hospital of choice in an emergent situation, due to the location of the preferred hospital or the type or level of care needed.

One commentator also requested that the Department add a subsection to require a facility to consider resident Medicare and MA health plan network limitations prior to proposing a transfer to a hospital. After careful consideration, the Department declines to make this amendment as part of the licensure requirements for a nursing facility. Payment provisions and participation requirements are governed by the Medicare and MA Programs.

§ 207.2. Administrator's responsibility

Subsection (a)

This subsection remains deleted on final-form. As explained on proposed, the requirement in existing subsection (a), pertaining to the administrator's responsibility for housekeeping and maintenance, is moved to § 201.18(e)(2.a) (relating to management). Thus, there is no need to retain this requirement here.

Subsection (b)

This subsection remains deleted on final-form. As explained on proposed, the Department deletes subsection (b) as this provision is outdated. In recent years, there has been a shift in the long-term care nursing environment to providing residents with a more homelike environment; therefore, services are sometimes provided by a limited set of nursing staff, who, as in a household, are responsible for a variety of tasks, including housekeeping duties. As provided below, facilities are still expected to comply with the requirement under 42 CFR 483.35(a)(1) (relating to nursing services) that the facility must provide services by sufficient numbers of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans. In addition, facilities still must meet the requirement in § 211.12(i)(1) (relating to nursing services) that only direct resident care provided by nursing service personnel may be counted towards the total minimum number of hours of general nursing care required under § 211.12(i).

A commentator thanked the Department for broadening the scope of tasks allowed to be completed by nursing personnel. Other commentators expressed concern that the deletion of this provision will result in facilities requiring nursing personnel to perform housekeeping duties, which will reduce the time nursing personnel spend on direct nursing care to residents. These commentators believe there is a risk that, without the language in subsection (b), nursing staff will be expected to complete an ever-increasing list of tasks, and facilities will use nursing staff to address staff shortages in other areas of the facility. IRRC agreed with commentators and questioned the reasonableness of expanding the duties of nursing personnel to include housekeeping duties given the numerous comments received on the existing nurse staffing shortage. IRRC asked the Department to explain how adding housekeeping duties to nursing personnel in the final regulation is reasonable and protects the public health, safety, and welfare.

In response to these comments, the Department clarifies that the deletion of this subsection is intended to promote the use of household model facilities where nursing personnel attend to a small number of residents, for example ten residents, in which the residents and staff contribute to the maintenance of the household. Such models are resident-centered and directed and include the empowerment of staff and residents to work as a team to provide care. PHI.

(2018) The Household Model: Creating a 'Home' in Nursing Homes. Retrieved from https://www.phinational.org/household-model-creates-real-home-people-living-nursing-homes/. As provided above, despite the deletion of subsection (b), facilities would still be expected to comply with the requirement under 42 CFR 483.35(a)(1) that the facility must provide services by sufficient numbers of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans, as well as the requirement in § 211.12(i)(1) (relating to nursing services) that only nursing service personnel may be counted towards the total number of minimum hours of general nursing care required under § 211.12(i).

A commentator also recommended adding a subsection requiring that housekeeping and maintenance staff be properly trained in infection control and that they operate at all times in accordance with the infection control instructions of the facility's infection preventionist. The Department declines to add this requirement because the training of all staff related to infection control is already required by the Federal requirements. Under 42 CFR 483.95(e) (relating to training requirements), 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) (relating to infection control). Facility staff are expected to follow the written standards, policies and procedures of the infection prevention and control program.

§ 209.3. Smoking

The Department amends this section on final-form. As explained on proposed, the Department deletes this section in its entirety to eliminate duplication and avoid conflict with the Federal requirements. Under 42 CFR 483.90(i)(5) (relating to physical environment), a facility is required to establish policies, in accordance with applicable Federal, State and local laws and regulations, regarding smoking, smoking areas and smoking safety that also take into account non-smoking residents. The *Life Safety Code*, which has been adopted in the Federal requirements at 42 CFR 483.90(a), also addresses requirements for smoking policies at 18.7.4 and 19.7.4.

Commentators commented that there are several aspects of this section that are not included in the Federal requirements, which should be retained, including the requirement that smoking policies be posted in a conspicuous place and in legible format, and the requirement that adequate supervision be provided for residents who smoke. Commentators indicated that they assume that requirements in this section are included in the *Life Safety Code*, but if they are not, they should be retained. Commentators also expressed concern for the rights of residents who smoke, indicating that it is extremely difficult for residents to give up smoking. Commentators recommended that the Department add a requirement that changes in smoking policies may only be implemented prospectively, with residents who were admitted under an earlier smoking policy being grandfathered into that policy. Commentators argued that at a minimum, smoking policies should be communicated with residents before admission so they can decide whether the facility will meet their needs.

IRRC noted the comments regarding the posting of smoking policies and adequate supervision of residents while smoking and asked the Department to explain how the regulation protects the public health, safety and welfare by not providing requirements related to the posting of smoking policies and a requirement for adequate supervision for residents while smoking.

After careful consideration, the Department amends § 209.3 in response to these comments to retain subsections (a), (c) and (d), to retain provisions related to the posting of smoking policies, adequate supervision for residents who require it, and to prohibit smoking in bed. The Department deletes the word "the" and adds the words "smoking and" before the word "nonsmoking" to make it clear that a facility's policies shall include provisions for the protection of the rights of both smoking and nonsmoking residents. In response to questions the Department received regarding whether subsections (b), (e), (f) and (g) are covered by the *Life Safety Code*, the Department notes that the *Life Safety Code* at sections 18.7.4 and 19.7.4. states the following with regards to smoking, which supplant these deleted subsections:

1) Smoking regulations shall be adopted and shall include not less than the following provisions: Smoking shall be prohibited in any room, ward, or individual enclosed space where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking.
2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.
3) Smoking by patients classified as not responsible shall be prohibited.
4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision.
5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.
6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.

§ 211.2. Medical director

The title of this section is unchanged from proposed to final-form. As explained on proposed, the Department amends the title of this section to "medical director" to more accurately reflect the substance of this section, as amended.

Subsection (a)

Subsection (a) remains deleted on final-form. As explained on proposed, the Department deletes this subsection to eliminate duplication and avoid conflict with the Federal requirements for facilities. Under 42 CFR 483.30 (relating to physician services), a physician is required to approve in writing an individual's admission to a facility, and each resident in a facility must remain under the care of a physician. Under 42 CFR 483.21(b), a facility is required to develop and implement a comprehensive person-centered care plan for each resident. This care plan is prepared by an interdisciplinary care team, that includes the attending physician, the resident and resident representative, and others who are involved in the resident's care.

A commentator suggested that the Department retain subsection (a), arguing that the Federal requirements do not provide the specificity required to ensure that the medical care delivered to residents is compliant on a consistent basis. The requirements under 42 CFR 483.80 (relating to infection control) require that the medical care of each resident is supervised by a physician, who must review the resident's total program of care, including medications and

treatments, at each visit. Further, the resident must be seen by a physician at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter. Under 42 CFR 483.70(h) (relating to administration), a facility must designate a physician to serve as medical director, who is responsible for the coordination of medical care in the facility. Facilities are required to comply with these requirements to ensure that residents are receiving quality medical care. As such, the Department declines to make this suggested amendment.

Subsection (b)

Subsection (b) remains deleted on final-form. As explained on proposed, the Department deletes this subsection to eliminate duplication and avoid conflict with the Federal requirements. Under 42 CFR 483.20(a) (relating to resident assessment), a facility is required to have, at the time of admission, a physician's orders for the resident's immediate care. Further, under 42 CFR 483.21 (relating to comprehensive person-centered care planning), a facility is required to develop and implement, within 48 hours of admission, a baseline care plan for each resident. The baseline care plan must include the minimum healthcare information necessary to properly care for a resident, including physician orders. A facility is also required, under 42 CFR 483.20(b), to conduct a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using a resident assessment instrument. Under 42 CFR 483.20(b)(2)(i), this assessment must be conducted within 14 days after admission.

A commentator recommended retaining subsection (b) but amending it to require that the initial medical assessment be conducted no later than 3 calendar days after admission, instead of the current requirement for no later than 14 days after admission. As noted, a facility must initially conduct a comprehensive resident assessment under 42 CFR 483.20(b)(2)(i), which must occur within 14 days after admission. However, prior to this comprehensive resident assessment, a facility must develop and implement a baseline care plan, under 42 CFR 483.21(a) within 48 hours of admission, which provides for initial goals based on admission orders, physician orders, dietary orders, therapy services, social services and a PASARR recommendation, if applicable. The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan is developed within 48 hours. The baseline care plan serves the same purpose as the "initial medical assessment" suggested by the commentator and is required to be completed in an even shorter timeframe than the one suggested by the commentator. The Department, therefore, declines to make this amendment.

Subsection (c)

Subsection (c) is unchanged from proposed to final-form. As explained on proposed, the Department amends the first sentence of subsection (c), to delete language that is duplicative of the Federal requirements for the provision of a medical director and to include a cross-reference to the Federal requirements for a medical director at 42 CFR 483.70(h) (relating to administration). Under 42 CFR 483.70(h), a facility is required to designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies and the coordination of medical care in the facility. The Department, however, retains the requirement that the medical director be licensed as a physician in this Commonwealth, as that is not specifically indicated in the Federal requirements for a medical director.

The Department also adds, at the request of stakeholders, a requirement that the medical director complete at least four hours annually of continuing medical education (CME) pertinent to the field of medical direction or post-acute and long-term care medicine. The Department has determined that this addition, which is not included in the Federal requirements, is necessary to ensure that the medical director of a facility remains current in the field. Having a knowledgeable medical director is critical to the provision of quality care. Additionally, requiring 4 hours of CME pertinent to the field of medical direction or post-acute and long-term care medicine will not present a burden for medical directors as these hours would count towards the 100 minimum CME hours required annually for physicians to maintain their licensure in this Commonwealth. In the second sentence, the Department removes the ability of a facility to have a medical director serve on a full or part-time basis. Under 42 CFR 483.70(f), a facility is required to have professional staff on a full-time, part-time or consultant basis as needed. This would extend to the medical director.

Several commentators were supportive of the amendments to this section on proposed. A commentator requested that the Department explain how it would oversee and track the medical director CME requirement. The commentator suggests that the Department consider changing its proposed 4-hour CME requirement to 1 hour of in-service training by the long-term care nursing facility within its Quality Assurance and Performance Improvement (QAPI) program. Finally, the commentator seeks clarification on whether there will be an approved training site for medical directors. IRRC also asked how this provision would be implemented; "[f]or example, who will monitor whether the training is completed?"

In response to these comments and questions, the Department notes that CME requirements would simply be noted in the medical director's personnel file with the facility, as required by § 201.19(7) (relating to personnel records). The Department will check for compliance with § 201.19(7) when it surveys a facility. Also, while the Department appreciates the suggestion that the CME requirement be replaced with in-service training in the QAPI program, training in the QAPI program is required separately under 42 CFR 483.95(d),(relating to training requirements) which requires mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program. Also, requiring 4 hours of relevant CME training will not be overly burdensome to medical directors, as they are already required to complete 100 hours of CME training annually to maintain their physician's license. These 4 hours of CME pertinent to the field of medical direction or post-acute and long-term care medicine would count towards (and would not be in addition to) the 100 minimum CME hours. With respect to the question as to whether there will be an approved training site for medical directors, the Department is not able to address CME training locations as the Department is not vested with the authority to vet and oversee CME training.

Commentators objected to the deletion of language permitting a medical director to serve on a full or part-time basis depending on the needs of the residents and facility. Commentators expressed concern that the deletion of the full or part-time language would permit a facility to hire a consultant to serve as the medical director. A commentator also expressed concern with the deletion of "depending on the needs of the residents and facility," asserting that this is not covered in the Federal requirements. The commentator believes that deferring to the Federal requirements in 42 CFR 483.70(f) (relating to administration) will lower the standard for medical director coverage in this Commonwealth. The commentator asserts that as the acuity of

residents' needs has increased, professional oversight in facilities is crucial to ensuring quality care and is needed now more than ever. IRRC asked the Department to explain how permitting a medical director to serve on a consultant basis protects the public health, safety and welfare, particularly without the qualifying provision that the needs of the residents and facility serve as the basis for the amount of time that a medical director is present.

After careful consideration, the Department declines to make the suggested amendments. Regardless of employment status as either an employee of the facility or a contractor, a medical director is held to the same Federal and state requirements related to resident health and safety. Specifically, the responsibility for the coordination of medical care in the facility remains the same. Additionally, the requirement for the presence of the Medical Director must not be conflated with the employment status of the director. Resident and facility needs, including the medical director's responsibilities under subsection (d), will dictate the level of medical director presence, as both medical directors and residents are involved in the development of residential care policies pursuant to 42 CFR 483.70(h).

Subsection (d)

Subsection (d) is amended from proposed to final-form. On proposed, the Department deleted this subsection in its entirety to eliminate duplication and avoid conflict with the Federal requirements. Paragraph (1) is covered by 42 CFR 483.75(g)(1) (relating to quality assurance and performance improvement), which requires a facility to maintain a quality assessment and assurance committee. The medical director or the medical director's designee serves on this committee. Paragraph (2) is covered under 42 CFR 483.70(h)(2). Under 42 CFR 483.70(h)(2), the medical director is responsible for the implementation of resident care policies and the coordination of medical care in the facility. This includes oversight of the responsibilities of attending physicians.

Commentators asked that the Department retain this subsection and add several requirements addressing the responsibility, role, and duties of the medical director in a facility. Commentators assert that the Federal regulations do not provide the specificity to ensure that medical care delivered to residents is compliant on a consistent basis. The Department has carefully considered the suggestions of the commentators. The Department declines to retain paragraphs (1) and (2) as these are covered by the Federal requirements, as explained above. However, the Department has decided to retain the introductory portion of subsection (d) and to add new requirements in paragraphs (3) through (10) to align with the Federal guidance. As amended on final-form, the medical director's responsibilities shall include at least the following:

Under paragraph (3), ensuring the appropriateness and quality of medical care and medically related care.

Under paragraph (4), assisting in the development of educational programs for facility staff and other professionals.

Under paragraph (5), working with the facility's clinical team to provide surveillance and develop policies to prevent the potential infection of residents in accordance with the infection control requirement under 42 CFR 483.80 (relating to infection control).

Under paragraph (6), cooperating with facility staff to establish policies for assuring that the rights of individuals are respected.

Under paragraph (7), supporting and promoting person-directed care such as the formation of advance directives, end-of-life care, and provisions that enhance resident decision making, including choice regarding medical care options.

Under paragraph (8), identifying performance expectations and facilitating feedback to physicians and other health care practitioners regarding their performance and practices.

Under paragraph (9), discussing and intervening, as appropriate, with a health care practitioner regarding medical care that is inconsistent with current standards of care.

Under paragraph (10), assisting in developing systems to monitor the performance of the health care practitioners including mechanisms for communicating and resolving issues related to medical care and ensuring that other licensed practitioners who may perform physician-delegated tasks act within their scope of practice.

The Department adds this language from guidance into regulation to provide additional clarity to the regulated community, advocacy organizations, and residents and resident representatives regarding the functions and roles of a medical provider in a facility.

Other Comments

Commentators suggested adding a new subsection to require that medical director communication and interactions with residents and resident representatives be person-centered and conducted in a manner easily understood by each resident and provided in the form, format, and language of the resident's need or preference. After careful consideration, the Department declines to make this suggested amendment. Under 42 CFR 483.10(c)(1) (relating to resident rights), a resident has the right to be fully informed in language that they can understand of their total health status, including but not limited to, their medical condition. Section 483.10(c)(2) further states that residents have the right to participate in the development and implementation of their person-centered plan of care. These rights would extend to communications with the medical director.

§ 211.3. Verbal and telephone orders

The title of this section is unchanged from proposed to final-form. As set forth on proposed, the Department replaces the word "oral" with the word "verbal" in the title of this section, as the word "verbal" is more commonly used now in the long-term care nursing environment to describe nonwritten communications.

Subsection (a)

This subsection is unchanged from proposed to final-form. As explained on proposed, the Department replaces "a physician's oral" with the word "verbal" at the beginning of this subsection. The amendment from "oral" to "verbal" is made for consistency in the use of terminology. The Department deletes the word "physician" because physicians are not the only individuals permitted to issue orders under scope of practice standards. Under 42 CFR 483.30(e) (relating to physician services), a physician may delegate tasks to a physician assistant, nurse practitioner or clinical nurse specialist acting within the scope of their practice as defined by

State law. The scope of practice for physician assistants, including supervision by a physician, is set forth under the Medical Practice Act at 63 P.S. § 422.13 and in regulation at 49 Pa. Code Chapter 18, Subchapter D (relating to physician assistants). The scope of practice for certified registered nurse practitioners is set forth under the Professional Nursing Law at 63 P.S. § 218.2, and in regulation at 49 Pa. Code Chapter 21, Subchapter C (relating to certified registered nurse practitioners). The scope of practice for clinical nurse specialists set forth under the Professional Nursing Law at 63 P.S. § 218.6, and in regulation at 49 Pa. Code Chapter 21, Subchapter H (relating to clinical nurse specialists). The Department deletes the last sentence allowing written orders to be faxed, as this is duplicative of existing language in subsection (d), which is retained with amendments, as described below.

Subsection (b)

This subsection is amended from proposed to final-form. As explained on proposed, the Department replaces "a physician's oral" with the word "verbal" in the first sentence for consistency with the proposed amendments to subsection (a). The Department replaces "and treatments" with "treatment or medication" to clarify that this subsection applies to medication orders as well as orders for care or treatment. The Department adds "or physician's delegee authorized under 42 CFR 483.30(e) (relating to physician services)" after the word "physician" to clarify which individuals are permitted to issue verbal orders. The Department deletes the second sentence to align with a physician's ability to delegate tasks under 42 CFR 483.30(e). On final-form, the Department replaces the words "treatment or medication" with "and treatment" and retains subsection (c), which the Department had proposed to delete, with amendment.

The Department had proposed to merge the requirement that verbal and telephone orders for care and treatment be dated and countersigned with the original signature of the physician or physician's delegee within 7 days, with the requirement, currently in existing subsection (c), that verbal and telephone orders for medications be dated and countersigned within 48 hours. The Department's rationale for shortening the length of time from 7 days to 48 hours was that it is imperative that orders be signed within 48 hours to ensure that the orders are correct, especially in cases where the medical issue that is being addressed is urgent.

Commentators, however, commented that the amendment from 7 days to 48 hours, in this subsection, is unreasonable and will be challenging for many facilities. One commentator suggested that 72 hours is a more reasonable timeframe. IRRC agreed regarding the importance of accuracy in orders but asked the Department to further explain the need for such a seemingly significant change. IRRC asked if the Department has data to support the need for this amendment and to explain the reasonableness for reducing the timeframe from 7 days to 48 hours. On final-form, the Department has decided to retain the existing requirement in subsection (c) that verbal and telephone medication orders be dated and countersigned within 48 hours, and amended the requirement that verbal and telephone orders for care and treatment be within 72 hours, in response to these comments. The timeframe for verbal and telephone orders for care and treatment is amended from 48 hours to 72 hours, on final-form, to provide an additional 24 hours for orders to be signed and countersigned. With the prevalence of electronic transmittal methods to help expedite the signing of orders, 72 hours is a practical and achievable timeframe.

Subsection (c)

This subsection is retained on final-form. The Department had proposed to move the 48-hour requirement from the first sentence of this subsection into subsection (b). The Department has decided to retain the existing 48-hour requirement for verbal and telephone medication orders to separate this requirement from orders for care and treatment. This timeframe is necessary to ensure prompt review and approval of resident medications and orders. As noted in subsection (b), the Department has amended the timeframe for verbal and telephone orders for care and treatment to 72 hours based on comments received by commentators and IRRC. On final-form, the second sentence of this subsection, pertaining to Schedule II medications, remains deleted because dispensation of controlled substances is covered under Federal law. *See* 21 CFR 1306.11 (relating to requirement of prescription).

Subsection (d)

This subsection is unchanged from proposed to final-form. As explained on proposed, the Department replaces the word "oral" with the word "verbal" for consistency in terminology. The Department replaces "medication or treatment" with "care, treatment or medication" for consistency with the proposed amendments to subsection (b), as described above. The Department replaces the term "responsible practitioner" with "physician, or physician's delegee authorized under 42 CFR 483.30(e)" as well for consistency with the proposed amendments in subsection (b). The Department replaces the word "received" with the word "sent" for grammatical reasons. The Department also adds "or secure electronic transmission" after the word "fax" to account for the use of electronic health record systems, as well as other electronic mechanisms, such as email or text, that are used to enter orders.

Subsection (e)

This subsection is unchanged from proposed to final-form. As explained on proposed, the Department, throughout this subsection, replaces the words "an oral" with the words "a verbal" for consistency in terminology. In paragraph (2), the Department replaces "practitioner" with "physician, or physician's delegee authorized under 42 CFR 483.30(e)" for consistency in terminology. In paragraph (4), the Department adds the words "or secure electronic" between the word "fax" and the word "transmissions" for consistency with the use of this term as proposed in subsection (d).

§ 211.4. Procedure in event of death

Subsection (a)

Subsection (a) is unchanged from proposed to final-form. As explained on proposed, the Department replaces the words "at each nursing station" with the words "to all personnel." The long-term care nursing industry has begun to shift away from terms such as "nurses' station" and "nursing station" towards terms that focus more on resident-centered care. The term "all personnel" is more specific and more accurately reflects who should have access to written postmortem procedures.

A commentator suggested that the Department add the word "readily" before the word "available" as well as a requirement that procedures be "kept onsite in a location accessible and familiar to" all personnel "at all times." The Department declines to make this suggested

amendment. Adding the word "readily" before the word "available" adds no additional value and would make this provision unnecessarily vague. Adding that the procedures be kept onsite would not allow a facility to make its procedures available electronically to personnel. As such, the Department declines to make this suggested amendment.

Subsection (b)

Subsection (b) is unchanged from proposed to final-form. As explained on proposed, the Department makes only one amendment to this subsection. The Department replaces the term "responsible party" with the term "resident representative" for consistency in the use of that term throughout the regulations.

§ 211.5. Medical records

The Department amends the title of this section from "clinical records" to "medical records" to align with the use of "medical records" in the Federal requirements throughout 42 CFR Part 483, Subpart B. Instead of "medical records," a commentator suggested the title be renamed "resident records." The Department appreciates this comment. However, the Department is maintaining the terminology "medical records" to be consistent with Federal requirements. *See e.g.*, 42 CFR 483.70(i) (relating to administration).

Subsection (a)

Subsection (a) remains deleted on final-form. The Department deletes subsection (a) to eliminate duplication and to avoid conflict with the Federal requirements at 42 CFR 483.10(h)(3)(ii) (relating to resident rights). Under 42 CFR 483.10(h)(3)(ii), a facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social and administrative records in accordance with State law.

On final-form, a commentator requested the language be retained and expanded to require records be comprehensive and include all assessments, treatments, items, services and case notes. Further, the commentator suggested the records be provided to Older Adult and Adult Protective Services and the state Protection and Advocacy entity. The Department, however, declines to make these amendments. Existing Federal requirements already require for medical records to contain the following: sufficient information to identify the resident; a record of the resident's assessments; the comprehensive plan of care and services provided; the results of any preadmission screening and resident review evaluations and determinations; the physician's, nurse's, and other licensed professional's progress notes; and laboratory, radiology and other diagnostic services reports. 42 CFR 483.70(i) (relating to administration). In addition, the access to records and whether a resident wants to receive protective services under the Older Adult Protective Services Act or the Adult Protective Services Act is determined by the resident in accordance with these respective acts. 35 P.S. §§ 10210.304(b) and 10225.304. As such, the Department declines to make these requested amendments.

Subsection (b)

Subsection (b) is amended from proposed to final-form. On proposed, the Department deleted this subsection. Commentators opposed this deletion, asserting the need to maintain written consent. Based on comments received, the Department is retaining this language, as

amended. On final-form, subsection (b) provides that information contained in the resident's record shall be privileged and confidential. Written consent of the resident or the resident representative is required for release of information, except as follows: written consent is not necessary for authorized representatives of the State and Federal government during the conduct of their official duties; and written consent is not necessary for the release of medical records for treatment purposes in accordance with Federal and State law.

Subsection (c)

Subsection (c) remains deleted on final-form. The Department deletes this subsection to eliminate conflict with the Federal requirements at 42 CFR 483.70(i)(4) (relating to administration), which requires medical records to be retained for the period of time required by State law or for 5 years from the date of discharge when there is no State law requirement, or in the case of a minor, for 3 years after the resident reaches legal age under State law. Commentators suggested this language be retained. The Department declines to make this requested amendment as the record retention policy provided under 42 CFR 483.70(i)(4) meets the Department's licensure needs during annual surveys.

Subsection (d)

Subsection (d) remains unchanged from proposed to final-form. The word "medical" replaces the word "clinical" for consistency in terminology.

Subsection (e)

Subsection (e) remains unchanged from proposed to final-form. The Department replaces the word "clinical" with the word "medical" before the word "records" for consistency in the use of the term "medical records." In the second sentence, the Department adds the word "resident" before medical records for clarity. The Department also replaces the phrase, "notify the Department of how the records may be obtained" with "provide to the Department, within 30 days of providing notice of closure under § 201.23 (relating to closure of facility), a plan for the storage and retrieval of medical records." When a facility closes, it is often difficult to determine where medical records have been stored as there is no longer a point of contact for the facility. Requiring a facility to have a plan for storage and retrieval and to provide the Department with that plan, ensures that residents will be able to access their medical records after the facility closes.

A commentator suggested that the closing facility retain a copy of each resident's record in addition to the receiving facility. After careful consideration, the Department declines to make this suggested amendment. If the records are transferred to the facility the resident is residing in, it is unnecessary for the closing facility to also maintain those records.

Subsection (f)

Subsection (f) remains unchanged from proposed to final-form. The Department replaces the word "clinical" with the word "medical" for consistency in the use of the term "medical record." The Department deletes the words "at a minimum, the" at the beginning of this subsection and add a cross-reference to 42 CFR 483.70(i)(5) (relating to administration) to clarify that the items listed in this subsection are required in addition to the items in the Federal

requirements. For clarity, the Department enumerates the items that are presently in subsection (f).

A commentator suggested this subsection be amended to include the following additional information in a resident's medical record: identification and demographic information, the comprehensive person-centered assessment, the person-centered service planning document and services notes. Another commentator requested all plans of care and reports, investigations and action taken concerning injuries be contained within the medical record. 42 CFR 483.70(i)(4), however, already requires a medical record to contain the following: sufficient information to identify the resident; a record of the resident's assessments; the comprehensive plan of care and services provided; the results of any preadmission screening and resident review evaluations and determinations; physician's, nurse's, and other licensed professional's progress notes; and laboratory, radiology and other diagnostic services reports. Further, subsection (f) requires observations, notes, medical reports and treatments be contained. As such, this would include reports related to injuries. To the extent there is a concern regarding potential abuse or neglect, employees, contractors and administrators are required to report suspected abuse for investigation under the Older Adults Protective Services Act (35 P.S. §§ 10225.101 – 10225.5102) and the Adult Protective Services Ac t(35 P.S. §§ 10210.101 – 10210.704). Therefore, the Department declines to makes this suggested amendment.

Subsection (g)

Subsection (g) remains deleted on final-form. The Department deletes this subsection to eliminate duplication and avoid conflict with the Federal requirements. A commentator opposes this deletion. The Department, however, is retaining the deletion of recording symptoms and other indications of illness or injury as duplicative. Under 42 CFR 483.70(i)(1), a facility must maintain medical records in accordance with accepted professional standards and practices. As provided above, medical records must contain sufficient information to identify the resident, a record of the resident's assessments, a comprehensive plan of care and services provided, the results of any preadmission screening and resident review evaluations and determinations, progress notes from physicians, nurses and other licensed professionals, and laboratory, radiology and other diagnostic services reports.

Subsection (h)

Subsection (h) remains deleted on final-form. The Department deletes this subsection to eliminate duplication and avoid conflict with the Federal requirements. A commentator suggested this language be retained and amended to include that each staff person, contracted provider or professional enter the appropriate historical, service and progress notes. The Department declines to make this change. Under 42 CFR 483.70(i)(5)(v), a resident's medical record must contain progress notes from physicians, nurses and other licensed professionals.

Subsection (i)

Subsection (i) remains unchanged from proposed to final-form. The Department replaces the word "clinical" with the word "medical" for consistency in the use of the term "medical record."

§ 211.6. Dietary services

Subsection (a)

Subsection (a) is unchanged from proposed to final-form. As explained on proposed, the Department adds language to require that menus not only be planned but also posted in the facility or distributed to residents at least two weeks in advance. The Department adds this requirement as part of its efforts to promote more resident-centered environments in long-term care nursing facilities.

Subsection (b)

Subsection (b) remains deleted on final-form. As explained on proposed, the Department deletes this subsection to eliminate duplication and avoid conflict with the Federal requirements. Under 42 CFR 483.60 (relating to food and nutrition services), a facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the resident's daily nutritional and special dietary needs, taking into consideration the resident's preferences. Further, facilities should utilize the emergency plan developed under 42 CFR 483.73 (relating to emergency preparedness) to determine how much food is needed in the event of an emergency. Specifically, a facility's emergency plan is required to be based on and include a documented, facility-based and community-based risk assessment, with the emergency preparedness policy and procedure addressing food, water, medical and pharmaceutical supplies. 42 CFR 483.73(a) and (b)(1)(i). Each facility's needs will be different in terms of facility size and the amount of time they need to shelter in place. Requiring a facility to have food on hand for a specific number of days could result in a cost and waste to some facilities; and be insufficient for others. Instead, facilities should utilize the emergency plan developed under 42 CFR 483.73 to determine how much food is needed for the subsistence needs of staff and residents in the event of an emergency.

Some commentators opposed the deletion of this subsection and the removal of the requirement that facilities must have enough food on site to last at least 3 days. Commentators underscored the importance of ensuring resident safety in the event of a natural disaster or storm, as well as human-caused emergencies, such as the sudden bankruptcy of a facility operator. A commentator indicated that facilities could interpret the requirements at 42 CFR 483.73 as not requiring them to have sufficient food on hand and asked how compliance would be determined. In addition, IRRC asked, "what are the minimum number of days' supply of food available in the facility provided for in an emergency plan?" IRRC requested that the Department explain the need for and reasonableness for the proposed deletion of this subsection in the final-form regulation. IRRC also asked the Department to explain how the final-form regulation protects the public health, safety, and welfare related to always having a sufficient food supply available in the facility.

After careful consideration, the Department declines to add the requirement that facilities always have at least 3 days' supply of food in the facility to the final-form regulation, as the current requirement imposed a uniform standard on facilities that do not have uniform needs. The Department also notes that while the current regulation requires a facility to have a specific amount of food onsite, there is not a corresponding standard for other supplies and provisions, such as medicine, medical supplies, water and clean linens.

Further, the Department is not removing the requirement for a sufficient food supply. Instead, a facility's emergency plan, which is based on and include a documented, facility-based and community-based risk assessment, addresses the food, water, medical and pharmaceutical supplies needs of the facility. 42 CFR 483.73(a) and (b)(1)(i). The Department will monitor and enforce this provision during its survey process. During a facility's survey, the Department will review the facility's emergency plan to see how much food the facility-specific plan requires the facility to have on site, and then check for compliance with the requirements of the emergency plan. The deletion of this specific requirement will create consistency in enforcement related to emergency preparedness.

Another commentator recommended that meals served should be tasty, interesting, of good variety, and nutritious, as needed and requested by each resident. The Department declines to make this amendment on final-form. Under 42 CFR 483.60 (relating to food and nutrition services), a facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the resident's nutritional and dietary needs, taking into consideration the resident's preferences. All facilities, including the three private-pay facilities are required to comply with the portion of 42 CFR 483.60 that requires the provision of a nourishing, palatable and well-balanced diet that meets the resident's daily nutritional and dietary needs, under existing § 201.2. The portion of 42 CFR 483.60 requiring that a facility take into consideration the preferences of each resident will be new under the expansion of the incorporation of the Federal requirements in § 201.2, as amended in final-form Rulemaking 1– *General Applicability and Definitions*. This assumes approval of Rulemaking 1.

Subsection (c)

Subsection (c) remains deleted on final-form. As explained on proposed, the Department deletes this subsection to eliminate duplication and avoid conflict with the Federal requirements. Under 42 CFR 483.60(a)(1), a facility is required to employ sufficient staff with the appropriate competencies and skills necessary to carry out the functions of the food and nutrition service, taking into account resident assessments, individual plans of care, and the number, acuity and diagnoses of the resident population in accordance with the facility assessment. In addition, a facility must employ a qualified dietitian or other clinically qualified nutrition professional on either a full-time, part-time or on a consultant basis. This individual must meet the requirements of 42 CFR 483.60(a)(1)(i) through (iv). If a qualified dietician or other clinically qualified nutrition professional is not employed full-time, the facility must designate a director of food and nutrition services, who meets the requirements set forth in 42 CFR 483.60(a)(2)(i) through (iii). All facilities that participate in Medicare or MA are required to comply with these requirements. The requirement for sufficient staff to carry out the functions of the food and nutrition service is not a new requirement for the three private-pay facilities under existing § 201.2. However, the remaining requirements identified above will be new for the three private-pay facilities by virtue of the expansion of the incorporation of the Federal requirements in § 201.2, as amended in Rulemaking 1 – *General Applicability and Definitions*. This assumes approval of Rulemaking 1.

A commentator opposed the deletion of this subsection but did not explain why they were opposed to the deletion. Therefore, the Department has not made any amendments in response to this comment, on final-form.

Subsection (d)

Subsection (d) remains deleted on final-form. As explained on proposed, the Department deletes this subsection to eliminate duplication and avoid conflict with the Federal requirements. A facility must employ sufficient dietary staff that meet the requirements in 42 CFR 483.60(a) to carry out the functions of the food and nutrition service, as described in 42 CFR 483.60. All facilities, including the three private-pay facilities, are currently required to comply with this requirement.

A commentator opposed the deletion of subsection (d). The commentator and IRRC noted that resident counseling is not included in the Federal requirements. IRRC asked whether the Department is reducing the standard of care for residents by eliminating this provision and asked that the Department explain how the final regulation protects the public health, safety, and welfare related to resident counseling by a dietary consultant. The Department is not reducing the standard of care for residents, and this final-form regulation protects the public health, safety, and welfare related to resident counseling by a dietary consultant because in addition to the requirements in 42 CFR 483.60, a resident's comprehensive care plan must be prepared by an interdisciplinary team that includes a member of food and nutrition services staff. 42 CFR 483.21(b)(2)(ii) (relating to comprehensive person-centered care planning). In addition, under 42 CFR 483.10(c)(2) (relating to resident rights), residents have a right to participate in the development of their person-centered care plan and, therefore, can discuss their dietary needs and preferences with a member of food and nutrition services staff.

Subsection (e)

Subsection (e) remains deleted on final-form. As explained on proposed, the Department deletes this subsection to eliminate duplication and avoid conflict with the Federal requirements. Under 42 CFR 483.60(b), a member of the food and nutrition services staff must participate on the interdisciplinary team as required by 42 CFR 483.21(b)(2)(ii) (relating to comprehensive person-centered care planning). The Federal requirements are also quite extensive regarding the requirements for menus and food and nutrition for residents. Menu requirements are addressed in 42 CFR 483.60(c), food and drink requirements are addressed in 42 CFR 483.60(d), therapeutic diets are addressed in 42 CFR 483.60(e), meal frequency requirements are addressed in 42 CFR 483.60(f), and equipment and utensils are addressed in 42 CFR 483.60(g).

A commentator opposed the deletion of this section but did not provide a reason. Therefore, the Department has not made any amendments in response to this comment, on final-form. The interdisciplinary team planning and some of the menu requirements identified above will be new for the three private-pay facilities by virtue of the expansion of the incorporation of the Federal requirements in § 201.2, as amended in Rulemaking 1 – *General Applicability and Definitions*. This assumes approval of Rulemaking 1.

Subsection (f)

Subsection (f) is unchanged from proposed to final-form. As explained on proposed, the Department replaces the words "an employe" with "employees" and "employes" with "employees." The Department makes these two amendments for grammatical reasons and for consistency in the usage and spelling of the term "employees."

A commentator suggested that subsection (f) be revised to say that dietary personnel shall follow facility infection control protocols. This requirement is not needed, however, because all facility staff are subject to the infection prevention and control program. Per 42 CFR 483.80(a)(1) (relating to infection control), a facility's infection prevention and control program must include 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 § 483.70(e) and following accepted national standards." Further, 42 CFR 483.80(a)(2)(v) requires that there be written standards, policies, and procedures that include the circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesion from direct contact with residents or their food. Therefore, the Department declines to make these suggested amendments.

§ 211.7. Physician assistants and certified registered nurse practitioners

This section is unchanged from proposed to final-form. As explained on proposed, the Department deletes subsections (a), (b)(1), (c), (d) and (e) to eliminate duplication and avoid conflict with the Federal requirements and State scope of practice standards. Under 42 CFR 483.30 (relating to physician services), each resident must remain under the care of a physician. The circumstances under which a physician may delegate tasks to a physician assistant, nurse practitioner or clinical nurse specialist are delineated in 42 CFR 483.30(e) and (f), and includes the requirement that the physician assistant, nurse practitioner or clinical nurse specialist be acting within the scope of their practice as defined by State law. The scope of practice for physician assistants, including supervision by a physician, is set forth under the Medical Practice Act at 63 P.S. § 422.13 and in regulation at 49 Pa. Code Chapter 18, Subchapter D (relating to physician assistants). The scope of practice for certified registered nurse practitioners is set forth under the Professional Nursing Law at 63 P.S. § 218.2, and in regulation at 49 Pa. Code Chapter 21, Subchapter C (relating to certified registered nurse practitioners). The scope of practice for clinical nurse specialists set forth under the Professional Nursing Law at 63 P.S. § 218.6, and in regulation at 49 Pa. Code Chapter 21, Subchapter H (relating to clinical nurse specialists).

The Department retains the requirements in subsection (b)(2) through (4) as the Federal requirements do not cover posting and notification requirements for supervising physicians. The Department makes one minor amendment to subsection (b)(2). As noted on proposed, the Department replaces the term "nursing station" with the term "workstation." As noted in the Department's other long-term care nursing regulatory packages, the long-term care nursing industry has begun to shift away from the use of the term "nurses' station" in favor of terms such as "workstations" that focus more on person centered care. When the proposed regulation was published at 52 Pa.B. 3070, an error occurred in which the word "workstation" was inadvertently missed being underscored and placed in bold faced text. On final-form, the word "workstation" is added in place of "nursing station."

§ 211.8. Use of restraints

Subsection (a)

Subsection (a) remains deleted on final-form. As explained on proposed, the Department deletes this subsection to eliminate duplication and avoid conflict with the Federal requirements

at 42 CFR 483.10(c)(1) (relating to resident rights) and 42 CFR 483.12(a)(2) (relating to freedom from abuse, neglect, and exploitation), which prohibit the use of physical or chemical restraints imposed for the purpose of discipline or convenience, and require that, 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.

Commentators recommended that the Department retain subsection (a) and add language to also prohibit the use of restraints for discipline or due to lack of staffing. A commentator also suggested that language be added to require the least restrictive means necessary be applied if restraints are necessary. The Department declines to make these suggested amendments because it is duplicative of the Federal requirements. As provided above, 42 CFR 483.10(c)(1) and 483.12(a)(2) prohibit any physical or chemical restraint imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with 42 CFR 483.12(a)(2). 42 CFR 483.12(a)(2) further provides that when the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time.

A commentator also recommended that the prohibition on locked restraints that the Department proposed to delete be retained and that it be expanded to prohibit "any mechanical apparatus or device, such as shackles, straightjackets, cage-like enclosures or other similar devices... that is not removable by that person." The Department declines to make this amendment because the definition of locked restraints has been removed from § 201.3 (relating to definitions) in final-form Rulemaking 1 – *General Applicability and Definitions* in favor of the Federal definition of "physical restraints" at 42 CFR 483.5 (relating to definitions). As defined, a "physical restraint" is "any manual method, physical or mechanical device, equipment or material that is attached or adjacent to the resident's body, cannot be removed easily by the resident, and restricts the resident's freedom of movement or normal access to the resident's body.

Subsection (b)

Subsection (b) remains deleted on final-form. As explained on proposed, the Department deletes this subsection, which requires that restraints may not be used or applied in a manner which causes injury to the resident. Some commentators requested that the Department retain this requirement. The Department declines to do so, because any restraint to a resident that results in injury to the resident would be considered abuse as defined in the Federal requirements at 42 CFR 483.5 (relating to definitions) and prohibited by 42 CFR 483.12(a)(1) (relating to freedom from abuse, neglect, and exploitation). The definition of "abuse" under 42 CFR 483.5 includes the "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish."

Subsections (c)

Subsection (c) remains deleted on final-form. The Department had proposed to delete this subsection and replace it with new language in proposed subsection (c.1) because it was concerned that setting forth a requirement in regulation for the removal of restraints for a specified period of time could result in a facility only complying with the minimum standard for removal, rather than considering the health and safety of the particular individual that is being restrained. Commentators opposed the deletion of this subsection and recommended that it be

added back into the regulations, in addition to the requirements in subsection (c.1). After careful consideration, the Department, amends subsection (c.1) on final-form to address these comments, as described below.

Subsection (c.1)

Subsection (c.1) is amended from proposed to final-form. The Department had proposed to add this new subsection in place of current subsection (c) to clarify that when a resident is restrained, the facility must determine what interventions are appropriate for each resident to protect their health and safety. A commentator and IRRC commented that the former subsection (c) provided finite time limits; whereas the new subsection (c.1) provided ambiguous and nonregulatory language. IRRC requested the Department to ensure that the final regulation sets standards of compliance related to the use of restraints that are clear, enforceable, lack ambiguity, and protect the public health, safety, and welfare. A commentator also recommended subsection (c) be retained and expanded. The commentator suggested this subsection address additional appropriate interventions be utilized in addition to subsection (c).

Based on the comments received, the Department amends subsection (c.1), on final-form, to provide that if restraints are used, a facility shall use the least restrictive method for the least amount of time to safely and adequately respond to individual resident needs in accordance with the resident's comprehensive assessment and comprehensive care plan. Further, when a recurring restraint is ordered, the facility shall document the need for the restraint and the personnel responsible for performing the intervention on each shift. In addition, a facility is required to document the type of restraint used and each time a restraint is used or removed. The Department also specifies that the following minimums apply when determining the least restrictive method for the least amount of time: (i) physical restraints shall be removed at least 10 minutes out of every 2 hours during normal waking hours to allow the resident an opportunity to move and exercise, and (2) during normal working hours, the resident's position shall be changed at least every 2 hours.

Subsection (d)

This subsection is unchanged from proposed to final-form. As explained on proposed, the Department deletes the words "a signed, dated, written" because orders for restraints may be either written or verbal. The Department also replaces the word "physician" with the phrase "from a physician, or physician's delegee authorized under 42 CFR 483.30(e) (relating to physician services)" for consistency in the use of terminology. The Department deletes the last two sentences of this subsection, because the requirement for an order for restraint applies to all types of restraints.

A commentator recommended subsection (d) be retained in its entirety and also be expanded to require that an order for restraints include the period for which the restraint is authorized and the circumstances under which the restraint may be used. The Department declines to make this requested amendment. As provided in amended subsection (c.1), a facility is required to document the need for the restraint, the type of restraint and each time a restraint is used or removed. However, since orders may be either written or verbal, the Department is deleting the signed and dated language from the subsection.

Subsection (e)

This subsection is unchanged from proposed to final-form. As explained on proposed, the Department adds "or physician's delegee authorized under 42 CFR 483.30(e)" after the word "physician" for consistency in the use of terminology.

Subsection (f)

Subsection (f) is amended from proposed to final-form. The Department did not propose any amendments to this subsection, which maintains the current requirement that every 30 days, or sooner, if necessary, the interdisciplinary team review and reevaluate the use of all restraints ordered. On final-form, the Department replaces the term "physicians" with "a physician or physician's delegee authorized under 42 CFR 483.30(e)" for consistency with the use of this terminology in subsections (d) and (e).

Some commentators suggested that the results of these reviews be documented in the resident's chart or care plan. The requirement in subsection (f) satisfies this recommendation because the review would have to be recorded in the resident's medical record for the Department to survey for compliance with this subsection. Additionally, 42 CFR 483.21(b)(2)(iii) (relating to comprehensive person-centered care planning) requires that the comprehensive care plan be reviewed and revised by the interdisciplinary team after each assessment. The requirement that the comprehensive care plan be reviewed and revised will not be new for the private-pay facilities; however, the requirement that the plan be reviewed and revised by the interdisciplinary team will be new for these facilities under amended § 201.2 in final-form Rulemaking 1– *General Applicability and Definitions*. This assumes approval of Rulemaking 1.

In addition to the comments on subsections (a) through (f) summarized above, commentators recommended adding language to this section. A commentator recommended adding language in this section stating that residents have the right to be free of physical, mechanical and chemical restraints. The commentator also recommended that restraints be prohibited unless:

(i) authorized in accordance with state and federal law,
(ii) ordered by a physician as appropriate to treat the individual's medical condition,
(iii) consented to by the resident or resident's representative, and
(iv) approved by the resident's person-centered service planning interdisciplinary team as part of the resident's written person-centered service plan and must include a written demonstration that less restrictive alternative means of controlling movement or behavior do not work. The person-centered service plan must outline how and when restraints are approved.

The Department declines to make this suggested amendment. Regarding the commentator's proposed language in (i), above, facilities are already required to follow all applicable State and Federal laws. The proposed language in (ii) above is already provided for in subsection (d), which requires a physician's order for a restraint. The language proposed in (iii) above is not needed because a resident already has the right, under 42 CFR 483.10(c)(6), to request, refuse, or discontinue treatment. For (iv), although person-centered planning is not specifically addressed, Federal regulations already require a facility to use the least restrictive alternative for the least

amount of time and to document the ongoing reevaluation of the need for restraints. 42 CFR 483.12(a) (relating to freedom from abuse, neglect, and exploitation). As such, the Department declines to make this amendment.

Commentators also recommended that a provision be added to require that the use of chemical restraints be monitored for any adverse reaction. The Department declines to make this amendment on final-form, as the Federal requirements already prohibit the use of "unnecessary drugs." This includes the use of any drug without adequate monitoring or a drug used in the presence of adverse consequences which indicate the dose should be reduced or discontinued. 42 CFR 483.45(d) (relating to pharmacy services). All residents who receive medication in a facility must, therefore, be monitored for adverse consequences related to the medications.

§ 211.9. Pharmacy services

Subsection (a)

Subsection (a) is unchanged from proposed to final-form. As explained on proposed, the Department retains the requirement in paragraph (1) with minor stylistic amendments. The Department deletes paragraph (2) because in practice, medications are dispensed by pharmacies to facilities, not directly to the residents. Medications are administered to residents by authorized persons to administer drugs and medication, as defined in § 201.3 (relating to definitions).

Subsection (b)

Subsection (b) is unchanged from proposed to final-form. As explained on proposed, the Department amends subsection (b) by replacing "medications shall be" with "facility policies shall ensure that medications are" before "administered by authorized persons." This amendment is made to clarify that a facility is required to have policies in place to ensure that medications are administered by authorized persons to administer drugs and medications.

Subsection (c)

Subsection (c) is unchanged from proposed to final-form. The Department retains the language in this subsection, without amendment.

Subsection (d)

Subsection (d) is unchanged from proposed to final-form. As explained on proposed, the Department adds the words "both prescription and non-prescription" after the word "medications" to clarify that a written order is required for both prescription and non-prescription medications. An order is necessary for both prescription and non-prescription medications so as to maintain a resident's continuity of care. Requiring an order for both prescription and non-prescription medications enables a facility to monitor and track all medications that a resident receives, to ensure that there are no contraindications or interactions between medications, and to help prevent accidental overdoses from residents self-administering non-prescription medications. The Department deletes the word "written" before the word "orders" because orders may be written or verbal. The Department also adds "or the physician's delegee authorized under 42 CFR 483.30(e) (relating to physician services) for consistency in the use of this term throughout the regulation, and because these individuals may also provide medication orders.

A commentator suggested adding a sentence to this subsection to require a facility to timely refill prescriptions for residents and to ensure that residents are not administered expired prescription or non-prescription medications. The commentator indicated that they were aware of instances in which facilities have not timely refilled prescriptions as well as times in which facilities have not taken care to ensure that medications are not expired. After careful consideration, the Department declines to make this suggested amendment. The Department takes very seriously the administration of medications and considers late administration to be a medication error. Under 42 CFR 483.45(f) (relating to pharmacy services), a facility must ensure that medication error rates are not 5 percent or greater and that residents are free of any significant medication errors. All facilities are required to comply with 42 CFR 483.45(f) under existing § 201.2.

Subsection (e)

Subsection (e) remains deleted on final-form. As explained on proposed, it is not necessary to retain this requirement given the amendment to subsection (d), to require an order for both prescription and non-prescription medications. A commentator opposed the deletion of this subsection, explaining that there needs to be a paper trail to resolve any concerns or discrepancies regarding medications. The Department believes that subsection (d), imposing the requirement for orders, is duplicative of subsection (e).

Subsection (f)

Subsection (f) is unchanged from proposed to final-form. As explained on proposed, the Department makes only one amendment to this subsection. In paragraph (1), the Department replaces the term "resident's responsible person" with the term "resident representative" for consistency in the use of that term throughout the regulations.

Subsections (g) and (h)

Subsections (g) and (h) remain deleted on final-form. As explained on proposed, the Department deletes subsections (g) and (h) to eliminate duplication and avoid conflict with the Federal requirements. Pharmacy services requirements for facilities are located at 42 CFR 483.45 (relating to pharmacy services). Under 42 CFR 483.45(a), a facility is required to provide pharmaceutical services, including procedures that assure accurate acquiring, receiving, dispensing and administering of all medications, to meet the needs of each resident. The Federal requirements further require that a facility employ a pharmacist and outline the responsibilities of the pharmacist, which include providing consultation on all aspects of the provision of pharmacy services. The pharmacist is to conduct a review of the medication regiment for each resident at least once a month and must report any irregularities to the attending physician, the medical director and the director of nursing. Other requirements in 42 CFR 483.45 address unnecessary medications, psychotropic medications, labeling and storage.

Subsections (i) and (j)

Subsections (i) and (j) remain deleted on final-form. As explained on proposed the Department deletes subsections (i) and (j) and adds subsection (j.1), pertaining to the disposition of medications, described as follows.

Subsection (j.1)

Subsection (j.1) is amended from proposed to final-form. As explained on proposed, the Federal requirements for pharmacy services do not directly address the disposition of medications. The Department, therefore, adds subsection (j.1) to require a long-term care nursing facility to have written policies and procedures for the disposition of medications. The Department also requires that a facility's policies and procedures address: (1) timely identification and removal of medications for disposition; (2) identification of storage methods for medications awaiting final disposition; (3) control and accountability of medications awaiting final disposition consistent with standards of practice; (4) documentation of actual disposition of medications to include the name of the individual disposing of the medication, the name of the resident, the name of the medication, the strength of the medication, the prescription number if applicable, the quantity of medication and the date of disposition; and (5) a method of disposition to prevent diversion or accidental exposure consistent with applicable Federal and State requirements, local ordinances and standards of practice. Proper procedures for the disposition of medications are vital for the health and safety of residents. On final-form, the Department makes one minor amendment by adding the words "and safe" after the word "timely" in paragraph (1), at the request of a commentator.

A commentator requested that the Department require that a facility submit its written policies and procedures for the disposition of medications to the Department for approval. After careful consideration, the Department declines to make this suggested amendment. As explained previously, it would be logistically impossible for the Department to manage and maintain a record of every policy and procedure for the approximately 682 licensed long-term care nursing facilities on an ongoing basis. In addition, it is important that facilities have the discretion to update policies and procedures as needed in response to resident and business needs without waiting for departmental approval.

Subsection (k)

This subsection is unchanged from proposed to final-form. The Department retains this subsection without amendment.

Subsection (l)

This subsection is unchanged from proposed to final-form. As explained on proposed, the Department moves the requirement that an emergency medication kit be "readily available to staff" from paragraph (4) to the first sentence in this subsection. Moving this requirement to the beginning of the subsection adds clarity to the requirement that a facility have at least one medication kit.

In paragraph (1), the Department adds the words "security" and "inventory tracking" to the policies and procedures that a facility is required to have for the emergency medication kit. The Department adds this language to prevent diversion and to protect the integrity of the contents of the emergency medication kit to ensure that the medications within it are available in the event of an emergency.

In paragraph (2), the Department deletes the phrase "kept to a minimum and shall be" because this language is unclear and unnecessary. It is more important that the medications

within the emergency kit meet the needs of the residents than to be kept at a minimum. The Department also adds, in paragraph (2), a requirement that the criteria for the contents of the emergency medication kit be reviewed not less than annually. This requirement will ensure that the emergency medication kits are tailored to the needs of the facility's current resident population.

In paragraph (3), the Department makes a grammatical amendment from the word "pre-scribe" to "prescribe." The Department also corrects the citation to the Pharmacy Act from (63 P.S. §§ 390.1—390.13) to (63 P.S. §§ 390-1—390-13).

The Department deletes paragraph (4). As noted, the Department moves the phrase "readily available to staff" to the first sentence of this subsection. The Department deletes the requirement that an emergency medical kit have a breakaway lock that is replaced after each use because this requirement is outdated. When the regulations were promulgated, facilities used tackle boxes with locks for emergency medication kits. A breakaway lock was required to ensure quick access in an emergency. Due to technological advances, many emergency medication kits now can be locked electronically, with the use of a code. Thus, the requirement for a breakaway lock is no longer necessary. Instead, the Department requires, in paragraph (1), that the facility has policies and procedures that address the security of the emergency medication kits. In this way, the facility will have discretion to determine the best way to secure the medication.

§ 211.10. Resident care policies

Subsection (a)

This subsection is amended from proposed to final-form.

As explained on proposed, the Department deletes the last sentence in this subsection to eliminate duplication and to avoid conflict with the Federal requirements. A facility is required to establish and implement an admissions policy under 42 CFR 483.15(a) (relating to admission, transfer, and discharge rights). Transfers and discharges are covered in 42 CFR 483.15(c). Admission, transfer and discharge planning are also part of the resident's comprehensive care plan and are covered in 42 CFR 483.21(b) and (c) (relating to comprehensive person-centered care planning). The Department retains the first sentence in subsection (a) because even though the Federal requirements address what is required for resident care planning, the requirements do not require a facility to have resident care policies, and the Department considers resident care policies to be an integral part of resident care planning.

A commentator asked the Department to add the word "cognitive" to the phrase, "meeting the total medical and psychosocial needs of residents," explaining that they feel that cognitive needs should be expressly stated in resident care policies. Under 42 CFR 483.21(b), the comprehensive person-centered care plan for each resident must include "measurable objectives and timeframes to meet a resident's *medical, nursing, and mental and psychosocial needs* that are identified in the comprehensive assessment" (emphasis added). The Department replaces "medical and psychosocial" with "medical, nursing, and mental and psychosocial" for consistency in the use of this terminology in the Federal requirements.

Subsections (b) through (d)

These subsections are unchanged from proposed to final-form. As explained on proposed, the Department retains these subsections without amendment.

§ 211.11. Resident care plan

This section remains deleted on final-form. As explained on proposed, the Department deletes this section to eliminate duplication and to avoid conflict with the Federal requirements. Under 42 CFR 483.21(b) (relating to comprehensive person-centered care planning), a facility is required to develop and implement a comprehensive person-centered care plan for each resident. This care plan is prepared by an interdisciplinary care team, that includes the attending physician, an RN and nurse aide with responsibility for the resident, a member of the food and nutrition services staff, the resident and resident representative and others who are involved in the resident's care. Nursing services personnel are responsible, under 42 CFR 483.35(a)(4) (relating to nursing services), for assessing, evaluating, planning, and implementing resident care plans.

Commentators requested that the Department retain this section, amend the title to "resident person-centered service plan" and make amendments throughout this section to reflect this language, and amend the substance of the section to include more detail around the "person-centered service planning process," frequency of meetings, involvement of managed long-term care MA plans through the Community HealthChoices program, training staff to understand person-centered service delivery and reading and following person-centered service plans. After careful consideration, the Department declines to make these suggested amendments, as described more fully below.

Commentators recommended that the Department add language in subsection (b) requiring that the interdisciplinary team include individuals selected by the resident or resident representative and requiring the team to meet at least every 3 months, at the request of the resident or resident representative, or upon a change of condition to revise, if necessary, the resident service plan. Another commentator suggested that the Department add language requiring that the plan be reviewed and updated at least once every 6 months and as needed for a significant change in the resident's condition, and that this review include various individuals to include the resident, staff, providers, and the resident's family or legal representative. Commentators also requested that the Department include language requiring the facility to encourage residents to include their insurer's service coordinator, if applicable, in the interdisciplinary team.

The Department declines to make these amendments as these are already covered by the Federal requirements. Specifically, under 42 CFR 483.21(b)(2)(ii), the interdisciplinary team includes, but is not limited to, the attending physician, an RN with responsibility for the resident, a nurse aide with responsibility for the resident, a member of the food and nutrition services staff, the resident and the resident representative to the extent practicable, and other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. Therefore, under 42 CFR 483.21(b)(2)(ii), the resident could choose to have other staff or professionals be a part of the interdisciplinary team, including their insurer's service coordinator. In addition, a facility is required to complete a comprehensive assessment within 14

calendar days after admission and within 14 calendar days after the facility determines or should have determined that there was a significant change in the resident's physical or mental condition under 42 CFR 483.20(b)(2)(i) and (ii) (relating to resident assessment). A facility is also required to assess a resident on a quarterly basis using the quarterly review instrument specified by the State and approved by CMS under 42 CFR 483.20(c). Under 42 CFR 483.21(b)(2)(i) and (iii), the comprehensive person-centered care plan must be developed within 7 days after the completion of the comprehensive assessment and must be reviewed and revised by the interdisciplinary team after each assessment of the resident, including both the comprehensive and quarterly review assessments. The resident can also request revisions to the person-centered care plan under 42 CFR 483.10(c)(2)(i) (relating to resident rights).

Commentators recommended that the Department add a new subsection between existing (b) and (c) requiring a facility to ensure an educational strategy so that staff have the knowledge and skills to understand and implement person-centered planning and care. After careful consideration, the Department declines to make this suggested amendment. Under 42 CFR 483.95 (relating to training requirements), a facility is required to develop, maintain, and implement an effective training program for staff, individuals providing services under a contractual agreement and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on their facility assessment. It is expected that a facility will train those who are required to develop and implement a resident's care plan in that function.

In subsection (d), commentators recommended adding language to require staff to acquaint themselves with and to refer to the person-centered care plans for all residents to ensure that needs and preferences are being met. After careful consideration, the Department declines to make this suggested amendment because, under 42 CFR 483.21(b)(1), the care plan must not only be developed, but implemented, which would require a facility to ensure that the plan is being followed. Commentators also recommended adding language to require, under a facility's policy, that person-centered care be provided to residents and that person-centered care plans be honored even during a pandemic or other disaster. After careful consideration, the Department declines to make this suggested amendment, because it may not be possible for a facility to follow all aspects of a resident's care plan in the event of an emergency, pandemic, or other disaster. For example, in cases of a weather emergency, a facility may not be able to provide a community quality of life activity under 42 CFR 483.25 (relating to quality of life).

In subsection (e), commentators requested that the Department add language to indicate that when desired by the resident, family and the resident representative shall participate in the development and review of the person-centered care plan. Commentators requested that the Department add language that the resident and the resident representative are the center of the interdisciplinary team, and the care planning process should maximize decision making and participation of residents at all cognitive functioning. Commentators also requested that the Department add language indicating that residents who have a legal guardian must have the opportunity to address any concerns. The Department declines to make these amendments as these concepts are covered by the Federal requirements. Specifically, under 42 CFR 483.5 (relating to definitions), the term person-centered care "means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives." The term "resident representative" as defined in 42 CFR 483.5 includes an

individual chosen by the resident to act on their behalf to support in decision-making, a person authorized under State or Federal law to act on behalf of the resident, a legal representative, and a court-appointed guardian or conservator. This could include family members. Also, as mentioned previously, the resident and resident representative are part of the interdisciplinary team under 42 CFR 483.21(b)(2)(ii) (relating to comprehensive person-centered care planning).

Commentators requested that the Department add a new subsection requiring a facility to provide information regarding the person-centered planning process in plain language and in a manner that is accessible to individuals with disabilities and persons who do not speak English. The Department declines to make this amendment because under 42 CFR 483.10(c) (relating to resident rights), a resident has the right to be informed of and participate in their treatment. This includes the right to be fully informed in a language that the resident can understand of their total health status, including but not limited to their medical condition. 42 CFR 483.10(c)(1).

Commentators requested that the Department add a new subsection requiring that the person-centered care plan include preferences around social interactions, with specific planning focused on supporting the resident during periods of prolonged isolation; ensure human dignity; reflect the individuality, values, and cultural considerations of the resident; identify any unmet needs while including clear language as to how staff can provide proper support to meet these needs; and identify and support ongoing opportunities for meaningful engagement, support interests and preferences, and allow for choice. Another commentator requested that the Department add a new subsection requiring that the care plan include the following: (1) a description of identified needs and date identified based upon the admission, physical examination, resident interview, fall risk, assessment of psychological, behavioral, and emotional functioning, and other sources; (2) a written description of what services will be provided to address identified needs, and if applicable, other services, and who will provide them; (3) preferences around social interaction, with specific planning focused on supporting the resident during periods of prolonged isolation; (4) considerations that reflect the individuality, values and cultural preferences of the resident; and (5) opportunities for meaningful engagement, support interests and preferences, and allow for choice.

After careful consideration, the Department declines to make these suggested amendments because these concepts are covered under the Federal requirements. First, as noted previously, under 42 CFR 483.21(b)(1), a facility is required to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident's rights under 42 CFR 483.10(c)(2) and (3), that includes measurable objectives and timeframes to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under 42 CFR 483.24 (relating to quality of life), 483.25 (relating to quality of care) and 483.40 (relating to behavioral health service). The requirements under 42 CFR 483.24 address activities of daily living; the requirements under 42 CFR 483.25 address physical care; and the requirements under 42 CFR 483.40 address behavioral health. A facility is also required to complete, initially and periodically, a resident assessment on each resident under 42 CFR 483.20 (relating to resident assessment), which takes into consideration the resident's needs, strengths, goals and life history and preferences.

A commentator recommended that the Department require that the comprehensive care plan be completed using a template approved by the Department within 30 days after admission. As mentioned previously, a facility is required to complete a comprehensive assessment within 14 calendar days after admission and within 14 calendar days after the facility determines or should have determined that there was a significant change in the resident's physical or mental condition under 42 CFR 483.20(b)(2)(i) and (ii). A facility is also required to assess a resident on a quarterly basis using the quarterly review instrument specified by the State and approved by CMS under 42 CFR 483.20(c). Under 42 CFR 483.21(b)(2)(i) and (iii), the comprehensive person-centered care plan must be developed within 7 days after the completion of the comprehensive assessment and must be reviewed and revised by the interdisciplinary team after each assessment of the resident, including both the comprehensive and quarterly review assessments. The Department declines to extend this timeline as doing so could be detrimental to residents.

A commentator requested that the Department add a subsection requiring that the care plan be signed and dated by the licensee, administrator or designee, and the resident or resident representative. The commentator requested that the Department also require the plan to indicate any other individuals who contributed to the development of the plan, with a notation as to the date of the contribution and the title or relationship to the resident of each person involved in the care plan. The commentator recommended that these requirements also apply to reviews and updates of the care plan. After careful consideration, the Department declines to make these suggested amendments. There is no explicit requirement in the Federal requirements that the care plan indicate who participated or that the plan be signed and dated by these individuals. Nonetheless, the Federal requirements at 42 CFR 483.21(b)(2)(ii) do require that certain individuals, as noted previously, be involved in the development of the care plan. To demonstrate compliance with that provision, the facility would need to have some record of their involvement, through notes or other documentation in the care plan. Also, it would not be appropriate for the licensee or the administrator to sign the care plan as these individuals are not involved in the care planning process.

A commentator requested that the Department add language to indicate that there may be a deviation from the care plan when mutually agreed upon between the facility and the resident and resident representative at the time the care or services are scheduled or when there is an emergency that prevents the care or services from being provided. The commentator also suggested adding language that would require this deviation to be documented, include a description of the circumstances warranting deviation and the date the deviation will occur, certify that notice of such deviation was provided to the resident and resident representative, be included in the resident's file, and be signed by an authorized representative of the facility and the resident or resident representative. After careful consideration, the Department declines to make this suggested amendment. The comprehensive care plan is a living document, which as discussed previously, is required to be reviewed and updated under 42 CFR 483.21(b)(2)(iii).

§ 211.12. Nursing services

Subsection (a)

Subsection (a) remains deleted on final-form. As explained on proposed, the Department deletes this subsection to eliminate duplication and to avoid conflict with the Federal

requirements. Under 42 CFR 483.35(a)(1) (relating to nursing services), a facility is required to provide services by a sufficient number of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans.

Subsection (b)

Subsection (b) is retained and not deleted on final-form. Existing subsection (b) requires a facility to have a full-time director of nursing services who shall be a qualified licensed RN. The Department had proposed to delete this subsection to eliminate duplication and to avoid conflict with the Federal requirements under 42 CFR 483.35(b)(2), which provide that a facility is required to designate an RN to serve as the director of nursing on a full-time basis, except when waived.

A commentator objected to the deletion of this subsection because the requirement that a facility designate an RN to serve as the director of nursing on a full-time basis could be waived under the Federal requirement. IRRC asked what the impact would be if this provision were waived. The requirement that an RN serve as the full-time director of nursing may be waived under 42 CFR 483.35(f)(1), under certain circumstances. Existing subsection (b), however, does not permit for the waiver of this requirement. The Department does not know of any instances in which a facility has obtained a waiver of this requirement but agrees with the commentator that this requirement should be mandatory. The Department therefore retains subsection (b) on final-form without amendment.

Subsection (c)

Subsection (c) remains unchanged from proposed to final-form. As explained on proposed, the Department replaces the word "staff" with the word "personnel" for consistency in the use of the term "nursing services personnel" throughout the regulations.

Subsection (d)

Subsection (d) remains unchanged from proposed to final-form. On proposed, the Department proposed to add the word "services" between the words "nursing" and "personnel" for consistency in the use of the term "nursing services personnel" throughout the regulations. When the proposed regulation was published at 52 Pa.B. 3070, an error occurred in which the word "services" was inadvertently missed being underscored and placed in bold faced text. On final-form, the word "services" is added before the word "personnel."

Subsection (e)

Subsection (e) is retained, with amendment, and not deleted on final-form. Existing subsection (e) requires a facility to designate an RN who is responsible for overseeing total nursing activities within the facility on each tour of duty each day of the week. The Department had proposed to delete this subsection to eliminate duplication and to avoid conflict with the Federal requirements at 42 CFR 483.35(a)(2), which provide that a facility is required to designate a licensed nurse to serve as a charge nurse on each tour of duty, unless waived.

A commentator objected to the deletion of this subsection because the requirement under 42 CFR 483.35(a)(2) may be waived under 42 CFR 483.35(e). The commentator also indicated that 42 CFR 483.35(a)(2) requires only a licensed nurse, while existing subsection (e) requires that an RN serve in this capacity. IRRC asked what the impact would be if this provision was waived under the Federal requirements. IRRC also asked what the impact would be of having an RN versus a licensed nurse designated with the responsibility of overseeing total nursing activities within a facility. IRRC asked the Department to explain how the deletion of a provision designating an RN to be responsible for overseeing total nursing activities within a facility protects the public health, safety, and welfare of residents. The Department does not know of any instances in which a facility has obtained a waiver of this requirement but agrees with the commentator that this requirement should be mandatory. The Department also agrees that an RN should be the one serving in this capacity. The Department therefore retains subsection (e) on final-form. However, the Department replaces the term "a registered nurse" with the term "charge nurse" as this term more accurately describes the person who is responsible for overseeing total nursing activities within the facility, on each tour of duty. The term "charge nurse" is defined in § 201.3.

Subsection (f)

Subsection (f) remains deleted on final-form. As explained on proposed, the Department deletes paragraph (1) and replaces it with new minimum staffing requirements in subsection (f.1). The requirement in paragraph (2) is retained and moved to subsection (f.2)(3)(i) on final-form, as explained below.

Subsection (f.1)

Paragraph (1)

Paragraph (1) is unchanged from proposed to final-form. As explained on proposed, the Department moves the requirement in existing subsection (j) to this paragraph for clarity and ease of readability.

Paragraphs (2) and (3)

The language that was proposed in paragraphs (2) and (3) is deleted on final-form. The Department had proposed to move the language in subsection (h), which required a facility to have a minimum of two nursing services personnel on duty, at all times, to paragraph (2), and to move the language in subsection (g), which required a facility to have a minimum of one nursing services personnel on duty, per 20 residents, to paragraph (3). A commentator indicated that they were confused by the language in proposed paragraph (3) because it was inconsistent with proposed requirements for nurse aides. Upon review, on final-form, the Department deletes the language that was proposed in paragraphs (2) and (3) because it conflicts with the new minimum requirements for each type of nursing services personnel on final-form, described below.

Due to the above deletions, the language that the Department proposed in paragraph (4) is moved to paragraph (2) on final-form. This language is amended to indicate that effective July

1, 2023, a facility is required to have a minimum of 1 nurse aide per 12 residents during the day, 1 nurse aide per 12 residents during the evening, and 1 nurse aide per 20 residents overnight. New language is also added to paragraph (3) on final-form to indicate that effective July 1, 2024, a facility is required to have a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight.

Paragraph (4)

Paragraph (4) is amended from proposed to final-form. As noted above, the language that was proposed in paragraph (4) is moved to paragraph (2) with amendment. New language is added to paragraph (4) to indicate that effective July 1, 2023, a facility is required to have a minimum of 1 LPN per 25 residents during the day, 1 LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight.

Paragraph (5)

Paragraph (5) is amended from proposed to final-form. The language that was proposed in paragraph (5) is deleted. New language is added to paragraph (5) on final-form to indicate that effective July 1, 2023, a minimum of 1 RN is required per 250 residents during all shifts.

The Department received numerous comments to proposed Rulemaking 1 and proposed Rulemaking 4 both in support of and in opposition to the proposed increase in the staffing ratio. These comments are detailed further in subsection (i). Some commentators, in comment to proposed Rulemaking 4, proposed a ramp-up period as a solution to balance the need for higher staffing with available resources and MA funding. These commentators recommended that the Department require, effective July 1, 2023, 1 nurse aide per 12 residents on the day shift, 1 nurse aide per 12 residents on the evening shift, 1 nurse aide per 20 residents on the overnight shift, 1 LPN per 25 residents on the day shift, 1 LPN per 30 residents on the evening shift, and 1 LPN per 40 residents on the overnight shift. For Year 2, effective July 1, 2024, they recommended, 1 nurse aide per 10 residents on the day shift, 1 nurse aide per 11 residents on the evening shift, and 1 nurse aide per 15 residents on the overnight shift.

The Department adopts this recommendation in paragraphs (2) through (4). Paragraph (5) reflects, in sentence form, the existing requirement for RNs in subsection (f)(1), except for language permitting an LPN to serve on the overnight shift in a facility with a census of 59 or under, which has been moved to subsection (f.2)(3)(i).

The Department after careful consideration, and weighing the need to ensure the health, safety and welfare with residents with the concerns raised by the regulated community agrees with commentators to adopt a graduated approach to the increase in types of nursing personnel. This graduated approach aligns with the graduated approach in the number of direct care hours that the Department has adopted in subsection (i), described below.

Subsection (f.2)

Subsection (f.2) is amended from proposed to final-form. The Department had proposed to add language to this subsection that would prohibit a facility from substituting a nurse aide for

an LPN or RN and substituting for an RN, but permitting the substitution of an RN for a nurse aide or an LPN to meet the minimum nursing staff ratio. Commentators were supportive of this language. On final-form, the Department breaks the proposed language down into paragraphs for ease of readability, and in paragraph (3) adds the language from existing subsection (f.1)(3), which permits a facility with a census of 59 or under to substitute an LPN for an RN on the overnight shift only if an RN is on call and located within a 30-minute drive of the facility. The Department adds this language back into regulation based on comments received in proposed Rulemaking 1, expressing concern that smaller facilities, particularly smaller rural facilities, may have difficulty meeting a more stringent requirement for an RN on the overnight shift.

Subsections (g) and (h)

Subsections (g) and (h) remain deleted on final-form. The Department had proposed to move the language in subsection (h), which required a facility to have a minimum of two nursing services personnel on duty, at all times, to subsection (f.1)(2), and to move the language in subsection (g), which required a facility to have a minimum of one nursing services personnel on duty, per 20 residents, to paragraph (3). A commentator indicated that they were confused by the language in proposed paragraph (3) because it was inconsistent with proposed requirements for nurse aides. As indicated above, on final-form, the Department deletes the language that was proposed in paragraphs (2) and (3) because it conflicts with the new minimum requirements for each type of nursing services personnel on final-form, described below.

Subsection (i)

Subsection (i) is amended from proposed to final-form. The Department had proposed in Rulemaking 1 to amend subsection (i) to add the phrase "for each shift" and to increase the minimum number of direct resident care hours from 2.7 to 4.1. The Department had also proposed to add language to align with 42 CFR 483.35 (relating to nursing services) to require a facility to have a sufficient number of staff with the appropriate competencies and skill sets to provide nursing care and related services to assure resident safety and to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.

The Department amended § 211.12 (relating to nursing services) in both proposed Rulemaking 1 and this rulemaking. In both rulemakings, the Department received comments regarding the difficulty of review and also specific comments regarding the minimum hours of direct resident care under subsection (i). To ease the concerns with clarity, readability and interrelatedness of this subsection, the Department is combining the amendments to this section in one rulemaking. In addition, in response to IRRC's comments, the Department is submitting all four final-form rulemakings to IRRC and the legislative standing committees of the General Assembly at the same time.

As discussed in final-form Rulemaking 1– *General Applicability and Definitions*, commentators to proposed Rulemaking 1 indicated that the use of the words "for each shift" were confusing and suggested this language could be construed to require the same number of nursing personnel at night when residents are sleeping as during the day when residents are more active and need more care. Commentators also stated that this language could be construed to require a facility to provide a total of 12.3 hours of direct care per day, rather than the proposed

4.1 hours of direct care. IRRC asked that the Department clarify whether the increase in direct care hours is intended to be per shift or per day. On final-form, the Department agrees that the addition of "during each shift" is confusing. As such, the Department deletes the words "during each shift" on final-form to alleviate this concern. The number of direct care hours per resident required by subsection (i) is calculated based a 24-hour period.

A large portion of the comments received by the Department on proposed Rulemaking 1 were related to the proposal to increase the number of hours of direct resident care from 2.7 to 4.1. The Department received comments in proposed Rulemaking 4 on this proposed amendment as well. Many commentators strongly supported the increase, citing to research that shows that 4.1 is essential to ensure that residents receive quality care and indicating that an increase is long overdue. These commentators cited to many of the benefits that the Department noted on proposed, including health benefits to residents, fewer reports of abuse, and higher job satisfaction for nursing services personnel. Some commentators also suggested that 4.1 is too low.

Commentators opposed to the increase asserted that a proposed increase to 4.1 is not realistic because the regulated community has experienced, and continues to experience, a dire workforce shortage that has only been exacerbated by the COVID-19 pandemic. Facility owners, operators and administrators described in detail the difficulties they have experienced recruiting and maintaining nursing services personnel at the existing minimum of 2.7 direct care hours per day. These commentators also described in detail the various incentives they have tried to recruit and maintain staff. Commentators also indicated that facilities have had to resort to the use of agency staff, who are not as familiar with the needs of residents that are specific to the facility they are assigned to, and thus, are not able to provide the same high-quality care as nursing services personnel who work with the residents on a day-to-day basis. Commentators cited to the high cost of utilizing agency staff as well and noted that it is often difficult to even find agency staff who are available. Commentators also felt that rural communities may be more greatly impacted due to their smaller populations and that the increase may impact the poor and minorities who already have limited access to care. Other commentators pointed out that the regulated community is still reeling from the impacts of COVID-19 and indicated that they feel now is not the time to be making changes to nursing services personnel requirements. Commentators indicated that nursing services personnel are burned out, are paid a very little amount for the type of work that they perform and can easily find other employment for more money and less stress.

Commentators felt that due to the fiscal impact of the increase to 4.1, facilities may need to close, sell to large out-of-state providers, or reduce admissions, pointing out that some facilities have already had to do this. Commentators felt that facilities may have to sacrifice other staff such as therapists, dietary staff, activity staff, housekeeping staff and office staff, who are just as crucial to residents' well-being, to hire more nursing services personnel. Some commentators felt that the cost of hiring additional nursing services personnel might result in costs needing to be passed on to residents, which would require residents to spend down faster to receive MA, which will impact the MA program. Many commentators also pointed out that the MA program has been underfunded for years, while costs to facilities have increased. Commentators argued that without a significant increase in MA funds, facilities will not have the resources to cover the cost of additional nursing services personnel. Commentators indicated

that there is already a shortfall in MA reimbursement to facilities, which the facilities or their residents must cover.

Commentators also argued that quantity does not necessarily equal quality, and a one size fits all approach will not work. Commentators argued that the Department should base the level of care on the needs of the facility, considering resident care plans, resident acuity, facility characteristics, and training, competency, and tenure of staff. Commentators argued, for example, that a facility with a ventilator unit may require a significantly higher staffing level, while a primary care facility with no specialty units may require lower staffing.[1] Some commentators stressed as well that 4.1 should be a floor, not a ceiling, and facilities should be required to staff higher if required by resident acuity. The Department notes, in response to this comment, that the requirement in subsection (i) is indeed a minimum, and under subsection (i)(3), a facility is required to have a sufficient number of nursing services personnel to provide nursing care and related services to assure resident safety and to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Other commentators argued that the Department's proposal to increase direct care hours would stifle innovation as facilities scramble to pay for increased staffing levels. Others argued that the Department should follow CMS' lead on this issue by not requiring a minimum staffing level at all.

Commentators suggested that the Department and the State develop strategies to address staffing shortages, such as assistance with education and training for nursing services personnel. Commentators suggested that the State provide incentives to those who choose to work in the profession, such as tax cuts, tuition reimbursement, loan forgiveness, and free training and certification. The Department is supportive of such efforts, and notes that many of the facilities that submitted comments indicate they are already providing these incentives as a mechanism to recruit and retain nursing services personnel. Some commentators indicated that the temporary nurse aide (TNA) waiver program was a great help and urged the State to make this program permanent. The TNA waiver program was a pathway for individuals to become a TNA, with extended deadlines to meet training requirements to become a certified nurse aide. The TNA waiver was one of several temporary Federal emergency declaration blanket waivers enacted by CMS to provide for extra flexibility needed to respond to the COVID-19 pandemic. Although CMS ended the waiver on June 6, 2022, CMS will accept waiver requests to extend the TNA certification testing deadline of October 6, 2022. Department of Education. Temporary Nurse Aide. Retrieved from https://www.education.pa.gov/K-12/Career%20and%20Technical%20Education/Nurse%20Aide%20Training%20Program/TempNurseAide/Pages/default.aspx. As such, the Commonwealth submitted a statewide waiver request to CMS in order to further extend this deadline to continue testing and retaining TNAs.

[1] One commentator suggested that staffing hours should be based on facility needs and resident acuity as determined by the completion of a monthly facility assessment under 42 CFR 483.40(e). Under 42 CFR 483.40(e), a facility must complete a facility assessment, as often as necessary, but at least annually. The Department has amended § 201.14(j) to require a facility assessment as often as necessary, but at least quarterly. This amendment is discussed more fully in the preamble for Rulemaking 3 – *Applications for Ownership, Management and Changes of Ownership; Health and Safety* at § 201.14(j).

IRRC, in proposed Rulemaking 1, noted that commentators both supported and opposed the proposed increase to 4.1 direct care hours and provided specific examples related to the above comments. IRRC asked that the Department explain how the final-form regulation protects residents, while also addressing the impact of the minimum number of direct care hours on facilities, regardless of whether the Department retains or amends § 211.12(i). IRRC also asked if the Department sees any potential negative impact for residents if positions remain unfilled when the regulation goes into effect.

As stated above, the Department received similar comments to subsection (i) in proposed Rulemaking 4. Some commentators proposed a ramp-up period as a solution to balance the need for higher staffing with available resources and MA funding. These commentators suggested staffing ratios that would equate to an increase to 2.87 direct care hours per resident per day in the first year, with the first year beginning on July 1, 2023, and 3.2 direct care hours per resident day in the second year, with the second year beginning on July 1, 2024. IRRC asked the Department to explain the need for and reasonableness for staffing ratios that are more stringent than the Federal requirements.

On final-form, the Department amends subsection (i) in accordance with the graduated period suggested by commentators. First, the Department rephrases the existing language in subsection (i) for ease of readability and adds two paragraphs to align with the graduated implementation period proposed by commentators. Under paragraph (1), effective July 1, 2023, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 2.87 hours of direct resident care for each resident. Under paragraph (2), effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum 3.2 hours of direct resident care for each resident. The language the Department had previously proposed in paragraph (2), in proposed Rulemaking 1, is deleted on final-form because this language is duplicative of 42 CFR 483.35 (relating to nursing services) and is not needed due to the expansion of the incorporation of the Federal requirements in § 201.2.

The Department carefully considered the varying comments in support of and in opposition to the increased direct resident care hours. In balancing the interests of consumers, advocates and industry stakeholders, in combination with the substantial increase in funding for nursing facilities, including new nursing facility funding and increased MA payments beginning January 2023 (Act 2022-54), the Department amended this section, as provided previously, with a graduated implementation date. The final rate of 3.2 hours of direct resident care for each resident, effective July 1, 2024, is comparable to surrounding states and similarly situated states: Delaware 3.28 hours; Maryland 3.00 hours; New York 3.50 hours; New Jersey 2.50 hours; District of Columbia 3.50-4.10 hours; Ohio 2.50 hours; Florida 3.6 hours; Rhode Island 3.58 hours; and West Virginia 2.25 hours. https://www.macpac.gov/publication/state-policies-related-to-nursing-facility-staffing/.

The increase in direct care hours from the current minimum of 2.7 to 2.87 represents a small increase, which should be achievable for facilities. In fact, 622 facilities are already meeting or exceeding this requirement. The increase from 2.87 to 3.2 in year 2 represents a small increase as well. Currently, 523 nursing facilities (or 77%) already meet a 3.0 standard, with 374 nursing facilities (or 55%) meeting or exceeding the 3.2 requirement. The delayed implementation date until July 1, 2023 for year 1, with a graduated implementation beginning

year 2, coupled with a reduced rate in combination with increased funding for nursing facilities generally and increased MA payments provides ample time and funding to fill positions. If positions are not filled, residents are impacted because they will not benefit from the quality of care that a higher staffing ratio would provide.

In response to IRRC's question regarding the need for staffing ratios, CMS is revisiting the need to set minimum staffing ratios in long-term care nursing facilities. The White House announced, earlier this year, that CMS intends to propose minimum standards for staffing and is conducting a new research study to determine the level and type of staffing needed to ensure safe and quality care. The White House. *Fact Sheet: Protecting Seniors by Improving Safety and Quality of Care in the Nation's Nursing Homes*. Retrieved from https://www.whitehouse.gov/briefing-room/statements-releases/2022/02/28/fact-sheet-protecting-seniors-and-people-with-disabilities-by-improving-safety-and-quality-of-care-in-the-nations-nursing-homes/. As noted by the White House, "establishing a minimum staffing level ensures that all nursing home residents are provided safe, quality care, and that workers have the support they need to provide high-quality care." As pointed out by commentators, as well, numerous studies have found a direct correlation between the quality of resident care, quality of resident life, and the number of direct care hours that the resident receives. The benefits of higher staffing ratios include improved activity levels, lower mortality rates, fewer infections, less antibiotic use, fewer pressure ulcers and fewer catheterized residents, improved eating patterns and pain levels, and improved mental health. Juh Hyun Shin, PhD, RN & Sung-Heui Bae, PhD, MPH, RN. *Nurse Staffing, Quality of Care, and Quality of Life in U.S. Nursing Homes, 1996-2011,* 38 Journal of Gerontological Nursing 46 (2012).

Subsection (i.1)

This subsection remains unchanged from proposed to final-form. As explained on proposed, under subsection (i.1), only direct resident care provided by nursing services personnel may be counted towards the total number of hours of general nursing care required under subsection (i). Under this requirement, only direct care provided to residents by RNs, LPNs and nurse aides count toward the number of direct care hours in subsection (i). As explained on proposed, RNs, LPNs and nurse aides are better positioned to provide this type of resident care based on their training and experience, than other types of professionals, such as physical therapists, who are primarily focused on providing residents with specialized care.

Commentators to proposed Rulemaking 1 commented that the Department should permit facilities to include staff, other than nursing services personnel, in the calculation of direct care hours. These commentators argued that staff, such as physical, occupational, and rehabilitative therapists, activities staff, dieticians, housekeeping staff, maintenance staff, dining staff, and social workers often assist residents with activities of daily living. Some commentators argued that CMS recognizes these individuals in its definition of "direct care." Some commentators, on the other hand, commented that direct care should only be provided by nursing services personnel. IRRC, in comment to proposed Rulemaking 1, questioned whether the health, safety and welfare of residents would be protected by expanding the definition of direct care staff to align with the Federal definition.

The Department received similar comments to proposed Rulemaking 4. Commentators additionally argued that ancillary staff, who meet the licensure requirements to be nursing

services personnel, also should not be included in the calculation for who provides direct care under subsection (i). In response to this comment, in practice, the Department only counts such staff if they are working in their capacity as licensed nursing services personnel, outside of the scope of their other role in the facility. For example, a facility that is required to have a full-time administrator cannot count the work of a licensed RN who is working as the administrator towards the direct care hours, if that work subtracts from the number of hours they are required to work as an administrator. IRRC, in comment to proposed Rulemaking 4, asked the Department to explain why the Federal requirements are not sufficient related to who provides direct care, given the Department's deference to Federal requirements throughout the regulations.

Direct care typically involves assisting residents with tasks such as grooming and dressing themselves, exercise, eating, changing soiled clothing, repositioning, and providing toileting assistance. As explained on proposed, RNs, LPNs, and nurse aides are in the best position to provide this type of resident care based on their training and experience compared to other types of professionals. While physical therapists and others may assist with such tasks on an ad hoc basis, residents benefit from having this care provided on a consistent basis from nursing personnel who are more familiar with the overall needs of the residents in their care, as opposed to other types of professionals such as physical therapists, who are primarily focused on providing residents with specialized care. John F. Schnelle PhD, L. Dale Schroyer MMS, Avantika A. Saraf MPH, Sandra F. Simmons PhD, *Determining Nurse Aide Staffing Requirements to Provide Care Based on Resident Workload: A Discrete Event Simulation Model*, JAMDA 17 (2016) 970-977; Charlene Harrington1, Susan Chapman, Elizabeth Halifax, Mary Ellen Dellefield, and Anne Montgomery, *Time to Ensure Sufficient Nursing Home Staffing and Eliminate Inequities in Care*, HSOA Journal of Gerontology and Geriatric Medicine, Geriatr Med 2021, 7:099.

Subsection (j)

This subsection remains deleted on final-form. As explained previously, and on proposed, the Department moves this requirement into subsection (f.1)(1) for clarity.

Subsection (k)

This subsection remains deleted on final-form. As explained on proposed, the Department deletes this subsection to eliminate duplication and to avoid conflict with the Federal requirements. Under 42 CFR 483.35(g), a facility is required to post on a daily basis and at the beginning of each shift, the total number and actual hours worked by RNs, LPNs and nurse aides.

A commentator requested that the Department require facilities to post this information online as well as inside and outside of the front door of the facility for residents and visitors to see. After careful consideration, the Department declines to make this suggested amendment. Under 42 CFR 483.35(g)(2)(ii)(B), a facility is required to post the nursing staff data specified in 42 CFR 483.35(g)(1) "in a prominent place readily accessible to residents and visitors." The facility must also, under 42 CFR 483.35(g)(3), "upon oral or written request make nurse staffing data available to the public for review at a cost not to exceed the community standard."

Subsection (l)

This subsection remains deleted on final-form. Commentators requested that the Department not delete subsection (l) and that the Department add language to specifically indicate that the nursing staff ratios are minimum levels, and that actual staffing levels, which shall meet or exceed these levels, must be determined specifically for each facility based on the actual needs of each resident as outlined in their comprehensive assessments and person-centered care plans, as well as in accordance with the quarterly facility assessment. In contrast, some commentators in both proposed Rulemakings 1 and 4 suggested that the Department should not have minimum staffing requirements at all and should instead require facilities to staff based on resident care needs, as determined by the facility assessment. After careful consideration of these comments, the Department declines to make these suggested amendments. As explained in subsections (f.1) and (i), the Department has determined that minimum nursing staff levels are needed to ensure the health, safety, and welfare of residents. The Department also declines to add the language requested by other commentators, regarding minimum standards. Under 42 CFR 483.35, a 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" 42 CFR 483.70(e) (relating to administration). In addition, under 42 CFR 483.35(a)(1), a facility must provide a sufficient number of licensed nurses and other nursing personnel "on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans." The Department considers the staffing levels in subsection (f.1) to be the minimum. If a facility's assessment or resident care plans show that a higher staffing level is required, then the facility must staff to that level under 42 CFR 483.35. This is not a new requirement for facilities.

§ 211.15. Dental services

Subsection (a)

This subsection remains deleted on final-form. As explained on proposed, the Department deletes this subsection because it is duplicative of 42 CFR 483.55 (relating to dental services), which requires a facility to provide or obtain from an outside resource routine and emergency dental services. In response to a commentator who requested that the Department add a provision requiring that a facility provide necessary assistance to ensure the resident can access their provider of choice, the Department notes that a facility is required under 42 CFR 483.55 to assist residents in making dental appointments and arranging transportation to and from dental services locations. The three private-pay facilities are currently exempted from the requirements in 42 CFR 483.55 under existing § 201.2, but will be required to comply with this section under § 201.2, as amended in Rulemaking 1– *General Applicability and Definitions*. This assumes approval of Rulemaking 1.

Subsection (b)

Subsection (b) is amended from proposed to final-form. The Department had proposed to delete this subsection because under 42 CFR 483.55, a facility is also required to have a policy to identify the circumstances in which the loss or damage of dentures is the facility's responsibility and to provide a referral for dental services for residents with lost or damaged dentures, within 3

days. A commentator, and IRRC, noted that the requirement in subsection (b), which ensures that resident dentures are retained by residents and marked for each resident, does not appear to be directly covered by the Federal requirements. IRRC asked if the deletion of this provision would reduce existing protections for residents of facilities. IRRC asked the Department to explain how the removal of this provision protects the public health, safety, and welfare of residents.

Upon further review, the Department has decided to retain, not delete, the requirement in this subsection on final-form, but to rephrase it for ease of readability. Although facilities are required under 42 CFR 483.55 to have policies in place regarding loss or damage of dentures, there is no explicit requirement for a facility to assure that resident dentures are retained by residents and marked for each resident. The Department has also added a cross-reference to 42 CFR 483.55 to make it clear to facilities that this requirement is in addition to the requirements in that section.

§ 211.16. Social services

Subsection (a)

This subsection is amended from proposed to final-form. The Department had proposed to require that all facilities have a full-time qualified social worker, regardless of size. The Federal requirements at 42 CFR 483.70(p) (relating to administration) only require a full-time qualified social worker for facilities with more than 120 beds.

One commentator indicated that smaller facilities may have someone working as a social worker who has not been professionally trained as a social worker, or a social worker who is serving in another capacity, such as the activities director. This commentator stated that requiring a full-time qualified social worker would result in a turnover of staff that do not meet the technical definition of a qualified social worker. In response to this comment, the Department notes that under existing § 211.16, a facility with more than 120 residents is required to have a qualified social worker on a full-time basis, and a facility with 120 beds or less that does not have a full-time qualified social worker is required to provide social work consultation by a qualified social worker. Therefore, all facilities, under the current standards, are already required to utilize a qualified social worker, just not on a full-time basis.

Other commentators felt that small facilities, who are also more likely to be small businesses, would be disproportionately harmed by the requirement to have a full-time qualified social worker, particularly with the Department's proposal to increase nursing staff ratios. One commentator suggested that the Department amend this subsection to require a full-time qualified social worker for facilities with 60 or more beds, allow facilities with 26 to 59 beds to have a part-time social worker based off the facility assessment and needs of the residents, and allow facilities with 25 beds or less to share a qualified social worker, like the provision in § 201.18, related to the sharing of administrators. However, some commentators did express support for the Department's proposal to require that all facilities have a full-time qualified social worker.

IRRC asked what alternatives the Department considered to assist rural and small facilities with implementation of this requirement. IRRC also asked that the Department explain

the reasonableness and feasibility of requiring a full-time qualified social worker for all facilities regardless of size.

As explained on proposed, the Department asserts that all facilities need to have a full-time social worker on staff regardless of the size of the facility. Social workers have specialized education and training and are well-suited to assist residents and their families with all aspects of their stay in a long-term care nursing facility, including the social, emotional, financial, and psychological aspects, and preparing residents and their families for life post-discharge. In addition, over time, the condition of residents seeking care in the long-term care nursing environment has changed, and there has been an increase in the number of residents presenting with a wide range of psychosocial or behavioral issues. For example, facilities may have younger residents with mental health conditions, veterans with post-traumatic stress disorder or older residents with dementia. These residents require engaged qualified social workers to assist with their care planning and to provide psychosocial support.

However, recognizing that requiring a full-time qualified social worker could be unduly burdensome to rural and small facilities, the Department amends this subsection. In accordance with the suggestion put forth by a commentator, this section is amended to permit a facility with 26 to 59 beds to employ a part-time qualified social worker if the facility assessment indicates that a full-time qualified social worker is not needed, and to permit facilities with 25 beds or less to either employ a part-time qualified social worker or share the services of a qualified social worker with another facility. All other facilities will be required to employ a full-time qualified social worker.

Subsection (b)

Subsection (b) remains deleted on final-form. As explained on proposed, the Department deletes this subsection due to the amendments to subsection (a) as described previously.

Other Comments

Commentators requested that the Department expand § 211.16 to require the social worker or a designee to meet with each resident and to document in the resident's person-centered care plan the resident's wants and needs as they relate to social services. Commentators also requested that the Department add language requiring that the person-centered care plan address how the resident might be supported during any prolonged periods of isolation caused by pandemic, infection, or other contagious disease, and to require the facility to consider best practices in minimizing isolation as it plans its social services and resident supports. The Department declines to make these suggested amendments, for the reasons stated below.

Existing Federal requirements at 42 CFR 483.21(a) and (b) (relating to comprehensive person-centered planning) require that a facility must develop and implement both a baseline care plan and a comprehensive care plan for each resident and include objectives and timeframes to meet a resident's social and psychosocial needs. Further, the comprehensive care plan must be developed and implemented by the facility with the input of the resident. Additionally, 42 CFR 483.21(b)(2)(ii) provides that the interdisciplinary care team that prepares the comprehensive care plan must include – but is not limited to – an enumerated team of individuals with an interest in the well-being of the resident. Subsection 483.21(b)(2)(ii)(F) specifies that an interdisciplinary care team may include "other appropriate staff or professionals in disciplines as

determined by the resident's needs or as requested by the resident." This language provides for a social worker to be part of the interdisciplinary team based either on the resident's needs or at the request of the resident.

With regards to planning for prolonged periods of isolation, 42 CFR 483.10(f)(4) (relating to resident rights) provides that a resident has a right to receive visitors of their choosing and a facility needs to provide immediate access to any resident by an enumerated group of persons including government officials, professionals, and most importantly to address the concerns of commentators in this subsection, immediate family and other visitors. Additionally, the facility must provide reasonable access to a resident "by any entity or individual that provides health, social, legal, or other services to the resident" pursuant to § 483.10(f)(4)(iv). Residents and their representatives, if applicable, must be provided notice of written visitation policies pursuant to § 483.21(f)(4)(v) and (vi).

In response to the COVID-19 pandemic, the Commonwealth also enacted legislation that helps address isolation for residents during declarations of emergency. Act 67 of 2021, the Access to Congregate Care Facilities Act (35 P.S. §§ 10281 -10289), provides for residents to name an essential caregiver to help provide physical or emotional support to the resident during a declaration of disaster emergency.

Commentators requested that the Department expand § 211.16 to also require the social worker or a designee to support residents in acquiring technology-based skills so that they can better connect with friends and family outside of the facility. The Department declines to make this suggested amendment. While the Department understands the need for residents to be supported in acquiring technology-based skills to ensure contact with persons outside the facility, 42 CFR 483.10(g)(7) requires facilities to ensure resident access to phones, internet, and stationary, postage and mail services. A resident has right to private use of electronic communication at the resident's expense. The Department will not require a social worker to teach residents technological skills, as it is outside the scope of the social worker's role.

§ 211.17. Pet therapy

This section is unchanged from proposed to final-form. As explained on proposed, the Department rephrases this section to require a facility to have written policies and procedures that incorporate the requirements that already exist in this section, with amendments, if pet therapy is utilized. The Department has made grammatical changes to paragraphs (2)—(4) and (6) for ease of readability. In paragraphs (4) and (6), the Department replaces the word "pets" with "animals" for consistency in the use of terms throughout this section. The Department deletes paragraph (5) and replaces it with paragraph (5.1) to address the health of animals and the health and safety of residents by requiring that a facility have policies and procedures in place to ensure that animals are up to date on vaccinations, are in good health and do not pose a risk to the health and safety of residents. In paragraph (6), the Department adds the words "or visit" to clarify that a facility shall have policies and procedures in place to ensure that animals and places where they visit, as well as where they reside, are kept clean and sanitary. Paragraph (7) is added to require a facility to have in place policies and procedures to ensure that infection prevention and control measures, such as hand hygiene, are followed by residents and personnel when handling animals, to reduce the risk of illness or infection that can sometimes occur when handling animals.

A commentator asked that the Department not unnecessarily regulate pet therapy requirements. The commentator stated that these visits are very appreciated and sometimes are the highlight of the residents' day. The commentator added that this is the least infectious thing that facilities do. The Department declines to further amend this section, on final-form, in response to this comment. The Department recognizes the benefit of permitting pets and animals to visit with residents. The Department, however, must balance this benefit with its goal of protecting the health, safety and welfare of residents. The Department believes that amending § 211.17 to add requirements such as hand washing, are minimal health and safety standards and necessary to ensure the health, safety and welfare of residents. The Department notes as well that these amendments align with CDC guidelines for pet therapy and visitation in healthcare facilities. *See* CDC. Guidelines for Environmental Infection Control in Health-Care Facilities. (2003). Retrieved from https://www.cdc.gov/infectioncontrol/guidelines/environmental/background/animals.html.

Fiscal Impact and Paperwork Requirements

Fiscal Impact

The Department participated in the Senate Health and Human Services and Aging and Youth Committees joint legislative hearing regarding proposed Rulemaking 1 on September 15, 2021. Various stakeholders participated, including the Pennsylvania Health Care Association (PHCA), AARP Pennsylvania, LeadingAge Pennsylvania, the Pennsylvania Coalition of Affiliated Healthcare & Living Communities (PACAH), SEIU Healthcare Pennsylvania, and the Center for Advocacy for the Rights & Interests of the Elderly (CARIE). During this hearing, there was much discussion about the proposed staffing increase from 2.7 to 4.1 hours of direct resident care and the related cost and staff concerns. Specifically, concerns were raised regarding stagnate MA rates since MA pays for 70 percent of all nursing home care. There were also comments regarding increased costs related to the increased staffing generally. During this hearing, stakeholder testimony provided that many facilities struggle to reach 3.3 hours of direct resident care. Resident advocates also expressed concerns with staff turnover and the need for greater transparency to understand how facilities are spending public funds. There was further testimony regarding staff burnout due to high demands of resident care, workers leaving the field, and the need to address systemic underfunding of these services in the commonwealth.

In response to the comments and concerns raised during this legislative hearing, throughout the public comment process, and in other discussions, the Governor's Fiscal Year 22-23 budget proposal proposed a MA rate increase of $190 million; $91 million in state funding to be matched with $99 million in federal funds for the first 6 months of calendar year 2023 and a proposed $250 million one-time investment of American Rescue Plan Act (ARPA) funds in long-term living programs, including direct one-time funding for all facilities to support their workforce and help them to hire more staff to meet the requirements of the forthcoming regulations. The funding was proposed to be provided to facilities in advance of the expected staffing increases to allow facilities to stabilize their existing workforce and recruit additional staff prior to the regulatory increases going into effect.

Following the Governor's budget proposal, industry stakeholders called for $294 million in MA funding in the Commonwealth's FY 22-23 budget. The FY 22-23 Appropriations Act signed by Governor Wolf included bipartisan support for a historic increase in one-time and ongoing funding for facilities. As enacted, $147 million in state funding was appropriated to support implementation of the Department's regulations. Specifically, this funding will be used to support a 17.5% Medicaid rate increase beginning January 1, 2023, which allows facilities time to ramp up staffing to meet the direct care staffing hours required on July 1, 2023. Assuming Federal approval, these state funds will be matched with an additional $159 million in federal funds, totaling $306 million in Medicaid funding for the first 6 months of calendar year 2023. All nursing facilities will also receive $131 million in one-time ARPA funding during FY 22-23. A detailed fiscal impact for the regulated community, the commonwealth and local government is as follows:

Regulated community

The amendments will apply to all 682 long-term care nursing facilities licensed by the Department. These facilities provide health services to approximately 72,000 residents. This total includes nineteen county-owned and operated facilities, six veterans' homes that are operated by the Department of Military and Veterans' Affairs, 645 privately-owned facilities that participate in the Medicare or MA Programs, and three private-pay facilities that do not participate in Medicare or MA.

Cost to add qualified social worker

Some long-term care nursing facilities will be financially impacted by the requirements in § 211.16 (relating to social services), which require facilities to employ a full-time or part-time social worker or permit sharing of the services of a social worker, depending on the size of the facility.

To estimate the number of facilities that will be impacted by the increased requirements in § 211.16, the Department pulled data from the most recent, available annual report, for fiscal year 2020-2021. This report is available on the Department's website. Department of Health. (2021). Nursing Home Reports. Retrieved from: https://www.health.pa.gov/topics/HealthStatistics/HealthFacilities/NursingHomeReports/Pages/nursing-home-reports.aspx. Data within the report is obtained through an annual survey of facilities. The data, therefore, is dependent on self-reporting from the facilities who complete the survey.

According to this Commonwealth's Center for Workforce Information & Analysis, the median annual wage for a healthcare social worker is $55,890. Center for Workforce Information & Analysis. (2021). Occupational Wages. Retrieved from https://www.workstats.dli.pa.gov/Products/Occupational%20Wages/Pages/default.aspx. This does not include the cost of benefits. According to the U.S. Bureau of Labor Statistics, benefits make up approximately 31 percent of an employer's cost for compensation in the private sector. U.S. Bureau of Labor Statistics. (2021). Economic News Release: Employer Costs for

Employee Compensation Summary. Retrieved from https://www.bls.gov/news.release/ecec.nr0.htm. The Department therefore estimates that the cost to hire a full-time social worker to be $73,216, which includes wages + benefits. The Department estimates the cost to hire a part-time social worker to be approximately half that amount, or $36,608. This assumes that a part-time social worker is working approximately 20 hours per week.

Under existing § 211.16, facilities with 120 beds or more are already required to have a full-time social worker. The amendment to § 211.16(a) will require facilities with 60 beds to 119 beds to have a full-time social worker. Based on data pulled from the annual report, the Department estimates that 9 facilities will need to staff up from a part-time social worker to a full-time social worker, at an approximate cost of $329,472 ($36,608 x 9). These facilities are all privately-owned facilities that participate in the MA program. According to data obtained from DHS, approximately 75.82%, or $249,806 of the total costs to MA facilities will be covered by the MA program. Applying the Federal share of approximately 52% to the total costs to the MA program results in an estimated Federal match of $129,899 and a State general fund investment of $119,907. There are 83 facilities that do not currently have a social worker, that will need to hire a full-time social worker, at an approximate cost of $6,076,928 ($73,216 x 83). Out of these 83 facilities, 3 are Medicare-only facilities ($219,648) and 80 are privately-owned MA facilities ($5,857,280). According to data obtained from DHS, approximately 75.82%, or $4,440,990 of the total costs to MA facilities will be covered by the MA program. Applying the Federal share of approximately 52% to the total costs covered by the MA program results in an estimated Federal match of $2,309,315 and a State general fund investment of $2,131,675. These estimates are for fiscal year 1.

The amendment to § 211.16(a)(1) will require facilities with 26 to 59 beds to employ at least a part-time social worker if their facility assessment indicates that a full-time social worker is not needed. There are 22 facilities that currently do not employ a social worker, that will need to hire a part-time social worker under this requirement, for an estimated cost of $805,376 ($36,608 x 22). Out of these 22 facilities, 3 are Medicare-only ($109,824) and 19 are privately-owned MA facilities ($695,552). According to data obtained from DHS, approximately 75.82%, or approximately $527,368 of the costs to MA facilities will be covered by the MA program. Applying the Federal share of approximately 52% to the total costs results in an estimated Federal match of $274,231 and a State general fund investment of $253,136. These estimates are for fiscal year 1.

The amendment to § 211.16(a)(2) will require facilities with 25 beds or less to employ either a part-time social worker or share the services of a social worker with another facility. Based on the annual report, all facilities that have 25 beds or less are currently meeting this requirement. Thus, there will be no fiscal impact on these facilities by the addition of § 211.16(a)(2).[2]

[2] DMVA indicated to the Department that the six veterans' homes that it operates will not be affected by the Department's amendment to § 211.16. In addition, out of the 19 county-owned facilities, 18 have more than 120 beds and thus, are already required to have a full-time social worker. The one county-

The cost to facilities to employ a full-time or part-time social worker is outweighed by the need to have a social worker on staff. As state above, social workers have specialized education and training and are well-suited to assist residents and their families with all aspects of their stay in a long-term care nursing facility, including the social, emotional, financial, and psychological aspects, and preparing residents and their families for life post-discharge. In addition, over time, the condition of residents seeking care in the long-term care nursing environment has changed, and there has been an increase in the number of residents presenting with a wide range of psychosocial or behavioral issues. These residents require engaged social workers to assist with their care planning and to provide psychosocial support.

Cost to meet proposed nursing staff ratio.

Privately-owned and MA Program; 2023-2024

The increase in LPNs set forth in § 211.12(f.1)(4), is projected to require the 589 privately-owned facilities that participate in MA[3] to employ an additional 522 FTE LPNs in the aggregate. In fiscal year 2023-2024, the cost for an LPN is projected to be $85,276, which is an increase of 13% from the average LPN wage across all industries in 2021, according to data from the Bureau of Labor Statistics. This estimate for the increased cost includes wages and benefits and is based on the 75th percentile of Bureau of Labor Statistics (BLS) wage data reported for these professions across all industries in Pennsylvania. The wages were increased to reflect the most recent benefit cost percentage (28%) and trended for inflation to 2023 (5%).[4] The 75th percentile wage was used as a proxy for expected wages in 2023 due to trends in the labor market for LPNs and nurse aides and unchecked pressures on staffing agency use and pricing. The total cost to the privately-owned facilities that participate in MA to add 522 FTE LPNs is estimated to be $44,514,072 in the aggregate. The affected privately-owned facilities will also need to hire an estimated 249 FTE nurse aides to meet the requirements in § 211.12(f.1)(2), which are effective from July 1, 2023 through June 30, 2024. The nurse aide salary during that period, fiscal year 2023-2024, is projected at $54,542, which is a 14% increase from the from the average nurse aide wage across all industries in 2021, according to data from the Bureau of Labor Statistics. The total estimated cost during fiscal year 2023-2024 to add 249 FTE NAs is $13,580,958 in the aggregate. There will be no additional cost to meet the total general nursing

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owned facility with 120 or less beds reported having a full-time social worker in the 2020-2021 annual report. If this continues to be the case, there will be no impact to this facility.

[3] This number includes facilities that participate only in MA and those that participate in both Medicare and MA.

[4] The Department is using a 5% inflation projection in 2023, even though the Federal outlook indicates a 2.5-2.9% inflation projection. Congressional Budget Office Outlook: 2022 to 2032; Figure 2-4. Inflation and Interest Rates. Retrieved at https://www.cbo.gov/publication/58147#_idTextAnchor075. The Department, however, erred on the side of a 5% projection due to the historic inflation rates and the desire to account for a potential higher rate if the 2023 projections are missed.

care hours per resident per day because facilities that meet or exceed the minimum RN, LPN, and nurse aide requirements will meet or exceed the minimum requirements for direct care hours set forth in § 211.12(i).

In fiscal year 2023-2024, the total increased cost for privately-owned MA facilities to meet the requirements of both §§ 211.12(f.1)(4) and 211.12(f.1)(2) will be approximately $58,095,030 in the aggregate. According to data obtained from DHS, approximately 75.82%, or about $44,047,652, of this cost will be covered by the MA program. Applying the Federal share of approximately 52% to the total costs results in an estimated Federal match of $22,904,779 and a state general fund investment of $21,142,873.

Privately-owned and MA Program; 2024-2025

In the following year, the requirements for nurse aides in § 211.12(f.1)(4) that go into effect on July 1, 2024 will require the privately-owned facilities that participate in MA to hire an additional 1,389 nurse aides, for a total of 1,638 FTE NAs in fiscal year 2024-2025. The nurse aide salary during that period, fiscal year 2024-2025, is projected at $57,958, which is a 21.5% increase from the from the average nurse aide wage across all industries in 2021, according to data from the Bureau of Labor Statistics. Therefore, the total estimated cost during fiscal year 2024-2025 for 1,638 FTE NAs is $ 94,935,204 in the aggregate. The annual LPN salary for that period is projected to increase to $90,281, which is a 20% increase from the from the average LPN wage across all industries in 2021, according to data from the Bureau of Labor Statistics. The cost to employ the 522 FTE LPNs in fiscal year 2024-2025 will, therefore, be approximately $47,126,682 in the aggregate.

In fiscal year 2024-2025, the total increased cost for privately-owned MA facilities to meet the requirements of both § 211.12(f.1)(4) and 211.12(f.1)(3) will be, in the aggregate, approximately $142,061,886. According to data obtained from DHS, approximately 75.82%, or about $107,711,322, of this cost will be covered by the MA program. Applying the Federal share of approximately 52% to the total costs results in an estimated Federal match of approximately $56,009,887 and a state general fund investment of approximately $51,701,435.

Medicare-only Facilities; 2023-2024

There are 59 facilities that participate only in Medicare. The increase in LPNs, set forth in § 211.12(f.1)(4), will require these 59 facilities to employ an additional 119 FTE LPNs. This estimate is based on data obtained from the Department's 2020-2021 annual report. In fiscal year 2023-2024, the cost for an LPN is projected to be $85,276. This estimate includes wages and benefits. The total cost to add 119 FTE LPNs in fiscal year 2023-2024, based on the same cost assumptions provided by DHS, will be approximately $10,147,844. In fiscal year 2023-2024, the affected Medicare facilities will also need to hire approximately 550 FTE nurse aides to meet the requirements in § 211.12(f.1)(2), which are effective from July 1, 2023 through June 30, 2024. The nurse aide salary during that period is projected at $54,542. The total estimated cost during fiscal year 2023-2024 to add 550 FTE NAs is $29,998,100. There will be no additional cost to meet the total general nursing care hours per resident per day because facilities that meet or

exceed the minimum RN, LPN, and nurse aide requirements will meet or exceed the minimum requirements for direct care hours set forth in § 211.12(i).

In fiscal year 2023-2024, the total increased cost for Medicare facilities to meet the requirements of both §§ 211.12(f.1)(4) and 211.12(f.1)(2) will be approximately $40,145,944. The Department is not able to assess to what extent these costs will be offset by Medicare as Medicare is a federally managed healthcare program and the Department does not have access to data regarding payment of Medicare to facilities.

Medicare-only Facilities; 2024-2025

In the following year, the requirements for nurse aides in § 211.12(f.1)(3) that go into effect on July 1, 2024 will require the facilities that participate only in Medicare to hire an additional 90 nurse aides, for a total of 640 FTE NAs in fiscal year 2024-2025. The nurse aide salary during that period, fiscal year 2024-2025, is projected at $57,958. Therefore, the total estimated cost during fiscal year 2024-2025 to employ 640 FTE NAs is $37,093,120. The annual LPN salary for that period is projected to increase to $90,281. The cost to employ the 119 FTE LPNs in fiscal year 2024-2025 will therefore be approximately $10,743,439. There will be no additional cost to meet the total general nursing care hours per resident per day because facilities that meet or exceed the minimum RN, LPN, and nurse aide requirements will meet or exceed the minimum requirements for direct care hours set forth in § 211.12(i).

In fiscal year 2024-2025, the total increased cost for Medicare facilities to meet the requirements of both §§ 211.12(f.1)(4) and 211.12(f.1)(3) will be approximately $47,836,559. The Department is not able to assess to what extent these costs will be offset by Medicare as Medicare is a federally managed healthcare program and the Department does not have access to data regarding payment of Medicare to facilities.

Private-pay facilities; 2023-2024

There are three private-pay facilities that do not participate in either Medicare or MA. The increase in LPNs, set forth in § 211.12(f.1)(4), will require these 3 facilities to employ an additional 4 FTE LPNs. This estimate is based on data obtained from the Department's 2020-2021 annual report. In fiscal year 2023-2024, the cost for an LPN is projected to be $85,276. This estimate includes wages and benefits. The total cost to add 4 FTE LPNs in fiscal year 2023-2024, based on the same cost assumptions provided by DHS, will be approximately $341,104. In fiscal year 2023-2024, the affected private-pay facilities will also need to hire approximately six FTE nurse aides to meet the requirements in § 211.12(f.1)(2), which are effective from July 1, 2023 through June 30, 2024. The nurse aide salary during that period is projected at $54,542. The total estimated cost during fiscal year 2023-2024 to add six FTE NAs is $327,252. There will be no additional cost to meet the total general nursing care hours per resident per day because facilities that meet or exceed the minimum RN, LPN, and nurse aide requirements will meet or exceed the minimum requirements for direct care hours set forth in § 211.12(i). In fiscal year 2023-2024, the total increased cost for private-pay facilities to meet the requirements of both §§ 211.12(f.1)(4) and 211.12(f.1)(2) will be approximately $668,356.

Private-pay facilities; 2024-2025

In the following year, the requirements for nurse aides in § 211.12(f.1)(3) that go into effect on July 1, 2024 will require the private-pay facilities to hire an additional four nurse aides, for a total of 10 FTE NAs in fiscal year 2024-2025. The nurse aide salary during that period, fiscal year 2024-2025, is projected at $57,958. Therefore, the total estimated cost during fiscal year 2024-2025 to employ 10 FTE NAs is $579,580. The annual LPN salary for that period is projected to increase to $90,281. The cost to employ the 4 FTE LPNs in fiscal year 2024-2025 will therefore be approximately $361,124. There will be no additional cost to meet the total general nursing care hours per resident per day because facilities that meet or exceed the minimum RN, LPN, and nurse aide requirements will meet or exceed the minimum requirements for direct care hours set forth in § 211.12(i). In fiscal year 2024-2025, the total increased cost for private-pay facilities to meet the requirements of both §§ 211.12(f.1)(4) and 211.12(f.1)(3) will be approximately $940,704.

County-owned facilities; 2023-2024

The increase in LPNs set forth in § 211.12(f.1)(4), is projected to require the 19 county-owned facilities that participate in MA to employ an additional 69 FTE LPNs in the aggregate. In fiscal year 2023-2024, the cost for an LPN is projected to be $85,276, as described above. The total cost to facilities to add 69 FTE LPNs is estimated to be $5,884,044 in the aggregate. The affected county-owned facilities will also need to hire an estimated 2 FTE nurse aides to meet the requirements in § 211.12(f.1)(2), which are effective from July 1, 2023 through June 30, 2024. The nurse aide salary during that period, fiscal year 2023-2024, is projected at $54,542, as described above. The total cost to facilities to add 2 FTE nurse aides is estimated to be $109,084 in the aggregate. There will be no additional cost to meet the total general nursing care hours per resident per day because facilities that meet or exceed the minimum RN, LPN, and nurse aide requirements will meet or exceed the minimum requirements for direct care hours set forth in § 211.12(i).

In fiscal year 2023-2024, the total increased cost for county-owned MA facilities to meet the requirements of both §§ 211.12(f.1)(4) and 211.12(f.1)(2) will be approximately $5,993,128 in the aggregate. According to data obtained from DHS, approximately 75.82%, or about $4,5473,990, of this cost will be covered by the MA program. Applying the Federal share of approximately 52% to the total costs results in an estimated Federal match of $2,362,875 and a state general fund investment of $2,181,115.

County-owned facilities; 2024-2025

In the following year, the requirements for nurse aides in § 211.12(f.1)(4) that go into effect on July 1, 2024 will require the county-owned facilities to hire an additional 96 nurse aides, for a total of 98 FTE NAs in fiscal year 2024-2025. The nurse aide salary during that period, fiscal year 2024-2025, is projected at $57,958, as described above. Therefore, the total estimated cost during fiscal year 2024-2025 for 98 FTE NAs is $5,697,884 in the aggregate. The annual LPN salary for that period is projected to increase to $90,281, as described above. The

cost to employ the 69 FTE LPNs in fiscal year 2024-2025 will, therefore, be approximately $6,229,389 in the aggregate.

In fiscal year 2024-2025, the total increased cost for county-owned MA facilities to meet the requirements of both § 211.12(f.1)(4) and 211.12(f.1)(3) will be, in the aggregate, approximately $11,909,273. According to data obtained from DHS, approximately 75.82%, or about $9,029,611, of this cost will be covered by the MA program. Applying the Federal share of approximately 52% to the total costs results in an estimated Federal match of approximately $4,695,398 and a state general fund investment of approximately $4,334,213.

DMVA-operated facilities

The Department consulted with DMVA to determine the impact of the increase to the nursing personnel staffing requirements in § 211.12. DMVA operates 6 veterans' homes across the state with the bed capacity to serve 1,526 total residents and employs more than 2,000 clinical and professional staff. Due to increased funding under the Commonwealth's enacted budget, the increase in LPNs in § 211.12(f.1)(4) and the increase in nurse aides in §§ 211.12(f.1)(2) and (3) will not impact DMVA staffing requirements. DMVA will also not be impacted by the increase in general nursing care hours per resident per day in § 211.12(i). DMVA staff levels are established by the resident acuity level which generally requires staffing between 3.6 and 3.8 hours of direct nursing care per resident per day.

Training requirements

Under § 201.20 of the final-form regulation, facilities will be required to have annual in-service training on accident prevention, restorative nursing techniques, resident rights, including nondiscrimination and cultural competency, and training needs identified through a facility assessment. Also, under § 201.20, orientation shall also include dementia management and communication skills, which is in addition to the current requirement of resident abuse prevention, detection and reporting training. These trainings are in addition to the training requirement under 42 CFR Part 483 (relating to requirements for States and Long-Term Care Facilities). Given that facilities have already incorporated various portion of these required trainings into their annual training curriculum, the Department anticipates an estimated 2 hours of additional training per year under this final-form regulation. The training costs are estimated as follows:

- The average hourly rate for physicians is $110/hour = $220 training costs per person. A 5% wage increase is applied in year 2 and thereafter.
- The average hourly rate for orderlies, aides and attendants is $16/hour = $32 training costs per person. A 5% wage increase is applied in year 2 and thereafter.
- The average hourly rate for other professionals, including therapists, technicians and nursing, is $32/hour = $64 training costs per person. A 5% wage increase is applied in year 2 and thereafter.

Statewide, the estimated total additional training costs, in the aggregate, is:

- FY 2023-2024 - $4,827,048 (or $67 per resident)
- FY 2024-2025 - $5,118,229 (or $71 per resident)

These aggregate costs are based on the following estimations:

Physicians:

- FY 2023-2024 – 1,990 * $220 = $437,800
- FY 2024-2025 – 1,990 * $231 = $459,690

Orderlies, aides and attendants:

- FY 2023-2024 – 61,310 * $32 = $1,961,920
- FY 2024-2025 – 62,793 * $33.60 = $2,109,845

Other professionals:

- FY 2023-2024 – 37,927 * $64 = $2,427,328
- FY 2024-2025 – 37,927 * $67.20 = $2,548,694

The totals for FY 2023-2024 include the additional social workers that will be needed to comply with § 201.16, as well as the LPNs and nurse aides that will be needed to comply with §§ 211.12(f.1)(2) and (4). The totals for FY 2024-2025 include both a 5% wage increase as well as the additional nurse aides that will be needed to comply with § 211.12(f.1)(3).

In addition, although the requirement for 4 hours annually of continuing medical education is not an additional cost since physicians are required to obtain 100 hours, the Department estimates the 4 hours of time would cost approximately $552 per physician.

Department

The amendments will not increase costs to the Department. The Department's surveyors perform the function of surveying and inspecting long-term care nursing facilities for compliance with both Federal and State regulations. For those facilities that participate in MA, there will a fiscal impact as identified above.

DMVA

The Department consulted with DMVA to determine the impact of the increase to the nursing personnel staffing requirements in § 211.12. DMVA operates six veterans' homes across the state with the bed capacity to serve 1,526 total residents and employs more than 2,000 clinical and professional staff. As provided above, due to increased funding under the Commonwealth's enacted budget, the increase in LPNs in § 211.12(f.1)(4) and the increase in nurse aides in §§ 211.12(f.1)(2) and (3) will not impact DMVA staffing requirements. DMVA will also not be impacted by the increase in general nursing care hours per resident per day in § 211.12(i). DMVA staff levels are established by the resident acuity level which generally requires staffing between 3.6 and 3.8 hours of direct nursing care per resident per day.

To address the increased staffing and related costs, a substantial increase in funding for nursing facilities, including new nursing facility funding and increased MA payments beginning January 2023, was enacted under Act 2022-54 and appropriated under the General Appropriations Act of 2022 (Act 2022-1A).

The training requirements set forth in § 201.20 will cost the DMVA facilities approximately $83,912 in fiscal year 2023-2024 and $88,108 in fiscal year 2024-2025, using the same cost estimations described in question 19 above. These costs are based on the following estimations:

Physicians:

- FY 2023-2024 – 14 * $220 = $3,080
- FY 2024-2025 – 14 * $231 = $3,234

Orderlies, aides and attendants:

- FY 2023-2024 – 1,396 * $32 = $44,672
- FY 2024-2025 – 1,396 * $33.60 = $46,906

Other professionals:

- FY 2023-2024 – 565 * $64 = $36,160
- FY 2024-2025 – 565 * $67.20 = $37,968

The totals for FY 2023-2024 include the additional social workers that will be needed to comply with § 201.16, as well as the LPNs and nurse aides that will be needed to comply with §§ 211.12(f.1)(2) and (4). The totals for FY 2024-2025 include both a 5% wage increase as well as the additional nurse aides that will be needed to comply with § 211.12(f.1)(3).

DHS

There will be costs to the MA program as noted above. To address the increased staffing and related costs, a substantial increase in funding for nursing facilities, including new nursing facility funding and increased MA payments beginning January 2023, was enacted under Act 2022-54 and appropriated under the General Appropriations Act of 2022 (Act 2022-1A).

Local Government

As mentioned previously, there are currently 19 county-owned long-term care nursing facilities, licensed by the Department. These facilities account for approximately 7.5% (6,524 beds) of licensed nursing facility beds across the Commonwealth. Allegheny County owns four of the nursing homes; the remaining homes are in the following 15 counties: Berks, Bradford, Bucks, Chester, Clinton, Crawford, Delaware, Erie, Indiana, Lehigh, Monroe, Northampton, Philadelphia, Warren and Westmoreland. As noted above, the county-owned facilities should not incur a cost related to § 211.16. However, the county-owned facilities will incur a cost related to the increase in LPNs and nurse aides in § 211.12(f.1) through (f.4).

The training requirements set forth in § 201.20 will also cost the county-owned facilities approximately $276,824 in fiscal year 2023-2024 and $290,665 in fiscal year 2024-2025, using the same cost estimations described in question 19 above. These costs are based on the following estimations:

Physicians:

- FY 2023-2024 – 98 * $220 = $21,560
- FY 2024-2025 – 98 * $231 = $22,638

Orderlies, aides and attendants:

- FY 2023-2024 – 3,885 * $32 = $124,320
- FY 2024-2025 – 3,885 * $33.60 = $130,536

Other professionals:

- FY 2023-2024 – 2,046 * $64 = $130,944
- FY 2024-2025 – 2,046 * $67.20 = $137,491

The totals for FY 2023-2024 include the additional social workers that will be needed to comply with § 201.16, as well as the LPNs and nurse aides that will be needed to comply with §§ 211.12(f.1)(2) and (4). The totals for FY 2024-2025 include both a 5% wage increase as well as the additional nurse aides that will be needed to comply with § 211.12(f.1)(3).

Residents of Long-Term Care Nursing Facilities

Approximately 72,000 individuals that reside in the 682 long-term care nursing facilities licensed by the Department will benefit from the increased minimum staffing requirements. Numerous studies have found a direct correlation between the quality of resident care, quality of resident life, and the number of direct care hours that the resident receives. The benefits of higher staffing ratios include improved activity levels, lower mortality rates, fewer infections, less antibiotic use, fewer pressure ulcers and fewer catheterized residents, improved eating patterns and pain levels, and improved mental health. Residents will also benefit from the expanded adoption of the Federal requirements because the same standards will now be applied to all long-term care nursing facilities, regardless of whether those facilities participate in the Medicare or MA programs.

Paperwork Requirements

This final-form rulemaking will result in new paperwork requirements as follows:

- Increased personnel record requirements, including documentation of suitability for employment under § 201.19 (relating to personnel records)
- Written policies and procedures for admission under § 201.24 (relating to admission policy)
- Closure plan development, including plan for storage and retrieval of medical records under § 211.5 (relating to medical records)
- Posting of resident rights under § 201.29 (relating to resident rights)

- Written policies and procedures for disposition of medications under § 211.9 (relating to pharmacy services)
- Posting of meal plans under § 211.6 (relating to dietary services)

In addition, the three private pay facilities will have the following new paperwork requirements under this final-form rulemaking:

- Quality assurance and performance improvement documentation under 42 CFR 483.75 (relating to quality assurance and performance improvement)
- Posting if nursing staff data under 42 CFR 483.35(g) (relating to nursing services)
- Information provided to resident in a form and manner the resident can access and understand under 42 CFR 483.10(g)(3) (relating to resident rights)
- Written standards for infection control under 42 CFR 483.80(a) (relating to infection control)
- Written policies and notifications related to abuse, neglect and exploitation under 42 CFR 483.12(b) (relating to freedom from abuse, neglect, and exploitation)
- Discharge plan and post-discharge plan of care under 42 CFR 483.21 (relating to comprehensive person-centered care planning

Small Business Analysis

A commentator expressed concern that the Department did not identify and estimate the number of small businesses that will be subject to the regulation. This commentator indicated that many facilities are small businesses under the definition of "small business" in the Regulatory Review Act. IRRC commented that the Department did not provide an estimate of the number of small businesses that will be impacted by the regulation. IRRC asked if the Department, in conjunction with other agencies, can evaluate potential impacts on small businesses. IRRC also asked that the Department work with the regulated community to calculate and address the economic impact of additional quarterly assessments on facilities, particularly those that are small businesses.

Under section 3 of the Regulatory Review Act, 71 P.S. § 745.3, a small business is "defined in accordance with the size standards described by the United States Small Business Administration's Small Business Size Regulations under 13 CFR Ch. 1 Part 121 (relating to Small Business Size Regulations) or its successor regulation." Under 13 CFR 121.101 (relating to what are SBA size standards), the Small Business Administration's (SBA) "size standards determine whether a business entity is small." Size standards are developed under the North America Industry Classification System (NAICS). The Department applied the NAICS standards to determine how many long-term care nursing facilities, licensed by the Department, are small businesses.

The Department conducted a search on the NAICS website to find the NAICS code for long-term care nursing facilities. The NAICS code for nursing care facilities (skilled nursing facilities) is 623110. The Department looked this code up in the table located at 13 CFR 121.201 (relating to what size standards has SBA identified by NAICS codes) and determined that a long-term care nursing facility is a small business if it has $30 million or less in annual receipts. The Department then pulled the latest long-term care nursing facility cost report from CMS to determine the impact to facilities that participate in Medicare or MA. The latest cost report data from CMS is 2018. Data.CMS.gov. Skilled Nursing Facility Cost Report. Retrieved from https://data.cms.gov/provider-compliance/cost-report/skilled-nursing-facility-cost-report/data. The Department applied current Federal Standards of Accounting to this data to determine each facility's annual receipts. Based on this analysis, the Department determined that 623 facilities that participate in Medicare or MA have $30 million or less in annual receipts. Although the data from CMS is from 2018, the Department believes that currently, at least the same number of facilities, if not more, would meet the definition of a small business. This analysis aligns with the Department's previous assumption that most long-term nursing facilities licensed by the Department meet the definition of a small businesses.

The Department also asked stakeholders during the meetings held in 2021 and 2022 for assistance in determining the impact to small businesses. The stakeholders were not able to provide the Department with specific information regarding how the Department's proposed regulations would impact small businesses. However, during the stakeholder meeting for Rulemakings 1 and 2, a stakeholder suggested that the Department search GuideStar, which provides financial information regarding nonprofit entities, to determine whether the three private-pay facilities are small businesses. The Department searched the GuideStar website at https://www.guidestar.org/ for the three private-pay facilities that are licensed by the Department. Based on this data, one of the private-pay facilities, Friends Home in Kennett/Linden Hall, meets the definition of a small business applying the NAICS standards. Another private-pay facility, Foulkeways at Gwynedd does not meet the definition of a small business based on its gross receipts. Data for the third private-pay facility, Dallastown Nursing Center, is not available on GuideStar, but for the purposes of this analysis, the Department assumes that Dallastown is a small business.

In sum, at least 91% of nursing facilities meet the definition of a small business. Consistent with the HCFA and function of licensure, the purpose of these regulatory amendments is to ensure the health, safety, and welfare of all residents of long-term care nursing facilities in this Commonwealth by providing the minimum health and safety standards. Given that most facilities are a small business and the need for surveying for the health and safety of residents, the Department did not establish differing criteria for nursing facilities that are small business compared to the minority of facilities that are not small businesses. Further, in determining the minimum health and safety requirements, the department considered the myriad of received comments, feedback from meetings and stakeholder groups and attempted to balance the interests between consumers and the stakeholder industry. The Department's responsibility to ensure that residents receive safe, quality care applies to all residents of long-term care nursing facilities in this Commonwealth, and it is critical that all residents of long-term care nursing facilities receive the same level of high-quality care, regardless of whether the facility they reside in is a small business.

Statutory Authority

Sections 601 and 803 of the HCFA (35 P.S. §§ 448.601 and 448.803) authorize the Department to promulgate, after consultation with the Health Policy Board, regulations necessary to carry out the purposes and provisions of the HCFA. Section 801.1 of the HCFA (35 P.S. § 448.801a) seeks to promote the public health and welfare through the establishment of regulations setting minimum standards for the operation of health care facilities that includes long-term care nursing facilities. The minimum standards are to assure safe, adequate, and efficient facilities and services and to promote the health, safety and adequate care of patients or residents of those facilities. In section 102 of the HCFA (35 P.S. § 448.102), the General Assembly has found that a purpose of the HCFA is, among other things, to assure that citizens receive humane, courteous and dignified treatment. Finally, section 201(12) of the HCFA (35 P.S. § 448.201(12)) provides the Department with explicit authority to enforce its rules and regulations promulgated under the HCFA.

The Department also has the duty to protect the health of the people of this Commonwealth under section 2102(a) of the Administrative Code of 1929 (71 P.S. § 532(a)). The Department has general authority to promulgate regulations under section 2102(g) of the Administrative Code of 1929).

Effectiveness/Sunset Date

This final-form rulemaking will become effective on July 1, 2023, except for §§ 211.12(f.1)(3) and (i)(2), which shall take effect on July 1, 2024. A sunset date will not be imposed. The Department will monitor the regulations and update them as necessary.

Regulatory Review

Under section 5(a) of the Regulatory Review Act (71 P.S. § 745.5(a)), on May 11, 2022, the Department submitted notice of this proposed rulemaking, published at 52 Pa.B. 3070 (May 28, 2022), to IRRC and the Chairpersons of the Senate Health and Human Services Committee and the House Health Committee for review and comment.

Under section 5(c) of the Regulatory Review Act, 71 P.S. § 745.5(c), IRRC, the Senate Health and Human Services Committee and the House Health Committee were provided with copies of the comments received during the public comment period, as well as other documents when requested. In preparing the final-form rulemaking, the Department has considered all comments from IRRC, the Senate Health and Human Services Committee, the House Health Committee, and the public.

Under section 5.1(e) of the Regulatory Review Act, 71 P.S. § 745.5a(e), on _____, 2022, the final-form rulemaking was deemed approved by the Senate Health and Human Services Committee and the House Heath Committee. Under section 5.1(e) of the Regulatory Review Act, IRRC met on _____, 2022 and approved the final-form rulemaking.

Contact Person

Additional information regarding this final-form rulemaking may be obtained by contacting Ann Chronister, Director, Bureau of Long-Term Care Programs, by phone at (717)

547-3131, by email at RA-DHLTCRegs@pa.gov or by mail at the following address: 625 Forster Street, Rm. 526, Health and Welfare Building, Harrisburg, PA 17120. Persons with a disability may submit questions in alternative format such as by audio tape, Braille, or by using V/TT (717) 783-6514 or the Pennsylvania Hamilton Relay Service at (800) 654-5984 (TT). Persons who require an alternative format of this document may contact Lori Gutierrez at the previous address or telephone number so that necessary arrangements can be made.

Findings

The Department finds that:

(1) Public notice of intention to adopt the regulations adopted by this order has been given under sections 201 and 202 of the Act of July 31, 1968 (P.L. 769, No. 240) (45 P.S. §§ 1201 and 1202), and the regulations promulgated under those sections at 1 Pa. Code §§ 7.1 and 7.2.

(2) A public comment period was provided as required by law and all comments were considered in drafting this final-form rulemaking.

(3) The amendments made to the final-form rulemaking do not enlarge the original purpose of the proposed rulemaking as published under section 201 of the Act of July 31, 1968 (P.L. 769, No. 240) (45 P.S. § 1201).

(4) The adoption of the regulations is necessary and appropriate for the administration of the Health Care Facilities Act (35 P.S. §§ 448.101—448.904b).

Order

(1) The regulations of the Department at Title 28 of the Pennsylvania Code at §§ 201.18—201.21, 201.24, 201.26, 201.29, 201.31, 209.3, 211.2—211.10, 211.12, 211.15—211.17 are amended and the regulations at Title 28 of the Pennsylvania Code §§ 201.25, 201.30, 207.2, and 211.11 are deleted as set forth in Annex A.

(2) The Department shall submit this final-form regulation to the Office of Attorney General and the Office of General Counsel for approval as required by law.

(3) The Department shall submit this final-form regulation to IRRC, the Senate Health and Human Services Committee and the House Health Committee as required by law.

(4) The Department shall certify this final-form regulation, as approved for legality and form, and shall deposit it with the Legislative Reference Bureau as required by law.

(5) This final-form regulation shall take effect on July 1, 2023, except for §§ 211.12(f.1)(3) and (i)(2), which shall take effect on July 1, 2024.

LIST OF COMMENTATORS WHO REQUESTED MORE INFORMATION ON DEPARTMENT OF HEALTH LONG-TERM CARE NURSING FACILITY REGULATION #s 10-221, 10-222, 10-223, 10-224[1]

Commentator Name	Commentator Address
Carol Dieffenbach	220 Main Street, Unit 2 Towanda, PA 18848-1822
Patricia Savage	998 Logan Boulevard Altoona, PA 16602
Jeffrey Long	685 Angela Drive Greensburg, PA 15601
John Cusick	Northampton County Government Center 669 Washington St. Easton, PA 18042
Representative Dawn Keefer	Room 422, IOB P.O. Box 202092 Harrisburg, PA 17120-2092
Gail Weidman	gweidman@phca.org
Jennifer A. Ebersole	jaebersole@alz.org
Ilene Warner-Maron	aldengeriatrics@gmail.com
Karen C. Buck	KBuck@SeniorLAWCenter.org
Adam Marles	amarles@leadingagepa.org
Georgia Goodman	ggoodman@leadingagepa.org
Richard J. Mollot	richard@ltccc.org
Mary A. O'Connor	oconnor-ret@calu.edu
George Alspach	galspach232@aol.com
Valarie McGoogan	mcgoovl@gmail.com
YVONNE DEFINIS-CAMPB	ycampb@comcast.net
Mordy Lahasky	mordyeph@gmail.com
Harry Yoder	hyoder@faithfriendship.org
Lisa Gallagher	Lisa.Gallagher@saberhealth.com
Holly Martin	HMartin@transitionshealthcarellc.com
Elizabeth Garrett	Elizabeth.Garrett@lutheranseniorlife.org
Sheila Layo	Sheila.Layo@saberhealth.com
Julian R. Beglin	jbeglin@gmail.com
Missy Swanson	mswanson@lutheranhomekane.org
Allen Bonace	abonace@stmaryshome.org
Maria Santangelo	msantangelo@pinerun.org;

[1] Due to the overlap in comments between regulatory packages, the Department has compiled the list of commentators who requested more information on the four final-form long-term care nursing facility regulations into one list and provided a copy of all four packages to these commentators.

Charlotte Floravit	cfloravit@lutheranhomekane.org
Marjorie Ziegler	marjorie.ziegler@genesishcc.com
Suzanne Lachman	slachman@wesleyenhancedliving.org
Richard Lee	richard.lee@saberhealth.com
Ken Beiler	kbeiler@wesleyenhancedliving.org
Lisa Defibaugh	lddefibaugh@hmwd.org
Rosemarie Janosko	rjanosko@roadrunner.com
Donovan Carper	donovanc@moravianmanor.org
Lori Mateyak	lorim@moravianmanor.org
Jessica M. Hoffman	jhoffman@brevillier.org
Dennis Johnson	dendi3838@yahoo.com
Mary Staller	mary@lgarpacorp.com
Joel Clausen	jclausen@hvillage.org
Todd Wagner	twagner@chrmail.com
Rachelle Arnold	rarnold@concordialm.org
John Carpenter	jfcarpenter52@gmail.com
Jennifer Howell	jhowell@nottinghamvillage.org
Steven Isaac	SIsaac@independencehm.com
Karen M. Karle	KarenKarle@sarahareed.org
Hope Lambert	HLambert@psl.org
Kathleen Laplante	kathleen.laplante1@genesishcc.com
John Sauder	jsauder@mennonitehome.org
Sharon S. Laverdure	CKing@monroecountypa.gov
David A Manton	dmanton@simpsonsenior.org
Susan McCrary	smccrary@stinrc.org
Steven Cherry	scherry@wesleyenhancedliving.org; stcherry10@gmail.com
Dan Davis	DDavis@psl.org
Mark D. Bondi	bondimd@upmc.edu
Mark J. Bushnell	mbushnell@stannehome.org
Edward Keenan	859keenan@gmail.com
Joe McLaughlin	jcmee@yahoo.com
Dan Mortensen	dmortensen@mennonitehome.org
Raven Schaetzle	rschaetzle@stannehome.org
Kathryn Spare	kspare@whitehorsevillage.org; Kspare65@gmail.com
Susan Teconchuk, CEO	STeconchuk@rouse.org
Rev. Dr. Michael E. Harris	rev.doc.harris@comcast.net
Karyn L. Seace	klseace@nescioseace.com
David Hoffman	dhoffman@dhoffmanassoc.com

Colby Hunsberger	colbyhunsberger@gmail.com
Charlene Harrington	Charlene.Harrington@ucsf.edu
Stephen Crystal	scrystal@ifh.rutgers.edu
Representative Thomas Mehaffie III	tmehaffie@pahousegop.com
Representative K.C. Tomlinson	tnaples@pahousegop.com
Senator Camera Bartolotta	ekratz@pasen.gov
Berks County Board of Commissioners	SWeaver@countyofberks.com
Connie Birrane	cbirrane5@gmail.com
Joyce Young	jlyoung17543@gmail.com
Linda Burns	lindaheleneburns1949@gmail.com
Toni Trobe Kestenbaum and Herbert Kestenbaum	tonisoprano@verizon.net
Jacquelyn Wenrich	nannyjackie74@gmail.com
Freda Tepfer M Ed	fstepfer@yahoo.com
Sharon Adesman Furlong	sfurlong5@verizon.net
Kathy Natwick	kathynatwick@hotmail.com
Jane McGarvey	jane.mcgarvey@gmail.com
Cynthia Erisman-Ward	cindyerismanward@gmail.com
John Hart	hartpk5@earthlink.net
Deborah Pirie	deborah.pirie@gmail.com
Nelson Simonson	ncsimonson@gmail.com
Lorraine Turberville	hturber1@gmail.com
Kay France	amelo11@hotmail.com
Bruce and Brenda Metzler	pheasant305@gmail.com
Michelle Lenox	mlenox@gmail.com
Sheldon Schwartz	sh371@aol.com
Jay Beckerman	blakrasp40@mail.com
Michelle Cohen	michelleandmorg@yahoo.com
Jo-Anne Levy-Lamoreaux	jlevylamoreaux@gmail.com
W. Mark Sutherland	wmarksutherland@icloud.com
Jessica Terrill	jdterrill@gmail.com
Kathleen Henry	kathleen19464@icloud.com
Jessica Palmer	wonderwoman2709@gmail.com
Jennifer Miller	bgm71112@icloud.com
Kimberly Peters	rkpeters129@yahoo.com
Sasha Lewis	b3s11ck@gmail.com
Dashawna Holmes	dashawna.janell.holmes@gmail.com
Pamela Albus	Palbus@comcast.net
Deb Holdeman	holdeman@comcast.net
Elizabeth Duffy	duffy3625@aim.com

Sharon Gray	s.gray@sharongraylaw.com
Genale Rambler	genalemrambler@gmail.com
Cate Kager	kagerz@msn.com
teresa. A achey	teresaachey@yahoo.com
Stella Ida Britcher	stellaida@comcast.net
Bernice C.	bernice1970@gmail.com
Susanne Sproll	RNsue1202@gmail.com
Renee Newberry	starrynotions1@aol.com
Christa Dailey	Clinicaldirector.york@comforcare.com
Dana CLARK	dclark@luzerne.edu
Margaret Herbstritt	margaret.herbstritt@gmail.com
Corina Warfield	cwarfield07@gmail.com
Donna Adkins	Professionalclassybusgrl@yahoo.com
Lauren Ringgold	laurenxringgold@gmail.com
Anna Arvelo	annasrvelo90@gmail.com
Aaron Troisi	aaron.troisi@seiuhcpa.org
Erica Payne	EPAYNE105@GMAIL.COM
Terri Cherry	terricherry68@gmail.com
Patricia Khan	patkhan4@gmail.com
Denise O'Donnell	kdtak@comcast.net
Carol McShqne	cmcshane4kids@gmail.com
Ty Tracy	tt887114@ohio.edu
Helen Andreassen	helenandreass@gmail.com
Linda Leonard	Lindaboo3738@Icloud.com
Rachael Taylor	Rachael_Smith08@yahoo.com
Diane Monderewicz	dmonderewicz@gmail.com
Jane Ewuzie	jane.ewuzie@jefferson.edu
Carla Gregory-Beckton	gregorybeckton@aol.com
Melissa Mills	melissamills81@gmail.com
Jayne Rau	Gtr.dun@gmail.com
Lori Farrell	lornan1111@gmail.com
Joni Mitchell	jonimitchell.66@gmail.com
Donald williams	dwilliams07@gmail.com
Victoria Petrick	vec11@verizon.net
Lisa Aguiar	lisa.aguiar1@gmail.com
Anita Feliz	felizanita04@gmail.com
Christine Gittens	Christinebagi5@msn.com
Christina Caputo	christina.caputo@yahoo.com
Lorraine Leap	lorraineleap@yahoo.com
Charlotte Barnes	charlottebarnes33@yahoo.com

Bobbi Maffeo	bjmercury1@gmail.com
Dawn Bachman	dawnbachman@yahoo.com
Sherry Dneaster	sherryad914@hotmail.com
Kayla Rath	Kayrath097@gmail.com
Pixie Casale	Pixmixuneek@gmail.com
Caryn Leifer	carynleifer@gmail.com
Nichole Van Dyke	lpnnichole@yahoo.com
Christine Ranck	Cranck@csiu.org
Diana Moore	dianamoore785@gmail.com
Colleen Schmidt	colleenschmidt4@gmail.com
Karen Wolf	kawolf26@mac.com
Barbarai Mesaros	bmesaros6@gmail.com
Nassou Diarra	batoma50@gmail.com
Cheryl Shaffer-Lloyd	shafcas@verizon.net
Linda Wilbur	lawilbur102@hotmail.com
Sharon Miller	Sharonimiller123@gmail.com
Brittany Waterhouse	Brittanyh2ohouse@gmail.com
Susan Babjak	ajbmom071697@yahoo.com
Sharon Jeffers	sharonjeffers325@gmail.com
Peggy Buckley	buckleybowwow@aol.com
Kristin Edwards	pmcdade33@gmail.com
Scott Miller	scott.miller@promedica.org
Rita Maher	RMaher@panaceahc.com
Tricia Whaley	TWhaley@chrmail.com
Lisa Schaeffer	Wilma622@aol.com
Jamie Funk	jfunkrn@gmail.com
Roberta Wood	rwoodnp@gmail.com
Dr Kate Oneill	kaoneill1@yahoo.com
Tanya M Walsh	tmwalshy6@gmail.com
LuAnne Grala	luanne.grala@brightstarcare.com
kevin Hefty	kevin.hefty@seiuhcpa.org
Lyn Musser	blmsyc@gmail.com
Megan Opaliski	megan.opaliski@gmail.com
Christine Berg	Chris@thetrainingfund.org
Zach Shamberg	zshamberg@phca.org
Chris Fisher	cfisher@phca.org
Peter Tartline	ptartline@phca.org
Diane Menio	menio@carie.org
Kathy Cubit	cubit@carie.org
Pam Walz	pwalz@clsphila.org

Anne Henry	ahenry@leadingagepa.org
David Hoffman	dhoffman@dhoffmanassoc.com
Tom Shelley	padretom@nfdc.net
Terri Clark	tcterri@hotmail.com
Alissa Halperin	ahalperin@halperinbutera.com
Mike Grier	mike.grier@thepcil.org
Laval Miller-Wilson	lmillerwilson@phlp.org
Amy Lowenstein	alowenstein@phlp.org
Tracy Roman	troman@fellowshipcommunity.com
Nancy Bullivant	NANCYB@moravian.com
Mark E. Constantino	MConstantino@heritage1886.org
Robert Etchells	retchells@psl.org
Alishia Stevenson	astevenson@wesbury.com
Susan Teconchuk	steconchuk@rouse.org

Annex A

TITLE 28. HEALTH AND SAFETY

PART IV. HEALTH FACILITIES

Subpart C. LONG-TERM CARE FACILITIES

CHAPTER 201. APPLICABILITY, DEFINITIONS, OWNERSHIP AND GENERAL OPERATION OF LONG-TERM CARE NURSING FACILITIES.

OWNERSHIP AND MANAGEMENT

§ 201.18. Management.

(a) **[The facility shall have an effective governing body or designated person functioning with full legal authority and responsibility for the operation of the facility.]** **(Reserved).**

(b) **[The]** **In addition to the requirements under 42 CFR 483.70(d) (relating to administration), the** governing body **of a facility** shall adopt and enforce rules relative to:

(1) The health care and safety of the residents.

(2) Protection of personal and property rights of the residents, while in the facility, and upon discharge or after death, INCLUDING THE RETURN OF ANY PERSONAL PROPERTY REMAINING AT THE FACILITY WITHIN 30 DAYS AFTER DISCHARGE OR DEATH.

(3) The general operation of the facility.

(c) The governing body shall **[provide the information required in § 201.12 (relating to application for license) and prompt reports of changes which would affect the current accuracy of the information required]** **report to the Department within 30 days changes to the information that was submitted with the facility's application for licensure under § 201.12**(B)(1) — § 201.12(B)(6) **(relating to application for license of a new facility or change in ownership)**.

(d) **[The governing body shall adopt effective administrative and resident care policies and bylaws governing the operation of the facility in accordance with legal requirements.]** The administrative and resident care policies and bylaws~~, established and implemented by the governing body under 42 CFR 483.70(d)(1),~~ shall be in writing; shall be dated; **[shall be made available to the members of the governing body, which shall ensure that they are operational;]** and shall be reviewed and revised, in writing, as OFTEN AS necessary BUT AT LEAST ANNUALLY. The policies and bylaws shall be available upon request, to residents, **[responsible persons]** **resident representatives** and for review by members of the public.

(d.1) The administrator appointed by the governing body under 42 CFR 483.70(d)(2) shall be currently licensed and registered in this Commonwealth and shall be employed full-time in facilities that have more than 25 beds. Facilities with 25 beds or less may share an administrator provided that all of the following apply:

(1) The Department is informed of this arrangement.

(2) There is a plan in the event of an emergency when the administrator is not working.

(3) There is a readily available method for residents AND RESIDENT REPRESENTATIVES **to contact the administrator should they find it necessary.**

(4) The director of nursing services has, AT A MINIMUM, ~~**adequate**~~ **knowledge and experience** OF THE FACILITY, ITS POLICIES AND PROCEDURES AND RESIDENT NEEDS **to compensate for the time the administrator is not in the building.**

(5) The sharing of an administrator shall be limited to two facilities.

(d.2) The administrator's ANTICIPATED BIWEEKLY WORK **schedule shall be publicly posted in the facility.** THE ANTICIPATED WORK SCHEDULE SHALL BE UPDATED WITHIN 24 HOURS OF A CHANGE.

(c) **[The governing body shall appoint a full-time administrator who is currently licensed and registered in this Commonwealth and who is responsible for the overall management of the facility. The Department may, by exception, permit a long-term care facility of 25 beds or less to share the services of an administrator in keeping with section 3(b) of the Nursing Home Administrators License Act (63 P.S. § 1103(b)). The sharing of an administrator shall be limited to two facilities. The schedule of the currently licensed administrator shall be publicly posted in each facility.]** ~~The~~ IN ADDITION TO THE REQUIREMENTS UNDER 49 PA. CODE § 39.91 (RELATING TO THE STANDARDS OF PROFESSIONAL PRACTICE AND PROFESSIONAL CONDUCT FOR NURSING HOME ADMINISTRATORS), THE administrator's responsibilities shall include the following:

(1) Enforcing the regulations relative to the level of health care and safety of residents and to the protection of their personal and property rights.

(2) Planning, organizing and directing responsibilities obligated to the administrator by the governing body.

(2.1) Ensuring THAT A SANITARY, ORDERLY AND COMFORTABLE ENVIRONMENT IS PROVIDED FOR RESIDENTS THROUGH **satisfactory housekeeping in the facility and maintenance of the building and grounds.**

(3) Maintaining an ongoing relationship with the governing body, medical and nursing staff and other professional and supervisory staff through meetings and ~~periodic~~ reports, OCCURRING AS OFTEN AS NECESSARY, BUT AT LEAST ON A MONTHLY BASIS.

(4) Studying and acting upon recommendations made by committees.

(5) Appointing, in writing and in concurrence with the governing body, a responsible **[employe]** **employee** to act on the administrator's behalf during temporary absences.

(6) Assuring that appropriate and adequate relief personnel are utilized for those necessary positions vacated either on a temporary or permanent basis.

(7) Developing a written plan to assure the continuity of resident care and services in the event of a strike in a unionized facility.

(f) A written record shall be maintained on a current basis for each resident with written receipts for personal possessions **[and funds]** received or deposited with the facility **[and for expenditures and disbursements made on behalf of the resident]**. The record shall be available for review by the resident or **[resident's responsible person]** **resident representative** upon request.

(g) The governing body shall disclose, upon request, to be made available to the public, the licensee's current daily reimbursement under Medical Assistance and Medicare as well as the average daily charge to other insured and noninsured private pay residents.

(h) When the facility accepts the responsibility for the resident's financial affairs, the resident or **[resident's responsible person]** **resident representative** shall designate, in writing, the transfer of the responsibility. **[The facility shall provide the residents with access to their money within 3 bank business days of the request and in the form—cash or check—requested by the resident.]** **The facility shall provide cash, if requested, within 1 day of the request or a check, if requested, within 3 days of the request.** IF A FACILITY UTILIZES ELECTRONIC TRANSFERS, THE FACILITY SHALL INITIATE AN ELECTRONIC TRANSFER OF FUNDS, IF REQUESTED, WITHIN ONE DAY OF THE REQUEST.

§ 201.19. Personnel [policies and procedures] records.

Personnel records shall be kept current and available for each **[employe]** **facility employee** and contain **[sufficient]** **all of the following** information **[to support placement in the position to which assigned.]**:

(1) The employee's job description, educational background and employment history.

(2) Employee performance evaluations, INCLUDING DOCUMENTATION OF ANY MONITORING, PERFORMANCE, OR DISCIPLINARY ACTION RELATED TO THE EMPLOYEE.

(3) Documentation of CREDENTIALS, WHICH SHALL INCLUDE, AT A MINIMUM, **current certification, registration or licensure, if applicable, for the position to which the employee is assigned.**

(4) A determination by a health care practitioner that the employee, as of the employee's start date, is free from the communicable diseases or conditions listed in § 27.155 (relating to restrictions on health care practitioners).

(5) ~~Records of the pre-employment health examinations and of subsequent health services rendered to the facility's employees as are necessary to ensure that all employees are physically able to perform their duties~~ RECORDS RELATING TO A MEDICAL EXAM, IF REQUIRED BY A FACILITY, OR ATTESTATION THAT THE EMPLOYEE IS ABLE TO PERFORM THE EMPLOYEE'S JOB DUTIES.

(6) Documentation of the employee's orientation to the facility and the employee's assigned position prior to or within 1 week of the employee's start date.

(7) Documentation of the employee's completion of required trainings UNDER THIS CHAPTER, INCLUDING DOCUMENTATION OF ORIENTATION AND OTHER TRAININGS.

(8) ~~A criminal history record~~ A COPY OF THE FINAL REPORT RECEIVED FROM THE PENNSYLVANIA STATE POLICE AND THE FEDERAL BUREAU OF INVESTIGATION, AS APPLICABLE, IN ACCORDANCE WITH THE OLDER ADULTS PROTECTIVE SERVICES ACT (35 P. S. §§ 10225.101–10225.5102), THE ADULT PROTECTIVE SERVICES ACT (35 P.S. §§ 10210.101–10210.704), AND APPLICABLE REGULATIONS.

(9) In the event of a conviction prior to or following employment, DOCUMENTATION THAT THE FACILITY DETERMINED **~~a determination by the facility of~~ the employee's suitability for initial or continued employment in the position to which the employee is assigned.** "SUITABILITY FOR EMPLOYMENT" SHALL INCLUDE A REVIEW OF THE OFFENSE; THE LENGTH OF TIME SINCE THE INDIVIDUAL'S CONVICTION; THE LENGTH OF TIME SINCE INCARCERATION, IF ANY; EVIDENCE OF REHABILITATION; WORK HISTORY; AND THE EMPLOYEE'S JOB DUTIES.

(10) THE EMPLOYEE'S COMPLETED EMPLOYMENT APPLICATION.

§ 201.20. Staff development.

(a) There shall be an ongoing coordinated educational program which is planned and conducted for the development and improvement of skills of the facility's personnel, including **[training related to problems, needs and rights of the residents], at a minimum, annual in-service training on the topics outlined in 42 CFR 483.95 (relating to training requirements) in addition to the following topics:**

(1) Accident prevention.

(2) Restorative nursing techniques.

(3) Emergency preparedness in accordance with 42 CFR 483.73(d) (relating to emergency preparedness).

(4) Fire prevention and safety in accordance with 42 CFR 483.90 (relating to physical environment).

(5) RESIDENT RIGHTS, INCLUDING NONDISCRIMINATION AND CULTURAL COMPETENCY.

(6) TRAINING NEEDS IDENTIFIED THROUGH A FACILITY ASSESSMENT.

(b) An **[employe]** **employee** shall receive appropriate orientation to the facility, its policies and to the position and duties. **[The orientation shall include training on the prevention of resident abuse and the reporting of the abuse.]** THE ORIENTATION SHALL INCLUDE TRAINING ON THE PREVENTION, DETECTION AND REPORTING OF RESIDENT ABUSE AND DEMENTIA MANAGEMENT AND COMMUNICATION SKILLS.

(c) **[There shall be at least annual in service training which includes at least infection prevention and control, fire prevention and safety, accident prevention, disaster preparedness, resident confidential information, resident psychosocial needs, restorative nursing techniques and resident rights, including personal property rights, privacy, preservation of dignity and the prevention and reporting of resident abuse.]** **(Reserved).**

(d) Written records shall be maintained which indicate the content of and attendance at **[the]** staff development programs.

§ 201.21. Use of outside resources.

(a) **[The facility is responsible for insuring that personnel and services provided by outside resources meet all necessary licensure and certification requirements, including those of the Bureau of Professional and Occupational Affairs in the Department of State, as well as requirements of this subpart.]** **(Reserved).**

(b) **[If the facility does not employ a qualified professional person to render a specific service to be provided by the facility, it shall make arrangements to have the service provided by an outside resource, a person or agency that will render direct service to residents or act as a consultant to the facility.]** **(Reserved).**

(c) **[The responsibilities, functions and objectives and the terms of agreement, including financial arrangements and charges of the outside resource shall be delineated in writing and signed and dated by an authorized representative of the facility and the person or agency providing the service.]** ~~**(Reserved).**~~ IN ADDITION TO THE REQUIREMENTS UNDER 42 CFR 483.70(g) (RELATING TO ADMINISTRATION), THE RESPONSIBILITIES, FUNCTIONS, OBJECTIVES AND TERMS OF AGREEMENTS RELATED TO OUTSIDE RESOURCES SHALL BE DELINEATED IN WRITING AND SIGNED AND DATED BY THE PARTIES.

(d) **[Outside resources supplying temporary employes to a facility shall provide the facility with documentation of an employe's health status as required under § 201.22 (c)—(j) and (l)—(m) (relating to prevention, control and surveillance of tuberculosis (TB)).]** **(Reserved).**

(e) If a facility acquires employees from outside resources, the facility shall obtain confirmation from the outside resource that the employees are free from the communicable diseases and conditions listed in § 27.155 (relating to restrictions on health care practitioners) and are ~~physically~~ able to perform their assigned JOB **duties.**

* * *

§ 201.24. Admission policy.

(a) **[The resident may be permitted to name a responsible person.] The resident is not required to name a ~~responsible person~~** RESIDENT REPRESENTATIVE **if the resident is capable of managing the resident's own affairs.]** ~~**(Reserved).**~~

(b) **[A facility may not obtain from or on behalf of residents a release from liabilities or duties imposed by law or this subpart except as part of formal settlement in litigation.]** ~~**(Reserved).**~~

(c) A facility shall admit only residents whose nursing care and physical needs can be provided by the staff and facility.

(d) A resident with a disease in the communicable stage may not be admitted to the facility unless it is deemed advisable by the attending physician—medical director, if applicable—and administrator and unless the facility has the capability to care for the needs of the resident.

(e) The governing body of a facility shall establish written policies for the admissions process for residents, and through the administrator, shall be responsible for the development of and adherence to procedures implementing the policies. The policies and procedures shall include all of the following:

(1) Introduction of residents to at least one member of the professional nursing staff for the unit where the resident will be living and to direct care staff who have been assigned to care for the resident. Prior to introductions, the professional nursing and direct care staff shall review the orders of the physician or other health care practitioner for the resident's immediate care.

(2) Orientation of the resident to the facility and location of essential services and key personnel, including the dining room, nurses' workstations and offices for the facility's social worker and grievance or complaint officer.

(3) A description of facility routines, including nursing shifts, mealtimes and posting of menus.

(4) Discussion and documentation of the resident's customary routines and preferences, to be included in the care plan developed for the resident under 42 CFR 483.21 (relating to comprehensive person-centered care planning).

(5) Assistance to the resident~~, if needed,~~ in creating a homelike environment and settling AND SECURING **personal possessions in the room to which the resident has been assigned.**

(f) The coordination of introductions, orientation and discussions, under subsection (e), shall be the responsibility of the facility's social worker, or a delegee designated by the governing body~~, and~~. THE ACTIVITIES INCLUDED UNDER SUBSECTION (E) (1) — (2) **shall occur within 2 hours of a resident's admission.** THE ACTIVITIES INCLUDED UNDER SUBSECTION (E) (3) — (4) SHALL OCCUR WITHIN 24 HOURS OF A RESIDENT'S ADMISSION. THE ACTIVITIES INCLUDED UNDER SUBSECTION (E)(5) SHALL OCCUR WITHIN 72 HOURS OF A RESIDENT'S ADMISSION.

§ 201.25. [Discharge policy] (Reserved).

[There shall be a centralized coordinated discharge plan for each resident to ensure that the resident has a program of continuing care after discharge from the facility. The discharge plan shall be in accordance with each resident's needs.]

§ 201.26. **[Power of attorney] Resident representative.**

[Power of attorney may not be assumed for a resident by the] **A resident representative may not be a** licensee, **[owner/operator]** **owner, operator,** members of the governing body, an **[employe]** **employee** or anyone **[having]** **with** a financial interest in the facility unless ordered by a court of competent jurisdiction**, except that:**

(1) ~~a~~ A **resident's family member who is employed in the facility may serve as a resident representative so long as there is no conflict of interest**.

(2) A FACILITY MAY BE DESIGNATED AS A REPRESENTATIVE PAYEE IN ACCORDANCE WITH TITLE II OR XVI OF THE SOCIAL SECURITY ACT (42 U.S.C.A. §§ 401 - 434 ; 1381 -1385) AND APPLICABLE REGULATIONS.

* * *

§ 201.29. Resident rights.

(a) The governing body of the facility shall establish written policies regarding the rights and responsibilities of residents AS PROVIDED FOR IN 42 CFR 483.10 AND THIS SECTION. ~~and, through~~ THROUGH the administrator, THE GOVERNING BODY shall be responsible for development of and adherence to procedures implementing the policies. **The written policies shall include a mechanism for the inclusion of residents**, OR A RESIDENT REPRESENTATIVE, **in the development, implementation and review of the policies and procedures regarding the rights and responsibilities of residents.**

(b) Policies and procedures regarding rights and responsibilities of residents shall be available to residents and members of the public.

(c) Policies of the facility shall be available to staff, residents, consumer groups and the interested public, including a written outline of the facility's objectives and a statement of the rights of its residents. The policies shall set forth the rights of the resident and prohibit mistreatment and abuse of the resident.

(C.1) THE FACILITY SHALL POST IN A CONSPICUOUS PLACE NEAR THE ENTRANCES AND ON EACH FLOOR OF THE FACILITY A NOTICE WHICH SETS FORTH THE LIST OF RESIDENT RIGHTS. THE POSTING OF RESIDENT RIGHTS SHALL INCLUDE THE RIGHTS UNDER SUBSECTION (C.3) AND 42 CFR 483.10 (RELATING TO RESIDENT RIGHTS).

(C.2) A FACILITY SHALL PROVIDE PERSONAL NOTICE OF A RESIDENT'S RIGHTS IN ACCORDANCE WITH 42 CFR 483.10(g)(16). A CERTIFICATE OF THE PROVISION OF PERSONAL NOTICE SHALL BE ENTERED IN THE RESIDENT'S MEDICAL RECORD.

(C.3) IN ADDITION TO THE RESIDENT RIGHTS SET FORTH IN 42 CFR 483.10, RESIDENTS HAVE A RIGHT TO THE FOLLOWING:

(1) IF CHANGES IN CHARGES OCCUR DURING THE RESIDENT'S STAY, THE RESIDENT, OR RESIDENT REPRESENTATIVE, SHALL BE ADVISED VERBALLY AND IN WRITING REASONABLY IN ADVANCE OF THE CHANGE. "REASONABLY IN ADVANCE" SHALL BE INTERPRETED TO BE 30 DAYS PRIOR TO THE CHANGE UNLESS CIRCUMSTANCES DICTATE OTHERWISE. IF A FACILITY REQUIRES A

SECURITY DEPOSIT, THE WRITTEN PROCEDURE OR CONTRACT THAT IS GIVEN TO THE RESIDENT, OR RESIDENT REPRESENTATIVE, SHALL INDICATE HOW THE DEPOSIT WILL BE USED AND THE TERMS FOR THE RETURN OF THE DEPOSIT. A SECURITY DEPOSIT IS NOT PERMITTED FOR A RESIDENT RECEIVING MEDICAL ASSISTANCE.

(2) PRIOR TO TRANSFER, THE FACILITY SHALL INFORM THE RESIDENT, OR THE RESIDENT REPRESENTATIVE, AS TO WHETHER THE FACILITY WHERE THE RESIDENT IS BEING TRANSFERRED IS CERTIFIED TO PARTICIPATE IN THE MEDICARE AND THE MEDICAL ASSISTANCE PROGRAMS.

(3) EXPERIMENTAL RESEARCH OR TREATMENT IN A FACILITY MAY NOT BE CARRIED OUT WITHOUT THE APPROVAL OF THE DEPARTMENT, INCLUDING THE DEPARTMENT'S INSTITUTIONAL REVIEW BOARD, AND WITHOUT THE WRITTEN APPROVAL AND INFORMED CONSENT OF THE RESIDENT, OR RESIDENT REPRESENTATIVE, OBTAINED PRIOR TO PARTICIPATION AND INITIATION OF THE EXPERIMENTAL RESEARCH OR TREATMENT. THE FOLLOWING APPLY:

(i) THE RESIDENT, OR RESIDENT REPRESENTATIVE, SHALL BE FULLY INFORMED OF THE NATURE OF THE EXPERIMENTAL RESEARCH OR TREATMENT AND THE POSSIBLE CONSEQUENCES, IF ANY, OF PARTICIPATION.

(ii) THE RESIDENT, OR RESIDENT REPRESENTATIVE, SHALL BE GIVEN THE OPPORTUNITY TO REFUSE TO PARTICIPATE BOTH BEFORE AND DURING THE EXPERIMENTAL RESEARCH OR TREATMENT.

(iii) FOR THE PURPOSES OF THIS SUBSECTION, "EXPERIMENTAL RESEARCH" MEANS THE DEVELOPMENT, TESTING AND USE OF A CLINICAL TREATMENT, SUCH AS AN INVESTIGATIONAL DRUG OR THERAPY THAT HAS NOT YET BEEN APPROVED BY THE UNITED STATES FOOD AND DRUG ADMINISTRATION OR MEDICAL COMMUNITY AS EFFECTIVE AND CONFORMING TO MEDICAL PRACTICE.

(4) A RESIDENT HAS THE RIGHT TO CARE WITHOUT DISCRIMINATION BASED UPON RACE, COLOR, FAMILIAL STATUS, RELIGIOUS CREED, ANCESTRY, AGE, SEX, GENDER, SEXUAL ORIENTATION, GENDER IDENTITY OR EXPRESSION, NATIONAL ORIGIN, ABILITY TO PAY, HANDICAP OR DISABILITY, USE OF GUIDE OR SUPPORT ANIMALS BECAUSE OF THE BLINDNESS, DEAFNESS OR PHYSICAL HANDICAP OF THE RESIDENT OR BECAUSE THE RESIDENT IS A HANDLER OR TRAINER OF SUPPORT OR GUIDE ANIMALS.

(d) **[The staff of the facility shall be trained and involved in the implementation of the policies and procedures.]** **(Reserved).**

(e) **[The resident or if the resident is not competent, the resident's responsible person, shall be informed verbally and in writing prior to, or at the time of admission, of services available in the facility and of charges covered and not covered by the per diem rate of the facility. If changes in the charges occur during the resident's stay, the resident shall be advised verbally and in writing reasonably in advance of the change. "Reasonably in**

advance" shall be interpreted to be 30 days unless circumstances dictate otherwise. If a facility requires a security deposit, the written procedure or contract that is given to the resident or resident's responsible person shall indicate how the deposit will be used and the terms for the return of the money. A security deposit is not permitted for a resident receiving Medical Assistance (MA).] **(Reserved).**

(f) **[The resident shall be transferred or discharged only for medical reasons, for his welfare or that of other residents or for nonpayment of stay if the facility has demonstrated reasonable effort to collect the debt. Except in an emergency, a resident may not be transferred or discharged from the facility without prior notification. The resident and the resident's responsible person shall receive written notification in reasonable advance of the impending transfer or discharge. Reasonable advance notice shall be interpreted to mean 30 days unless appropriate plans which are acceptable to the resident can be implemented sooner. The facility shall inform the resident of its bed-hold policy, if applicable, prior to discharge. The actions shall be documented on the resident record. Suitable clinical records describing the resident's needs, including list of orders and medications as directed by the attending physician shall accompany the resident if the resident is sent to another medical facility.]** **(Reserved).**

(g) **[Unless the discharge is initiated by the resident or resident's responsible person, the facility is responsible to assure that appropriate arrangements are made for a safe and orderly transfer and that the resident is transferred to an appropriate place that is capable of meeting the resident's needs.]** ~~Prior to transfer, the facility shall inform the resident or the~~ **[resident's responsible person]** ~~**resident representative** as to whether the facility where the resident is being transferred is certified to participate in the Medicare and **[MA] Medical Assistance** reimbursement programs.~~ (RESERVED).

(h) **[It is not necessary to transfer a resident whose condition had changed within or between health care facilities when, in the opinion of the attending physician, the transfer may be harmful to the physical or mental health of the resident. The physician shall document the situation accordingly on the resident's record.]** **(Reserved).**

(i) **[The resident shall be encouraged and assisted throughout the period of stay to exercise rights as a resident and as a citizen and may voice grievances and recommend changes in policies and services to the facility staff or to outside representatives of the resident's choice. The resident or resident's responsible person shall be made aware of the Department's Hot Line (800) 254-5164, the telephone number of the Long-Term Care Ombudsman Program located within the Local Area Agency on Aging, and the telephone number of the local Legal Services Program to which the resident may address grievances. A facility is required to post this information in a prominent location and in a large print easy to read format.]** **(Reserved).**

(j) **[The resident shall be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and in care for the necessary personal and social needs.]** **(Reserved).**

(k) **[The resident shall be permitted to retain and use personal clothing and possessions as space permits unless to do so would infringe upon rights of other residents and unless medically contraindicated, as documented by his physician in the medical record. Reasonable provisions shall be made for the proper handling of personal clothing and possessions that are retained in the facility. The resident shall have access and use of these belongings.]** **(Reserved).**

(l) **[The resident's rights devolve to the resident's responsible person as follows:**

(1) When the resident is adjudicated incapacitated by a court.

(2) As Pennsylvania law otherwise authorizes.] **(Reserved).**

(m) **[The resident rights in this section shall be reflected in the policies and procedures of the facility.]** **(Reserved).**

(n) ~~The facility shall post in a conspicuous place near the entrances and on each floor of the facility a notice which sets forth the list of resident's rights.~~ **[The facility shall on admission provide a resident or resident's responsible person with a personal copy of the notice. In the case of a resident who cannot read, write or understand English, arrangements shall be made to ensure that this policy is fully communicated to the resident.]** ~~A certificate of the provision of personal notice as required in this section shall be entered in the resident's~~ **[clinical]** ~~medical record.~~ (RESERVED).

(o) ~~Experimental research or treatment in a~~ **[nursing home]** ~~facility may not be carried out without the approval of the Department and without the written approval~~ **and informed** ~~consent of the resident~~ **[after full disclosure.]** ~~, or resident representative, obtained prior to participation and initiation of the experimental research or treatment. The resident, or resident representative, shall be fully informed of the nature of the experimental research or treatment and the possible consequences of participating. The resident, or resident representative, shall be given the opportunity to refuse to participate both before and during the experimental research or treatment. For the purposes of this subsection, "experimental research"~~ **[means an experimental treatment or procedure that is one of the following:**

(1) Not a generally accepted practice in the medical community.

(2) Exposes the resident to pain, injury, invasion of privacy or asks the resident to surrender autonomy, such as a drug study.] ~~refers to the development, testing and use of a clinical treatment, such as an investigational drug or therapy that has not yet been approved by the United States Food and Drug Administration or medical community as effective and conforming to medical practice.~~ (RESERVED).

~~(p) A resident has the right to care without discrimination based upon race, color, familial status, religious creed, ancestry, age, sex, gender, sexual orientation, gender identity or expression, national origin, ability to pay, handicap or disability, use of guide or support animals because of the blindness, deafness or physical handicap of the resident or because the resident is a handler or trainer of support or guide animals.~~ (RESERVED).

§ 201.30. [Access requirements] (Reserved).

[(a) The facility may limit access to a resident when the interdisciplinary care team has determined it may be a detriment to the care and well-being of the resident in the facility. The facility may not restrict the right of the resident to have legal representation or to visit with the representatives of the Department of Aging Ombudsman Program. A facility may not question an attorney representing the resident or representatives of the Department, or the Department of Aging Ombudsman Program, as to the reason for visiting or otherwise communicating with the resident.

(b) A person entering a facility who has not been invited by a resident or a resident's responsible persons shall promptly advise the administrator or other available agent of the facility of that person's presence. The person may not enter the living area of a resident without identifying himself to the resident and without receiving the resident's permission to enter.]

§ 201.31. ┤Transfer agreement├ (Reserved).

┤(a) The facility shall have in effect a transfer agreement with one or more hospitals, located reasonably close by, which provides the basis for effective working arrangements between the two health care facilities. Under the agreement, inpatient hospital care or other hospital services shall be promptly available to the facility's residents when needed.

(b) A transfer agreement between a hospital and a facility shall be in writing and specifically provide for the exchange of medical and other information necessary to the appropriate care and treatment of the residents to be transferred. The agreement shall further provide for the transfer of residents' personal effects, particularly money and valuables, as well as the transfer of information related to these items when necessary.┤

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CHAPTER 207. HOUSEKEEPING AND MAINTENANCE STANDARDS FOR LONG-TERM CARE NURSING FACILITIES

HOUSEKEEPING AND MAINTENANCE

* * *

§ 207.2. [Administrator's responsibility] (Reserved).

[(a) The administrator shall be responsible for satisfactory housekeeping and maintenance of the buildings and grounds.

(b) Nursing personnel may not be assigned housekeeping duties that are normally assigned to housekeeping personnel.]

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CHAPTER 209. FIRE PROTECTION AND SAFETY PROGRAMS FOR LONG-TERM CARE NURSING FACILITIES

FIRE PROTECTION AND SAFETY

* * *

§ 209.3. [Smoking] ~~(Reserved).~~

[(a) Policies regarding smoking shall be adopted. The policies shall include provisions for the protection of the rights of ~~the~~ SMOKING AND **nonsmoking residents. The smoking policies shall be posted in a conspicuous place and in a legible format so that they may be easily read by residents, visitors and staff.**

(b) [Proper safeguards shall be taken against the fire hazards involved in smoking.] (RESERVED).

(c) Adequate supervision while smoking shall be provided for those residents who require it.

(d) Smoking by residents in bed is prohibited unless the resident is under direct observation.

(e) [Smoking is prohibited in a room, ward or compartment where flammable liquids, combustible gases or oxygen is used or stored, and in other hazardous locations. The areas shall be posted with "NO SMOKING" signs.] (RESERVED).

(f) [Ash trays of noncombustible material and safe design shall be provided in areas where smoking is permitted.] (RESERVED).

(g) Noncombustible containers with self-closing covers shall be provided in areas where smoking is permitted.] (RESERVED).

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CHAPTER 211. PROGRAM STANDARDS FOR LONG-TERM CARE NURSING FACILITIES

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§ 211.2. [Physician services] Medical director.

(a) [The attending physician shall be responsible for the medical evaluation of the resident and shall prescribe a planned regimen of total resident care.] (Reserved).

(b) **[The facility shall have available, prior to or at the time of admission, resident information which includes current medical findings, diagnoses and orders from a physician for immediate care of the resident. The resident's initial medical assessment shall be conducted no later than 14 days after admission and include a summary of the prior treatment as well as the resident's rehabilitation potential.]** **(Reserved).**

(c) **[A facility shall have a medical director who is]** **In addition to the requirements of 42 CFR 483.70(h) (relating to administration), the medical director of a facility shall be** licensed as a physician in this Commonwealth **[and who is responsible for the overall coordination of the medical care in the facility to ensure the adequacy and appropriateness of the medical services provided to the residents]** **and shall complete at least four hours annually of continuing medical education (CME) pertinent to the field of medical direction or post-acute and long-term care medicine**. The medical director may **[serve on a full- or part-time basis depending on the needs of the residents and the facility and may]** be designated for single or multiple facilities. There shall be a written agreement between the physician and the facility.

(d) **[The medical director's responsibilities shall include at least the following:**

(1) [Review of incidents and accidents that occur on the premises and addressing the health and safety hazards of the facility. The administrator shall be given appropriate information from the medical director to help insure a safe and sanitary environment for residents and personnel.] (RESERVED).

(2) [Development of written policies which are approved by the governing body that delineate the responsibilities of attending physicians.] **(Reserved).**

(3) ENSURING THE APPROPRIATENESS AND QUALITY OF MEDICAL CARE AND MEDICALLY RELATED CARE.

(4) ASSISTING IN THE DEVELOPMENT OF EDUCATIONAL PROGRAMS FOR FACILITY STAFF AND OTHER PROFESSIONALS.

(5) WORKING WITH THE FACILITY'S CLINICAL TEAM TO PROVIDE SURVEILLANCE AND DEVELOP POLICIES TO PREVENT THE POTENTIAL INFECTION OF RESIDENTS IN ACCORDANCE WITH THE INFECTION CONTROL REQUIREMENT UNDER 42 CFR 483.80 (RELATING TO INFECTION CONTROL).

(6) COOPERATING WITH FACILITY STAFF TO ESTABLISH POLICIES FOR ASSURING THAT THE RIGHTS OF INDIVIDUALS ARE RESPECTED.

(7) SUPPORTING AND PROMOTING PERSON-DIRECTED CARE SUCH AS THE FORMATION OF ADVANCE DIRECTIVES, END-OF-LIFE CARE, AND PROVISIONS THAT ENHANCE RESIDENT DECISION MAKING, INCLUDING CHOICE REGARDING MEDICAL CARE OPTIONS.

(8) IDENTIFYING PERFORMANCE EXPECTATIONS AND FACILITATING FEEDBACK TO PHYSICIANS AND OTHER HEALTH CARE PRACTITIONERS REGARDING THEIR PERFORMANCE AND PRACTICES.

(9) DISCUSSING AND INTERVENING, AS APPROPRIATE, WITH A HEALTH CARE PRACTITIONER REGARDING MEDICAL CARE THAT IS INCONSISTENT WITH CURRENT STANDARDS OF CARE.

(10) ASSISTING IN DEVELOPING SYSTEMS TO MONITOR THE PERFORMANCE OF HEALTH CARE PRACTITIONERS, INCLUDING MECHANISMS FOR COMMUNICATING AND RESOLVING ISSUES RELATED TO MEDICAL CARE AND ENSURING THAT OTHER LICENSED PRACTITIONERS WHO MAY PERFORM PHYSICIAN-DELEGATED TASKS ACT WITHIN THEIR SCOPE OF PRACTICE.

§ 211.3. **[Oral]** **Verbal** and telephone orders.

(a) **[A physician's oral]** **Verbal** and telephone orders shall be given to a registered nurse, physician or other individual authorized by appropriate statutes and the State Boards in the Bureau of Professional and Occupational Affairs and shall immediately be recorded on the resident's clinical record by the person receiving the order. The entry shall be signed and dated by the person receiving the order. **[Written orders may be by fax.]**

(b) **[A physician's oral]** **Verbal** and telephone orders for care **[and treatments]**~~, treatment or medication~~, AND TREATMENT shall be dated and countersigned with the original signature of the physician**, or physician's delegee authorized under 42 CFR 483.30(e) (relating to physician services),** within **[7 days]** **48** 72 **hours** of receipt of the order. **[If the physician is not the attending physician, he shall be authorized and the facility so informed by the attending physician and shall be knowledgeable about the resident's condition.]**

(c) **[A physician's telephone and oral orders for medications shall be dated and countersigned by the prescribing practitioner within 48 hours. Oral orders for Schedule II drugs are permitted only in a bona fide emergency.]** ~~(Reserved).~~ VERBAL AND TELEPHONE ORDERS FOR MEDICATIONS SHALL BE DATED AND COUNTERSIGNED BY THE PRESCRIBING PHYSICIAN, OR PHYSICIAN'S DELEGEE AUTHORIZED UNDER 42 CFR 483.80(e), WITHIN 48 HOURS.

(d) **[Oral]** **Verbal** orders for **[medication or treatment]** **care, treatment or medication** shall be accepted only under circumstances where it is impractical for the orders to be given in a written manner by the **[responsible practitioner]** **physician, or physician's delegee authorized under 42 CFR 483.30(e)**. An initial written order as well as a countersignature may be **[received]** **sent** by a fax **or secure electronic transmission** which includes the practitioner's signature.

(e) The facility shall establish policies identifying the types of situations for which **[oral]** **verbal** orders may be accepted and the appropriate protocols for the taking and transcribing of **[oral]** **verbal** orders in these situations, which shall include:

(1) Identification of all treatments or medications which may not be prescribed or dispensed by way of **[an oral]** **a verbal** order, but which instead require written orders.

(2) A requirement that all **[oral]** **verbal** orders be stated clearly, repeated by the issuing **[practitioner]** **physician, or physician's delegee authorized under 42 CFR 483.30(e)**, and be read back in their entirety by personnel authorized to take the **[oral]** **verbal** order.

(3) Identification of all personnel authorized to take and transcribe **[oral]** **verbal** orders.

(4) The policy on fax **or secure electronic** transmissions.

§ 211.4. Procedure in event of death.

(a) Written postmortem procedures shall be available **[at each nursing station]** **to all personnel**.

(b) Documentation shall be on the resident's clinical record that the next of kin, guardian or **[responsible party]** **resident representative** has been notified of the resident's death. The name of the notified party shall be written on the resident's clinical record.

§ 211.5. [Clinical] Medical records.

(a) **[Clinical records shall be available to, but not be limited to, representatives of the Department of Aging Ombudsman Program.]** **(Reserved).**

(b) **[Information contained in the resident's record shall be privileged and confidential. Written consent of the resident, or of a designated responsible agent acting on the resident's behalf, is required for release of information. Written consent is not necessary for authorized representatives of the State and Federal government during the conduct of their official duties.]** ~~**(Reserved).**~~ INFORMATION CONTAINED IN A RESIDENT'S RECORD SHALL BE PRIVILEGED AND CONFIDENTIAL. WRITTEN CONSENT OF THE RESIDENT OR THE RESIDENT REPRESENTATIVE IS REQUIRED FOR RELEASE OF INFORMATION, EXCEPT AS FOLLOWS:

(1) WRITTEN CONSENT IS NOT NECESSARY FOR AUTHORIZED REPRESENTATIVES OF THE STATE AND FEDERAL GOVERNMENT DURING THE CONDUCT OF THEIR OFFICIAL DUTIES.

(2) WRITTEN CONSENT IS NOT NECESSARY FOR THE RELEASE OF MEDICAL RECORDS FOR TREATMENT PURPOSES IN ACCORDANCE WITH FEDERAL AND STATE LAW.

(c) **[Records shall be retained for a minimum of 7 years following a resident's discharge or death.]** **(Reserved).**

(d) Records of discharged residents shall be completed within 30 days of discharge. **[Clinical]** **Medical** information pertaining to a resident's stay shall be centralized in the resident's record.

(e) When a facility closes, resident **[clinical]** **medical** records may be transferred with the resident if the resident is transferred to another health care facility. Otherwise, the owners of the facility shall make provisions for the safekeeping and confidentiality of **resident** medical records and shall **[notify the Department of how the records may be obtained]** **provide to the**

Department, within 30 days of providing notice of closure under § 201.23 (relating to closure of facility), a plan for the storage and retrieval of medical records.

(f) **[At a minimum, the] In addition to the items required under 42 CFR 483.70(i)(5) (relating to administration), a** resident's **[clinical] medical** record shall include **[physicians' orders, observation and progress notes, nurses' notes, medical and nursing history and physical examination reports; identification information, admission data, documented evidence of assessment of a resident's needs, establishment of an appropriate treatment plan and plans of care and services provided; hospital diagnoses authentication—discharge summary, report from attending physician or transfer form—diagnostic and therapeutic orders, reports of treatments, clinical findings, medication records and discharge summary including final diagnosis and prognosis or cause of death. The information contained in the record shall be sufficient to justify the diagnosis and treatment, identify the resident and show accurately documented information.] at a minimum:**

(i) Physicians' orders.

(ii) Observation and progress notes.

(iii) Nurses' notes.

(iv) Medical and nursing history and physical examination reports.

(v) Admission data.

(vi) Hospital diagnoses authentication.

(vii) Report from attending physician or transfer form.

(vii) Diagnostic and therapeutic orders.

(viii) Reports of treatments.

(ix) Clinical findings.

(x) Medication records.

(xi) Discharge summary, including final diagnosis and prognosis or cause of death.

(g) **[Symptoms and other indications of illness or injury, including the date, time and action taken shall be recorded.] (Reserved).**

(h) **[Each professional discipline shall enter the appropriate historical and progress notes in a timely fashion in accordance with the individual needs of a resident.] (Reserved).**

(i) The facility shall assign overall supervisory responsibility for the **[clinical] medical** record service to a medical records practitioner. Consultative services may be utilized**[,]**; however, the facility shall employ sufficient personnel competent to carry out the functions of the medical record service.

§ 211.6. Dietary services.

(a) Menus shall be planned **and posted in the facility or distributed to residents** at least 2 weeks in advance. Records of menus of foods actually served shall be retained for 30 days. When changes in the menu are necessary, substitutions shall provide equal nutritive value.

(b) **[Sufficient food to meet the nutritional needs of residents shall be prepared as planned for each meal. There shall be at least 3 days' supply of food available in storage in the facility at all times.]** **(Reserved).**

(c) **[Overall supervisory responsibility for the dietary services shall be assigned to a full-time qualified dietary services supervisor.]** **(Reserved).**

(d) **[If consultant dietary services are used, the consultant's visits shall be at appropriate times and of sufficient duration and frequency to provide continuing liaison with medical and nursing staff, advice to the administrator, resident counseling, guidance to the supervisor and staff of the dietary services, approval of menus, and participation in development or revision of dietary policies and procedures and in planning and conducting inservice education and programs.]** **(Reserved).**

(c) **[A current therapeutic diet manual approved jointly by the dietitian and medical director shall be readily available to attending physicians and nursing and dietetic service personnel.]** **(Reserved).**

(f) Dietary personnel shall practice hygienic food handling techniques. **[An employe]** **Employees** shall wear clean outer garments, maintain a high degree of personal cleanliness and conform to hygienic practices while on duty. **[Employes]** **Employees** shall wash their hands thoroughly with soap and water before starting work, after visiting the toilet room and as often as necessary to remove soil and contamination.

§ 211.7. Physician assistants and certified registered nurse practitioners.

(a) **[Physician assistants and certified registered nurse practitioners may be utilized in facilities, in accordance with their training and experience and the requirements in statutes and regulations governing their respective practice.]** **(Reserved).**

(b) If the facility utilizes the services of physician assistants or certified registered nurse practitioners, the following apply:

(1) **[There shall be written policies indicating the manner in which the physician assistants and certified registered nurse practitioners shall be used and the responsibilities of the supervising physician.]** **(Reserved).**

(2) There shall be a list posted at each **[nursing station]** WORKSTATION of the names of the supervising physician and the persons, and titles, whom they supervise.

(3) A copy of the supervising physician's registration from the State Board of Medicine or State Board of Osteopathic Medicine and the physician assistant's or certified registered nurse practitioner's certificate shall be available in the facility.

(4) A notice plainly visible to residents shall be posted in prominent places in the institution explaining the meaning of the terms "physician assistant" and "certified registered nurse practitioner."

(c) **[Physician assistants' documentation on the resident's record shall be countersigned by the supervising physician within 7 days with an original signature and date by the licensed physician. This includes progress notes, physical examination reports, treatments, medications and any other notation made by the physician assistant.]** **(Reserved).**

(d) **[Physicians shall countersign and date their verbal orders to physician assistants or certified registered nurse practitioners within 7 days.]** **(Reserved).**

(e) **[This section may not be construed to relieve the individual physician, group of physicians, physician assistant or certified registered nurse practitioner of responsibility imposed by statute or regulation.]** **(Reserved).**

§ 211.8. Use of restraints.

(a) **[Restraints may not be used in lieu of staff effort. Locked restraints may not be used.]** **(Reserved).**

(b) **[Restraints may not be used or applied in a manner which causes injury to the resident.]** **(Reserved).**

(c) **[Physical restraints shall be removed at least 10 minutes out of every 2 hours during the normal waking hours to allow the resident an opportunity to move and exercise. Except during the usual sleeping hours, the resident's position shall be changed at least every 2 hours. During sleeping hours, the position shall be changed as indicated by the resident's needs.]** **(Reserved).**

(c.1) If restraints are used, a facility shall ~~ensure that appropriate interventions are in place~~ USE THE LEAST RESTRICTIVE METHOD FOR THE LEAST AMOUNT OF TIME **to safely and adequately respond to** INDIVIDUAL **resident needs** IN ACCORDANCE WITH THE RESIDENT'S COMPREHENSIVE ASSESSMENT AND COMPREHENSIVE CARE PLAN. THE FOLLOWING SHALL APPLY:

(1) WHEN A RECURRING RESTRAINT IS ORDERED, THE FACILITY SHALL DOCUMENT THE NEED FOR THE RESTRAINT AND THE PERSONNEL RESPONSIBLE FOR PERFORMING THE INTERVENTION ON EACH SHIFT.

(2) A FACILITY SHALL DOCUMENT THE TYPE OF RESTRAINT AND EACH TIME A RESTRAINT IS USED OR REMOVED.

(3) IN DETERMINING THE LEAST RESTRICTIVE METHOD FOR THE LEAST AMOUNT OF TIME, THE FOLLOWING MINIMUMS APPLY:

(I) PHYSICAL RESTRAINTS SHALL BE REMOVED AT LEAST 10 MINUTES OUT OF EVERY 2 HOURS DURING NORMAL WAKING HOURS TO ALLOW THE RESIDENT AN OPPORTUNITY TO MOVE AND EXERCISE.

(II) DURING NORMAL WAKING HOURS, THE RESIDENT'S POSITION SHALL BE CHANGED AT LEAST EVERY 2 HOURS.

(d) **[A signed, dated, written physician]** **An** order **from a physician, or physician's delegee authorized under 42 CFR 483.30(e) (relating to physician services),** shall be required for a restraint. **[This includes the use of chest, waist, wrist, ankle, drug or other form of restraint. The order shall include the type of restraint to be used.]**

(e) The physician**, or physician's delegee authorized under 42 CFR 483.30(e),** shall document the reason for the initial restraint order and shall review the continued need for the use of the restraint order by evaluating the resident. If the order is to be continued, the order shall be renewed by the physician**, or physician's delegee authorized under 42 CFR 483.30(e),** in accordance with the resident's total program of care.

(f) Every 30 days, or sooner if necessary, the interdisciplinary team shall review and reevaluate the use of all restraints ordered by ~~physicians~~ A PHYSICIAN OR PHYSICIAN'S DELEGEE AUTHORIZED UNDER 42 CFR 483.30(e).

§ 211.9. Pharmacy services.

(a) Facility policies shall ensure that:

(1) **Facility** staff involved in the administration of resident care shall be knowledgeable of the policies and procedures regarding pharmacy services including medication administration.

(2) **[Only licensed pharmacists shall dispense medications for residents. Licensed physicians may dispense medications to the residents who are in their care.]** **(Reserved).**

(b) **[Medications shall be]** **Facility policies shall ensure that medications are** administered by authorized persons as indicated in § 201.3 (relating to definitions).

(c) Medications and biologicals shall be administered by the same licensed person who prepared the dose for administration and shall be given as soon as possible after the dose is prepared.

(d) Medications**, both prescription and non-prescription,** shall be administered under the **[written]** orders of the attending physician**, or the physician's delegee authorized under 42 CFR 483.30(e) (relating to physician services)**.

(e) **[Each resident shall have a written physician's order for each medication received. This includes both proprietary and nonproprietary medications.]** **(Reserved).**

(f) Residents shall be permitted to purchase prescribed medications from the pharmacy of their choice. If the resident does not use the pharmacy that usually services the facility, the resident is responsible for securing the medications and for assuring that applicable pharmacy regulations and facility policies are met. The facility:

(1) Shall notify the resident or the **[resident's responsible person]** **resident representative**, at admission and as necessary throughout the resident's stay in the facility, of the right to purchase medications from a pharmacy of the resident's choice as well as the resident's and pharmacy's responsibility to comply with the facility's policies and State and Federal laws regarding packaging and labeling requirements.

* * * * *

(g) **[If over-the-counter drugs are maintained in the facility, they shall bear the original label and shall have the name of the resident on the label of the container. The charge nurse may record the resident's name on the nonprescription label. The use of nonprescription drugs shall be limited by quantity and category according to the needs of the resident. Facility policies shall indicate the procedure for handling and billing of nonprescription drugs.]** **(Reserved).**

(h) **[If a unit of use or multiuse systems are used, applicable statutes shall be met. Unit of use dispensing containers or multiuse cards shall be properly labeled. Individually wrapped doses shall be stored in the original container from which they were dispensed.]** **(Reserved).**

(i) **[At least quarterly, outdated, deteriorated or recalled medications shall be identified and returned to the dispensing pharmacy for disposal in accordance with acceptable professional practices. Written documentation shall be made regarding the disposition of these medications.]** **(Reserved).**

(j) **[Disposition of discontinued and unused medications and medications of discharged or deceased residents shall be handled by facility policy which shall be developed in cooperation with the consultant pharmacist. The method of disposition and quantity of the drugs shall be documented on the respective resident's chart. The disposition procedures shall be done at least quarterly under Commonwealth and Federal statutes.]** **(Reserved).**

(j.1) The facility shall have written policies and procedures for the disposition of medications that address all of the following:

(1) Timely AND SAFE **identification and removal of medications for disposition.**

(2) Identification of storage methods for medications awaiting final disposition.

(3) Control and accountability of medications awaiting final disposition consistent with standards of practice.

(4) Documentation of actual disposition of medications to include the name of the individual disposing of the medication, the name of the resident, the name of the medication, the strength of the medication, the prescription number if applicable, the quantity of medication and the date of disposition.

(5) A method of disposition to prevent diversion or accidental exposure consistent with applicable Federal and State requirements, local ordinances and standards of practice.

(k) The oversight of pharmaceutical services shall be the responsibility of the quality assurance committee. Arrangements shall be made for the pharmacist responsible for the adequacy and accuracy of the services to have committee input. The quality assurance committee, with input from the pharmacist, shall develop written policies and procedures for drug therapy, distribution, administration, control, accountability and use.

(l) A facility shall have at least one emergency medication kit **that is readily available to staff**. The kit used in the facility shall be governed by the following:

(1) The facility shall have written policies and procedures pertaining to the use, content, storage **[and]**, **security,** refill of **and inventory tracking for** the kits.

(2) The quantity and categories of medications and equipment in the kits shall be **[kept to a minimum and shall be]** based on the immediate needs of the facility **and criteria for the contents of the emergency medication kit shall be reviewed not less than annually**.

(3) The emergency medication kits shall be under the control of a practitioner authorized to dispense or **[pre-scribe]** **prescribe** medications under the Pharmacy Act **[(63 P.S. §§ 390.1—390.13)]** **(63 P.S. §§ 390-1—390-13)**.

(4) **[The kits shall be kept readily available to staff and shall have a breakaway lock which shall be replaced after each use.]** **(Reserved).**

§ 211.10. Resident care policies.

(a) Resident care policies shall be available to admitting physicians, sponsoring agencies, residents and the public; AND shall reflect an awareness of, and provision for, meeting the total medical, NURSING, MENTAL and psychosocial needs of residents. **[The needs include admission, transfer and discharge planning.]**

(b) The policies shall be reviewed at least annually and updated as necessary.

(c) The policies shall be designed and implemented to ensure that each resident receives treatments, medications, diets and rehabilitative nursing care as prescribed.

(d) The policies shall be designed and implemented to ensure that the resident receives proper care to prevent pressure sores and deformities; that the resident is kept comfortable, clean and well-groomed; that the resident is protected from accident, injury and infection; and that the resident is encouraged, assisted and trained in self-care and group activities.

§ 211.11. [Resident care plan] (Reserved).

[(a) The facility shall designate an individual to be responsible for the coordination and implementation of a written resident care plan. This responsibility shall be included as part of the individual's job description.

(b) The individual responsible for the coordination and implementation of the resident care plan shall be part of the interdisciplinary team.

(c) A registered nurse shall be responsible for developing the nursing assessment portion of the resident care plan.

(d) The resident care plan shall be available for use by personnel caring for the resident.

(e) The resident, when able, shall participate in the development and review of the care plan.]

§ 211.12. Nursing services.

(a) **[The facility shall provide services by sufficient numbers of personnel on a 24-hour basis to provide nursing care to meet the needs of all residents.]** **(Reserved).**

(b) ~~[~~**There shall be a full-time director of nursing services who shall be a qualified licensed registered nurse.**~~]~~ ~~**(Reserved).**~~

(c) The director of nursing services shall have, in writing, administrative authority, responsibility and accountability for the functions and activities of the nursing services **[staff,]** **personnel** and shall serve only one facility in this capacity.

(d) The director of nursing services shall be responsible for:

(1) Standards of accepted nursing practice.

(2) Nursing policy and procedure manuals.

(3) Methods for coordination of nursing services with other resident services.

(4) Recommendations for the number and levels of nursing SERVICES personnel to be employed.

(5) General supervision, guidance and assistance for a resident in implementing the resident's personal health program to assure that preventive measures, treatments, medications, diet and other health services prescribed are properly carried out and recorded.

(e) **[The facility shall designate** ~~**a registered nurse**~~ CHARGE NURSE **who is responsible for overseeing total nursing activities within the facility on each tour of duty each day of the week.]** ~~**(Reserved).**~~

(f) **[In addition to the director of nursing services, the following daily professional staff shall be available.**

(1) The following minimum nursing staff ratios are required:

Census	*Day*	*Evening*	*Night*
59 and under	1 RN	1 RN	1 RN or 1 LPN
60/150	1 RN	1 RN	1 RN
151/250	1 RN and 1 LPN	1 RN and 1 LPN	1 RN and 1 LPN
251/500	2 RNs	2 RNs	2 RNs
501/1,000	4 RNs	3 RNs	3 RNs
1,001/Upward	8 RNs	6 RNs	6 RNs

(2) When the facility designates an LPN as a nurse who is responsible for overseeing total nursing activities within the facility on the night tour of duty in facilities with a census of 59 or under, a registered nurse shall be on call and located within a 30-minute drive of the facility.] **(Reserved).**

(f.1) In addition to the director of nursing services, a facility shall provide all of the following:

(1) Nursing services personnel on each resident floor.

~~**(2) A minimum of two nursing services personnel on duty at all times.**~~

~~**(3) A minimum of 1 nursing services personnel on duty, per 20 residents.**~~

~~**(4) A minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 10 residents during the evening and 1 nurse aide per 15 residents overnight.**~~

~~**(5) A minimum of 2 RNs and 1 LPN during the day, 1 RN and 1 LPN during the evening and 1 RN overnight, per 60 residents, as follows:**~~

~~*Census*~~	~~*Day*~~	~~*Evening*~~	~~*Night*~~
~~1—60~~	~~2 RNs and 1 LPN~~	~~1 RN and 1 LPN~~	~~1 RN~~
~~61—120~~	~~4 RNs and 2 LPNs~~	~~2 RNs and 2 LPNs~~	~~2 RNs~~
~~121—180~~	~~6 RNs and 3 LPNs~~	~~3 RNs and 3 LPNs~~	~~3 RNs~~
~~181—240~~	~~8 RNs and 4 LPNs~~	~~4 RNs and 4 LPNs~~	~~4 RNs~~
~~241—300~~	~~10 RNs and 5 LPNs~~	~~5 RNs and 5 LPNs~~	~~5 RNs~~
~~301—360~~	~~12 RNs and 6 LPNs~~	~~6 RNs and 6 LPNs~~	~~6 RNs~~
~~361—420~~	~~14 RNs and 7 LPNs~~	~~7 RNs and 7 LPNs~~	~~7 RNs~~
~~421—480~~	~~16 RNs and 8 LPNs~~	~~8 RNs and 8 LPNs~~	~~8 RNs~~
~~481—540~~	~~18 RNs and 9 LPNs~~	~~9 RNs and 9 LPNs~~	~~9 RNs~~

~~**Facilities with more than 540 residents shall calculate and provide additional nursing services personnel in accordance with the ratios provided under this subsection.**~~

(2) EFFECTIVE JULY 1, 2023, A MINIMUM OF 1 NURSE AIDE PER 12 RESIDENTS DURING THE DAY, 1 NURSE AIDE PER 12 RESIDENTS DURING THE EVENING, AND 1 NURSE AIDE PER 20 RESIDENTS OVERNIGHT.

(3) EFFECTIVE JULY 1, 2024, A MINIMUM OF 1 NURSE AIDE PER 10 RESIDENTS DURING THE DAY, 1 NURSE AIDE PER 11 RESIDENTS DURING THE EVENING, AND 1 NURSE AIDE PER 15 RESIDENTS OVERNIGHT.

(4) EFFECTIVE JULY 1, 2023, A MINIMUM OF 1 LPN PER 25 RESIDENTS DURING THE DAY, 1 LPN PER 30 RESIDENTS DURING THE EVENING, AND 1 LPN PER 40 RESIDENTS OVERNIGHT.

(5) EFFECTIVE JULY 1, 2023, A MINIMUM OF 1 RN PER 250 RESIDENTS DURING ALL SHIFTS.

(f.2) ~~**A facility may substitute a nurse aide with an LPN or RN and an LPN with an RN, but may not substitute an RN with a nurse aide or an LPN, to meet the requirements of**~~

~~subsection (f.1).~~ TO MEET THE REQUIREMENTS OF SUBSECTIONS (F.1)(2) THROUGH (5):

(1) A FACILITY MAY SUBSTITUTE AN LPN OR RN FOR A NURSE AIDE BUT MAY NOT SUBSTITUTE A NURSE AIDE FOR AN LPN OR RN.

(2) A FACILITY MAY SUBSTITUTE AN RN FOR AN LPN.

(3)(i) A FACILITY MAY NOT SUBSTITUTE AN LPN FOR AN RN EXCEPT AS PROVIDED UNDER SUBPARAGRAPH (ii).

(ii) A FACILITY WITH A CENSUS OF 59 OR UNDER MAY SUBSTITUTE AN LPN FOR AN RN ON THE OVERNIGHT SHIFT ONLY IF AN RN IS ON CALL AND LOCATED WITHIN A 30-MINUTE DRIVE OF THE FACILITY.

(g) **[There shall be at least one nursing staff employe on duty per 20 residents.]** **(Reserved).**

(h) **[At least two nursing service personnel shall be on duty.]** **(Reserved).**

~~(*Editor's Note*: The text of subsection (i) is printed as it currently appears in the *Pennsylvania Code*. This subsection is proposed to be amended as set forth in the proposed rulemaking published at 51 Pa.B. 4074 (July 31, 2021)).~~

(i) ~~A minimum number of general nursing care hours shall be provided for each 24-hour period. The total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 2.7 hours of direct resident care for each resident.~~ A MINIMUM NUMBER OF GENERAL NURSING CARE HOURS SHALL BE PROVIDED FOR EACH 24-HOUR PERIOD AS FOLLOWS:

(1) EFFECTIVE JULY 1, 2023, THE TOTAL NUMBER OF HOURS OF GENERAL NURSING CARE PROVIDED IN EACH 24-HOUR PERIOD SHALL, WHEN TOTALED FOR THE ENTIRE FACILITY, BE A MINIMUM OF 2.87 HOURS OF DIRECT RESIDENT CARE FOR EACH RESIDENT.

(2) EFFECTIVE JULY 1, 2024, THE TOTAL NUMBER OF HOURS OF GENERAL NURSING CARE PROVIDED IN EACH 24-HOUR PERIOD SHALL, WHEN TOTALED FOR THE ENTIRE FACILITY, BE A MINIMUM OF 3.2 HOURS OF DIRECT RESIDENT CARE FOR EACH RESIDENT.

(i.1) Only direct resident care provided by nursing service personnel may be counted towards the total number of hours of general nursing care required under subsection (i).

(j) **[Nursing personnel shall be provided on each resident floor.]** **(Reserved).**

(k) **[Weekly time schedules shall be maintained and shall indicate the number and classification of nursing personnel, including relief personnel, who worked on each tour of duty on each nursing unit.]** **(Reserved).**

(l) **[The Department may require an increase in the number of nursing personnel from the minimum requirements if specific situations in the facility—including, but not limited to, the physical or mental condition of residents, quality of nursing care administered, the location of residents, the location of the nursing station and location of the facility—**

indicate the departures as necessary for the welfare, health and safety of the residents.] **(Reserved).**

* * *

§ 211.15. [Dental services] ~~(Reserved).~~

[(a) The facility shall assist residents in obtaining routine and 24-hour emergency dental care.

(b) The facility shall make provisions to assure that resident dentures are retained by the resident. Dentures shall be marked for each resident.] IN ADDITION TO THE REQUIREMENTS IN 42 CFR 483.55 (RELATING TO DENTAL SERVICES), A FACILITY SHALL MAKE PROVISIONS TO ASSURE THAT RESIDENT DENTURES ARE RETAINED BY THE RESIDENT. DENTURES SHALL BE MARKED FOR EACH RESIDENT.

§ 211.16. Social services.

(a) **[The facility shall provide social services designed to promote preservation of the resident's physical and mental health and to prevent the occurrence or progression of personal and social problems. Facilities with a resident census of more than 120 residents]** **A facility** shall employ a qualified social worker on a full-time basis. EXCEPT:

(1) A FACILITY WITH 26 TO 59 BEDS MAY EMPLOY A PART-TIME QUALIFIED SOCIAL WORKER IF THE FACILITY ASSESSMENT INDICATES THAT A FULL-TIME QUALIFIED SOCIAL WORKER IS NOT NEEDED.

(2) A FACILITY WITH 25 BEDS OR LESS MAY EITHER EMPLOY A PART-TIME QUALIFIED SOCIAL WORKER OR SHARE THE SERVICES OF A QUALIFIED SOCIAL WORKER WITH ANOTHER FACILITY.

(b) **[In facilities with 120 beds or less that do not employ a full-time social worker, social work consultation by a qualified social worker shall be provided and documented on a regular basis.]** **(Reserved).**

§ 211.17. Pet therapy.

If pet therapy is utilized, **[the following standards apply]** **a facility shall have written policies and procedures to ensure all of the following**:

(1) Animals are not permitted in the kitchen or other food service areas, dining rooms when meals are being served, utility rooms and rooms of residents who do not want animals in their rooms.

(2) Careful selection of types of animals **[shall be]** **is** made so **[they]** **the animals** are not harmful or annoying to residents.

(3) The number and types of pets **[shall be]** **are** restricted according to the layout of the building, type of residents, staff and animals.

(4) **[Pets shall be]** **Animals are** carefully selected to meet the needs of the residents involved in the pet therapy program.

(5) **[The facility shall have written procedures established which will address the physical and health needs of the animals. Rabies shots shall be given to animals who are potential victims of the disease. Care of the pets may not be imposed on anyone who does not wish to be involved.]** **(Reserved).**

(5.1) Animals are up to date on vaccinations, are in good health and do not pose a risk to the health and safety of residents.

(6) **[Pets]** **Animals** and places where they reside **[shall be]** **or visit are** kept clean and sanitary.

(7) Infection prevention and control measures, such as hand hygiene, are followed by residents and personnel when handling animals.

COMMONWEALTH OF PENNSYLVANIA
OFFICE OF THE SECRETARY OF HEALTH

September 27, 2022

Mr. David Sumner
Executive Director
Independent Regulatory Review Commission
14th Floor, 333 Market Street
Harrisburg, PA 17101

Re: Department of Health – Final Regulation No. 10-224
Long-Term Care Nursing Facility Regulations
28 Pa. Code §§ 201.18—201.21, 201.24—201.31, 207.2, 209.3, 211.2—211.17
Rulemaking 4 – Qualifications, Training, Job Duties, Recordkeeping, Program Standards, and Resident Rights and Services

Dear Mr. Sumner:

Enclosed are final-form regulations for review by the Independent Regulatory Review Commission (IRRC) in accordance with the Regulatory Review Act (71 P.S. §§ 745.1—745.15). This is the last of four rulemaking packages that amend Subpart C (relating to long-term care facilities) of Part IV of Title 28 of the Pennsylvania Code. Subpart C consists of 6 different chapters: Chapters 201, 203, 205, 207, 209 and 211.

This final-form rulemaking amends various qualification, training, program standards, and resident rights and services provisions. Specifically, other amendments include increasing the number of registered nurses (RNs) and licensed practical nurses (LPNs) required under § 211.12 (relating to nursing services), adding a requirement that facilities have a full-time or part-time qualified social worker based on the size of the facility, requiring facilities to have admissions policies and procedures that include introductions and orientation for new residents to key personnel and services, and adding an anti-discrimination provision and training regarding resident rights, including nondiscrimination and cultural competency. The purpose of this final-form rulemaking is to update the health and safety standards for the licensure of nursing facilities, including programmatic and training standards. In addition, this final-form rulemaking aims to create consistency between Federal and State requirements for long-term care nursing facilities.

The Regulatory Review Act provides that upon completion of the agency's review of comments following proposed rulemaking, the agency is to submit to IRRC and the Standing Committees of the General Assembly a copy of the agency's response to the comments received, the names and addresses of the commentators who have requested additional information relating

to the final-form regulations, and the text of the final-form regulations which the agency intends to adopt. *See* 71 P.S. §§745.5a(a).

A list of the names and addresses of the commentators who requested a copy of the final-form regulations is enclosed. The Department previously forwarded these comments to the Commission.

The Act also provides that IRRC may have until its next scheduled meeting which occurs no less than 30 days after receipt of the final-form regulation to approve or disapprove the final-form regulation. 71 P.S § 745.5a(e).

The Department will provide IRRC with any assistance it requires to facilitate a thorough review of the regulations. If you have any questions, please contact David Toth, Director of the Office of Legislative Affairs, at (717) 787-6436.

Sincerely,

Denise Johnson, MD
Acting Secretary of Health

Enclosures

From:	Bradbury, Joan
To:	Smith, Pamela (Health); Brooks, Senator Michele
Subject:	RE: Final-Form Long-Term Care Nursing Facility Regulations - Rulemaking 4 (10-224)
Date:	Tuesday, September 27, 2022 9:49:53 AM

Received, thank you Pam.

Joan Bradbury
Executive Director
Senate Health & Human Services Committee
717-787-1475 (direct)

From: Smith, Pamela (Health) <pamesmith@pa.gov>
Sent: Tuesday, September 27, 2022 8:34 AM
To: Brooks, Senator Michele <mbrooks@pasen.gov>
Cc: Bradbury, Joan <jbradbury@pasen.gov>
Subject: Final-Form Long-Term Care Nursing Facility Regulations - Rulemaking 4 (10-224)
Importance: High

Good morning,

Attached are final-form long-term care nursing facility regulations – rulemaking 4 (10-224) from the Department of Health. This is the fourth of four long-term care nursing facility packages that are being delivered to you today.

Under the Regulatory Review Act, the Department is required to deliver a final-form regulatory package to the Standing Committees of the General Assembly and the Independent Regulatory Review Commission (IRRC) **on the same day**, with IRRC receiving the package last. Confirmation of receipt by the Standing Committees is required for delivery to IRRC.

Please respond as soon as possible to this email indicating that you have received the attached final-form regulatory package so that I can deliver the package to IRRC **today, September 27, 2022**.

Thanks,
Pam

Pamela G. Smith | Assistant Counsel
Pennsylvania Department of Health | Office of Legal Counsel
625 Forster Street | Harrisburg, PA 17120 - 0701
Phone: 717.783.2500 | Fax: 717.705.6042
www.health.state.pa.us

From:	Fricke, Erika L.
To:	Smith, Pamela (Health); Frankel, Dan
Subject:	RE: Final-Form Long-Term Care Nursing Facility Regulations - Rulemaking 4 (10-224)
Date:	Tuesday, September 27, 2022 10:46:20 AM

Received

From: Smith, Pamela (Health) <pamesmith@pa.gov>
Sent: Tuesday, September 27, 2022 8:33 AM
To: Frankel, Dan <DFrankel@pahouse.net>
Cc: Fricke, Erika L. <EFricke@pahouse.net>
Subject: Final-Form Long-Term Care Nursing Facility Regulations - Rulemaking 4 (10-224)
Importance: High

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Phone: 717.783.2500 | Fax: 717.705.6042
www.health.state.pa.us

From: Freeman, Clarissa
To: Smith, Pamela (Health)
Subject: Re: Final-Form Long-Term Care Nursing Facility Regulations - Rulemaking 4 (10-224)
Date: Tuesday, September 27, 2022 9:27:17 AM

Received.
Thank you,
Clarissa

Get Outlook for iOS

From: Smith, Pamela (Health) <pamesmith@pa.gov>
Sent: Tuesday, September 27, 2022 8:34:54 AM
To: Haywood, Senator Art <art.haywood@pasenate.com>
Cc: Freeman, Clarissa <clarissa.freeman@pasenate.com>
Subject: Final-Form Long-Term Care Nursing Facility Regulations - Rulemaking 4 (10-224)

■ EXTERNAL EMAIL ■

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www.health.state.pa.us

From:	Michael Siget
To:	Smith, Pamela (Health); Kathy Rapp
Subject:	RE: Final-Form Long-Term Care Nursing Facility Regulations - Rulemaking 4 (10-224)
Date:	Tuesday, September 27, 2022 8:36:40 AM

Received.

From: Smith, Pamela (Health) <pamesmith@pa.gov>
Sent: Tuesday, September 27, 2022 8:28 AM
To: Kathy Rapp <Klrapp@pahousegop.com>
Cc: Michael Siget <Msiget@pahousegop.com>
Subject: Final-Form Long-Term Care Nursing Facility Regulations - Rulemaking 4 (10-224)
Importance: High

Good morning,

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