Regulatory Analysis Form

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INDEPENDENT REGULATORY REVIEW COMMISSION

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Independent Regulatory Review Commission

IRRC Number: 3343

(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—201.31, 207.2, 209.3, 211.2—211.17

(4) Short Title: Long-term care nursing facilities

Please note that this is the last of four proposed 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):

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(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 proposed regulation is the last of four proposed rulemaking packages, with respect to long-term care nursing facilities, to be promulgated by the Department.

The proposed amendments include additional elimination of provisions that are duplicative and that conflict with the Federal requirements. Other proposed amendments include increasing the number of registered nurses (RNs) and licensed practical nurses (LPNs) required under section 211.12 (relating to nursing services), adding a requirement that facilities have a full-time qualified social worker regardless of 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.

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

Sections 601 and 803 of the Health Care Facilities Act (the 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 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, 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)).

(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 proposed regulations are not mandated by any Federal or State law or court order or decision, or Federal regulation. With respect to State law, the Department is authorized under the act 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%. Pennsylvania also has a higher percentage of older adults when compared to other states. In 2017, Pennsylvania 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 (aged 65 or older) for every 100-working age Pennsylvanians (15 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.As the number of older Pennsylvanians increases, the number of those needing long-term nursing care will also increase. It has been estimated that an individual turning 65 today has an almost 70% chance of needing some type of long-term nursing care during the 3 remainder of their lifetime. 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.

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 act. 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. This proposed rulemaking is necessary to improve the quality of care delivered to residents, increase resident safety and minimize procedural burdens on health care practitioners who provide care to residents in long-term care nursing facilities.

The Department's surveyors, as well as the 689 long-term care nursing facilities licensed by the Department, will benefit from the consistency and efficiency created by the elimination of sections that are outdated and duplicative of the Federal requirements.

The more than 72,000 residents of the 689 licensed long-term care nursing facilities will also benefit from these proposed regulations. Residents will benefit from the proposed 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 Medicare or Medical Assistance (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 proposed increase in direct care hours provided by RNs and LPNs.

(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 proposed provisions that are more stringent than Federal standards, as described below.

In proposed section 201.19 (relating to personnel records), the Department is proposing that facilities maintain certain specific employee personnel records, including the employee's job description, records of trainings, records of such pre-employment health examinations and of subsequent health services rendered to the facility's employees as are necessary to ensure that all employees are physical able to perform their duties, documentation of the employee's licensure, if applicable, and information pertaining to criminal background checks. Requiring a facility to maintain these types of records will assist both the facility and the Department should a concern arise regarding an employee at the facility. In addition, criminal background checks for prospective employees are required under State law by the Older Adult Protective Services Act (OAPSA). 35 P.S. § 10225.502.

In proposed section 201.24(e) (relating to admission policy), the Department is proposing to require 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 proposed section 201.29(p) (relating to resident rights), the Department is proposing to add 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. The Department's proposal to include race, color,

familial status, religious creed, ancestry, age, sex, national origin, handicap or disability, use of guide or support animals because of the blindness, deafness or physical handicap of the user or because the user is a handler or trainer of support or guide animals in this subsection mirrors existing protections under the Pennsylvania Human Relations Act (PHRA). 43 P.S. § 955(i). Federal and State law do not specifically prohibit discrimination based on sexual orientation or gender identity, though the Federal requirements for long-term care nursing facilities do provide some protections for same-sex spouses and residents based on sexual orientation and gender identity. *See* 42 CFR 483.10(b)(3); 42 CFR 483.10(f)(4)(vi)(B) and (C). In 2018, the Pennsylvania Human Relations Commission (PHRC), the entity charged with enforcing the PHRA, released guidance stating that its interpretation of the term "sex" in the PHRA "may refer to sex assigned at birth, sexual orientation, transgender identity, gender transition, gender identity, and/or gender expression." PHRC. Pennsylvania Human Relations Commission Guidance on Discrimination on the Basis of Sex under the Pennsylvania Human Relations Act. Retrieved from https://www.phrc.pa.gov/AboutUs/Documents/APPROVED%20Sex%20Discrimination%20Guidance%20PHRA.pdf. The result of that guidance is that the PHRC will accept filing of complaints arising out of discrimination based on sex assigned at birth, sexual orientation, transgender identity, gender transition, gender identity or gender expression in places of public accommodation. As mentioned, long-term care nursing facilities are places of public accommodation under both Federal and State law and therefore, will be subject to the PHRC guidance. Further, the Department's proposal in subsection (p) is consistent with its duty and authority under the act to ensure that "all citizens receive humane, courteous, and dignified treatment." 35 P.S. § 448.102. That duty cannot be met if the Department allows or remains silent on discrimination against any class of persons, especially persons that otherwise have not been afforded clear protections under the law. Section 804 of the act further prohibits any provider from discriminating on the basis of sex. 35 P.S. § 448.804. Consistent with the PHRC guidance, discrimination on the basis of "sex" will include discrimination based on sex assigned at birth, sexual orientation, transgender identity, gender transition, gender identity or gender expression. The Department is proposing to make clear to long-term care nursing facilities the Department's interpretation of this statutory provision, which is consistent with the text of the statute and the intent and purpose of the act.

In proposed section 211.2(c), the Department is proposing to add, at the request of a stakeholder, 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 four 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 proposed section 211.6(a) (relating to dietary services), the Department is proposing to require menus to be posted in the facility or distributed to residents at least two weeks in advance. The Department is proposing this requirement as part of its overall efforts to promote more resident-centered environments in facilities. Requiring that menus be posted or distributed to residents contributes to a more resident-centered environment by allowing residents and their visitors to view and plan meals in advance.

In proposed section 211.8(c.1) (relating to use of restraints), the Department is proposing to require that a facility ensure that appropriate interventions are in place to adequately respond to resident needs. Physical or chemical restraints are permitted by the Federal requirements, but only in limited

circumstances. When used, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. The Department is proposing to add the language in subsection (c.1) to clarify that appropriate interventions are in place, when restraints are used, to protect the health and safety of residents. These interventions would include, for example, turning and repositioning residents, providing distractions while the resident is in restraints, checking the skin of the resident underneath the restraint, and supervising the resident to ensure that the resident is not harmed while in restraints.

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With respect to proposed section 211.12(f.1)(5) (relating to nursing services), the Federal requirements for long-term care nursing facilities do not specify a minimum number of direct care hours to be provided to residents, nor do the requirements specify a minimum number or type of nursing services personnel for resident care. In the Department's first proposed rulemaking, the Department proposed a minimum of 4.1 direct care hours for residents. CMS, however, in a 2001 study, found that a minimum of 4.1 hours of direct care per resident day will improve the quality of care provided to a resident, and that anything below that amount "could result in harm and jeopardy to residents." Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities, 80 Fed. Reg. 42168, 42202 (July 16, 2015). In the 2001 study, CMS identified a pattern of incremental benefits in increased staffing until a threshold was reached, where no significant quality improvements were observed. This threshold occurred when 2.8 hours of care per resident day were provided by nurse aides, .75 hours of care per resident day were provided by RNs and .55 hours of care per resident day were provided by other licensed staff, *i.e.*, LPNs. Feuerberg, Marvin. CMS. (December 2001). Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes. Overview of the Phase II Report: Background, Study Approach, Findings, and Conclusions. Retrieved from: https://www.justice.gov/sites/default/files/elderjustice/legacy/2015/07/12/Appropriateness_of_Minimum_Nurse_Staffing_Ratios_in_Nursing_Homes.pdf.

The Department considered the breakdown of RNs, LPNs and nurse aides recommended by CMS, but ultimately determined that a somewhat lower breakdown is more feasible in this Commonwealth, given the funding concerns shared by facilities in response to the Department's first proposed rulemaking as well as the ongoing nurse staffing challenges and shortages in this Commonwealth and nationally. The Department, therefore, is proposing to require fewer RNs and LPNs than those recommended by CMS, but to require more nurse aides, proportionally, to achieve the 4.1 hours of direct care per resident per day proposed in section 211.12(i) of the Department's first proposed rulemaking. Based on the experience and expertise of Department staff with first-hand knowledge of the administration of long-term care nursing facilities, the Department determined that the lowest acceptable level of nursing services personnel will be 2 RNs and 1 LPN per 60 residents during the day shift, 1 RN and 1 LPN per 60 residents during the evening shift, and 1 RN per 60 residents during the night shift, so that there is always an RN on duty. Therefore, per resident day, a minimum of 4 RNs and a minimum of 2 LPNs will be required per 60 residents, with nurse aides making up the remaining number of staff needed to meet the minimum 4.1 hours of direct care required by proposed section 211.12(i). By contrast, at the staffing levels recommended in the CMS study, a minimum of 6 RNs and 4 LPNs will be required per day, per 60 residents, with nurse aides making up the remaining number of nursing services personnel needed to meet the minimum 4.1 hours of direct care.[1]

[1] The Department reached this conclusion by multiplying the minimum proposed hours per resident day by 60 residents and dividing by 8 to represent 8-hour shifts. For example, for RNs, the Department multiplied .75 hours per resident day times 60 and divided by 8, to determine that the CMS staffing equivalent will be 6 RNs per resident day.

The nursing staff ratios proposed by the Department represent a significant increase from current minimum requirements, which the Department believes will result in improvements in resident care and reduced professional nurse staff workloads. 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. 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). Requiring a proportionally higher rate of nurse aides, as proposed by the Department, will also 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 proposed section 211.16, the Department is proposing to delete the first sentence of this subsection and to replace the phrase "facilities with a resident census of more than 120 residents" with "a facility." The effect of this proposed amendment will be to require that all facilities have a full-time qualified social worker, regardless of the size of the facility. This exceeds the Federal requirements at 42 CFR 483.70(p) which only require a full-time qualified social worker for facilities with more than 120 beds. The Department believes strongly 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 social workers to assist with their care planning and to provide psychosocial support.

(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 proposed 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 types of proposed amendments.

Notable differences between the Department's proposed amendments and the surrounding states include the Department's proposal to align with the Federal requirements and the Department's proposal to increase the nursing staff ratio in section 211.12(f.1)(5).

The Department's proposed 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 Medicaid 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, while Maryland has incorporated by

reference the CMS Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual and the CMS Manual System. Md. Code Ann. 10.07.02.02

The Department's proposed amendment to section 211.12(f.1)(5) to require a specific ratio of RNs and LPNs to meet the required 4.1 direct care hours proposed by the Department in section 211.12(i) in the first proposed rulemaking, places Pennsylvania ahead of the surrounding states for proposed minimum staffing levels. Surrounding states requirements for nursing staff ratios vary, as described below.

- 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. By way of comparison to the Department's proposal, 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 proposal in section 211.16 to require that all facilities have a full-time qualified social worker, regardless of size, will not affect Pennsylvania's ability to compete and will actually place Pennsylvania ahead of other states. 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.

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

The proposed regulations will not affect the regulations of any other state agency. The Department is revising other parts of the regulations relating to long-term care nursing facilities (28 Pa. Code Ch. 28, Subpart C). These proposed regulations will complement those revisions.

(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 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.

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 proposed regulations to the Health Policy Board on October 29, 2020.

(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

Proposed elimination of sections that are duplicative of Federal requirements

The proposed amendments will apply to all 689 long-term care nursing facilities licensed by the Department. These facilities provide health services to more than 72,000 residents. The Department anticipates little to no effect on these facilities as a result of the proposed elimination of sections that are duplicative of the Federal requirements. All but three of the 689 long-term care nursing facilities participate in either Medicare or MA and thus, are required already to comply with existing Federal requirements. The three long-term care nursing facilities that do not participate in Medicare or MA may be affected if they do not already meet the minimum standards within the Federal requirements. However, any effect on these three facilities is outweighed by the need for consistency in the application of standards to all long-term care nursing facilities, regardless of whether they participate in Medicare or MA.

Cost to meet proposed nursing staff ratio.

Of the 689 facilities licensed by the Department, 620 facilities participate in MA. Six of these are operated by DMVA, 20 are county-owned, and the remaining 594 are privately-owned. The Department consulted with DMVA to determine the impact of the proposed increase to the nursing staff ratio in section 211.12(f.1)(5) as well as the proposed increase in the number of direct care nursing hours to 4.1 as proposed in the Department's first proposed rulemaking. The proposed increase in RNs and LPNs, as proposed by the Department in section 211.12(f.1)(5) will require DMVA to employ an additional 166 RNs and 83 LPNs. The average cost to DMVA for an RN is $136,031.24 and for an LPN is $103,720.67. This estimate includes wages and benefits. The total cost to DMVA to add 166 RNs will be $22,581,185.84 and to add 83 LPNs will be $8,608,815.61, for a total cost of $31,189,918.45. DMVA will need to hire an additional 43 nurse aides in addition to the 166 RNs and 83 LPNs to meet the Department's proposal in the first proposed rulemaking to require, in section 211.12(i), 4.1 direct care resident hours, per day. The average cost to DMVA for a nurse aide, including wages and benefits, is $75,871.34 for a total cost of $3,262,467.62. The total cost to DMVA under the proposed amendments to meet the requirements of both section 211.12(f.1)(5) and 211.12(i) will be $34,452,469.07. Based on the number of eligible MA residents, about 35% of the total cost, an estimated $12 million, will be covered by the MA program; therefore, the Federal MA Program rate, estimated to be 52%, will apply to these costs, for an estimated $6.2 million. Applying the Federal share of approximately $6.2 million to the total costs of approximately $34 million needed to staff up to the 4.1 ratio results in an estimated increase of approximately $28 million in state funding ($5.8 million state fund for the MA program and $22.2 million DMVA share non-MA eligible residents).

The Department consulted with DHS to determine the impact of the proposed increase in section 211.12(f.1)(5) to the 20 county-owned facilities and the 594 privately-owned facilities, that are not operated by DMVA. The proposed increase in RNs and LPNs, as proposed by the Department in section 211.12(f.1)(5), will require the 20 county-owned facilities that participate in MA[2], to employ an additional estimated 184 Full Time Equivalent (FTE) RNs but no LPNs. The average cost for an RN is projected to average $127,072, which is an increase of 28% from the average current cost report data provided by county owned facilities. 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%). The 75th percentile wage was used as a proxy for expected wages in 2023 with increased demand from the 4.1 requirement along with trends in the labor market for RNs, LPNs and nurse aides and unchecked pressures on agency use and

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

pricing. The total cost to county-owned facilities that participate in MA to add 184 RNs at the increased salary assumption is estimated to be $23,381,248. The affected county-owned facilities will also need to hire an estimated 539 FTE nurse aides in addition to the 184 RNs in order to meet the Department's proposal in the first rulemaking to require, in section 211.12(i), 4.1 direct resident care hours, per day. The average cost for a nurse aide, including wages and benefits, is projected to increase to $56,477, which is an increase of 23%, from the average salary paid as reported by facilities in the current cost report data reported to DHS. The cost to hire an additional 539 FTE nurse aides is projected to be $30,441,103. The total cost to meet the requirements of both section 211.12(f.1)(5) and 211.12(i) therefore will be $53,822,351. According to data obtained from DHS, approximately 84.51%, or $45,485,269, of this cost will be covered by the MA program. The Federal MA Program rate, estimated to be 52%, will apply to MA payments made to fund these costs, for an estimated Federal match of $23,652,340 and a state general fund investment of $21,832,929.

The proposed increase in RNs and LPNs, as proposed by the Department in section 211.12(f.1)(5), is projected to require the 594 privately-owned facilities that participate in MA[3] to employ an additional 2,374 FTE RNs and 26 FTE LPNs. The average cost for an RN is projected at $127,072, which is an increase of 28% from the average current cost report data for privately owned facilities that participate in MA. The average cost for an LPN is projected at $67,395, which is an increase of 4% from the average current cost report data. This estimate of increased costs includes wages and benefits determined using the assumptions and data described in the county facility cost explanation. The total cost to facilities to add an estimated 2,374 FTE RNs is estimated to be $301,540,749. The total cost to facilities to add 26 FTE LPNs is estimated to be $1,752,277. The affected privately-owned facilities will also need to hire an estimated 5,988 FTE nurse aides in addition to the estimated 2,374 FTE RNs and estimated 26 FTE LPNs in order to meet the Department's proposal in the first rulemaking to require, in section 211.12(i), 4.1 direct resident care hours, per day. The average nurse aide salary is projected at $56,477, which is a 23% increase from the average current cost report data. The total estimated cost to add 5,988 FTE NAs is $338,128,429. The total increased cost to meet the requirements of both section 211.12(f.1)(5) and 211.12(i) therefore will be $641,421,455. According to data obtained from DHS, approximately 75.82%, or $486,325,747, 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 $252,889,388 and a state general fund investment of $233,436,359.

There are 62 facilities that participate only in Medicare. The proposed increase in RNs and LPNs, as proposed by the Department in section 211.12(f.1)(5), will require these 62 facilities, to employ an additional 258 FTE RNs and 3 FTE LPNs. This estimate is based on data obtained from the Department's 2019-2020 annual report. The average projected annual cost for an RN is $127,072 and the average projected annual cost for an LPN is $67,395. This estimate includes wages and benefits. The total cost to facilities to add approximately 258 FTE RNs, based on the same cost assumptions provided by DHS, will be approximately $32,784,576. The total cost to add 3 FTE LPNs will be approximately $202,186. The affected Medicare facilities will also need to hire 659 nurse aides in addition to the 258 RNs and 3 LPNs in order to meet the Department's proposal in the first rulemaking to require, in section 211.12(i), 4.1 direct resident care hours per day. The average cost for a nurse aide, including wages and benefits, is $56,477. The total cost to add 659 nurse aides is approximately $37,218,412. The total cost for Medicare facilities to meet the requirements of both sections 211.12(f.1)(5) and 211.12(i) therefore will be $70,205,174. The Department is not able to assess to what extent these costs will be offset by Medicare as Medicare is a federally managed

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

healthcare program and the Department does not have access to data regarding payment of Medicare to facilities.

There are three private-pay facilities that do not participate in either Medicare or MA. The proposed increase in RNs and LPNs, as proposed by the Department in section 211.12(f.1)(5), will require the 3 privately-owned facilities, to employ an additional 3 FTE RNs, but no LPNs. This estimate is based on data obtained from the Department's 2019-2020 annual report. The average projected annual cost for an RN is $127,072. This estimate includes wages and benefits. The total cost to facilities to add 3 RNs is estimated to be $381,216. The affected facilities will also need to hire 8 nurse aides in addition to the 3 RNs in order to meet the Department's proposal in the first rulemaking to require, in section 211.12(i), 4.1 direct resident care hours, per day. The average cost for a nurse aide, including wages and benefits, is $56,477. The total cost to meet the requirements of both section 211.12(f.1)(5) and 211.12(i) therefore will be $833,031.

The Department's proposal in section 211.12(f.1)(4) to require one nurse aide per ten residents during the day, one nurse aide per ten residents during the evening and one nurse aide per fifteen residents overnight will not result in any costs beyond those already described above.

Cost of proposal to add qualified social worker.
Some long-term care nursing facilities will be affected by the Department's proposal, in section 211.16, to require all facilities to employ a full-time qualified social worker. Currently, a full-time social worker is only required for facilities with more than 120 beds. To estimate how many facilities will be impacted, the Department pulled data from the most recent, available annual report, for fiscal year 2019-2020. 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 annual report is obtained through an annual survey of facilities. The data therefore is dependent on self-reporting from the facilities who complete the survey. Based on a review of the report, the Department estimates that the proposal in section 211.16 will impact 91 privately-owned facilities.[4] Out of these 91 facilities, ten indicated that they only have a part-time social worker, and the remaining 81 reported that they do not have either a full-time or part-time social worker. Of the 81 facilities that reported they do not have either a full-time or part-time social worker, 70 participate in MA, 10 participate only in Medicare, and one is private pay only. Of the ten facilities that have only a part-time social worker, nine participate in MA and one is private pay only.

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.

[4] DMVA indicated to the Department that the six veterans' homes that it operates will not be affected by the Department's proposal in section 211.16. In addition, out of the 20 county-owned facilities, nineteen 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 2019-2020 annual report. If this continues to be the case, there will be no impact to this facility.

The Department estimates, based on the above, that the annual cost to employ one full-time social worker, in the private sector, in the first year, will be approximately $73,216 on average, including wages and benefits. Assuming that the data provided to the Department in the 2019-2020 annual report remains unchanged, the Department estimates that the total cost to the 70 privately-owned MA facilities, with 120 beds or less, that do not employ either a full-time or part-time social worker, will be approximately $5,125,120, in the first year. According to data obtained from DHS, approximately 73%, or $3,741,338, 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 $1,945,496 and a state general fund investment of $1,795,842.

The total estimated cost to the 10 Medicare-only facilities that do not employ either a full-time or part-time social worker is $73,216. The total estimated cost to the one private pay facility that does not employ either a full-time or part-time social worker is $73,216. The Department estimates a 5% increase in wages and benefits for each year thereafter.

The Department estimates that it will cost facilities with 120 beds or less $36,608 each to staff up from a part-time social worker to a full-time social worker. This assumes that the part-time social workers, currently employed, are earning half the salary of a full-time social worker. The total cost to the nine MA facilities is estimated to be $329,472. According to data obtained from DHS, approximately 73%, or $240,515, of the cost to the nine 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 $125,068 and a state general fund investment of $115,447. The total estimated cost to the one private pay facility that needs to staff up from a part-time social worker to a full-time social worker is $36,608. The Department estimates a 5% increase in wages and benefits for each year thereafter.

The Department applied the North America Industry Classification System (NCAICS) standards to the long-term care nursing facilities identified above. Under the NCAICS, a long-term care facility is a small business if it has $35.5 million or less in total income annually. The Department does not maintain data on long-term care nursing facility annual income. According to the U.S. Small Business Administration, there are approximately 30.7 million small businesses, which account for 99.9% of all businesses in the United States. U.S. Small Business Administration, Office of Advocacy. 2019 Small Business Profile. Retrieved from: https://cdn.advocacy.sba.gov/wp-content/uploads/2019/04/23142610/2019-Small-Business-Profiles-States-Territories.pdf. The Department has no reason to dispute this assumption or to question whether the same percentage applies to long-term care nursing facilities in the Commonwealth. If any of the Commonwealth's 689 licensed long-term care nursing facilities are considered to be a small business, they will still be required to meet the requirements of the Department's long-term care nursing facilities regulations, as will any long-term care nursing facility that is not considered a small business. The Department's responsibility to the quality of care to residents in long-term care nursing facilities applies to all of those residents and is not altered by the fact that a long-term care nursing facility may be considered a small business.

General Public and Residents of Long-Term Care Nursing Facilities

More than 72,000 individuals reside in the 689 long-term care nursing facilities licensed by the Department and will be affected by the proposed regulations. These residents, and their family members, will benefit from the proposed 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 proposed increase in direct care hours provided by RNs and LPNs.

The Department is not able to determine the extent to which residents may be financially affected by the proposed regulations. Various insurance options cover the costs residents pay for long-term nursing care, including Original Medicare, Medicare Supplement Insurance (Medigap), a Medicare Advantage Plan, long-term care insurance, MA, and out-of-pocket.

Most people with Medicare get their health care through Original Medicare, which is managed by the Federal government. For residents of long-term care nursing facilities, only short-term stays of up to 100 days are covered by Original Medicare. Original Medicare does not cover all services provided by a long-term care nursing facility. Original Medicare does not cover custodial care, such as assistance with getting in and out of bed, eating, bathing, dressing, and using the bathroom, if that is the only kind of care that is needed. Centers for Medicare & Medicaid Services. (2019). Medicare Coverage of Skilled Nursing Facility Care. Retrieved from https://www.medicare.gov/Pubs/pdf/10153-Medicare-Skilled-Nursing-Facility-Care.pdf.

Original Medicare will cover long-term nursing care if the resident has Medicare Part A, has had a qualifying hospital stay of 3 consecutive days or more and enters the facility within 30 days of leaving the hospital, the resident needs inpatient services which require the skill of professional personnel, and the resident needs skilled care on a daily basis and the services can only be given in a facility. Original Medicare pays the full cost of the first 20 days of a long-term care nursing facility stay. For days 21-100, Original Medicare pays all but a daily coinsurance, which is the resident's responsibility. In 2019, the coinsurance was up to $170.50 per day. For days beyond 100, Original Medicare pays nothing, and the resident is responsible for the full cost of covered services. *Id.*

Covered services and costs in a long-term care nursing facility may be different if the resident has Medigap, a Medicare Advantage Plan, MA, or long-term care insurance. Covered services and costs vary under these types of plans depending on the type of plan the resident has. *Id.* MA is managed by the state and provides benefits for residents with limited income and resources. Any costs not covered by the above resources would result in an out-of-pocket cost to the resident. Medicare.gov. How Can I Pay for Nursing Home Care? https://www.medicare.gov/what-medicare-covers/what-part-a-covers/how-can-i-pay-for-nursing-home-care.

Because the circumstances of each resident are unique with respect to the types of insurance coverage they may have as well as to their length of stay and needs while in the facility, the Department is not able to estimate to what extent costs of a long-term care nursing stay, including costs for professional nursing staff, may be offset by Original Medicare, Medigap, a Medicare Advantage Plan, MA, or long-term care insurance. The Department is also not able to estimate how much a resident may pay out-of-pocket for such care, based on these variables.

Department
The Department licenses long-term care nursing facilities, and thus, will be affected by the proposed regulations. 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 proposed elimination of sections that are duplicative of the Federal requirements will streamline the survey process for long-term care nursing facilities. This, in turn, will create consistency and eliminate confusion in the application of the standards that apply to long-term care nursing facilities.

DHS

Cost to meet proposed nursing staff ratio.
The Department consulted with DHS to determine the effect of the proposed increase in section 211.12(f.1)(5) to the 20 county-owned facilities and the 594 privately-owned facilities, that are not operated by DMVA, and to determine the effect on the MA program. The proposed increase in RNs and LPNs, as proposed by the Department in section 211.12(f.1)(5), will require the 20 county-owned facilities that participate in MA[5] to employ an additional estimated 184 Full Time Equivalent (FTE) RNs but no LPNs. The average cost for an RN is projected to average $127,072, which is an increase of 28% from the average current cost report data provided by county owned facilities. 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%). The 75th percentile wage was used as a proxy for expected wages in 2023 with consideration of increased demand from the 4.1 requirement along with trends in the labor market for RNs, LPNs and nurse aides and unchecked pressures on agency use and pricing. The total cost to county-owned facilities that participate in MA, to add 184 RNs at the increased salary assumption is estimated to be $23,381,248. The affected county-owned facilities will also need to hire an estimated 539 FTE nurse aides in addition to the 184 RNs in order to meet the Department's proposal in the first rulemaking to require, in section 211.12(i), 4.1 direct resident care hours, per day. The average cost for a nurse aide, including wages and benefits, is projected to increase to $56,477 which is an increase of 23%, from the average salary paid as reported by facilities in the current cost report data reported to DHS. The cost to hire an additional 539 FTE nurse aides is projected to be $30,441,103. The total cost to meet the requirements of both section 211.12(f.1)(5) and 211.12(i) therefore will be $53,822,351. According to data obtained from DHS, approximately 84.51% or $45,485,269 of this cost will be covered by the MA program. The Federal MA Program rate, estimated to be 52%, will apply to MA payments made to fund these costs, for an estimated Federal match of $23,652,340 and a state general fund investment of $21,832,929.

The proposed increase in RNs and LPNs, as proposed by the Department in section 211.12(f.1)(5), is projected to require the 594 privately-owned facilities that participate in MA[6] to employ an additional 2,374 FTE RNs and 26 FTE LPNs. The average cost for an RN is projected at $127,072, which is an increase of 28% from the average current cost report data for privately owned facilities that participate in MA. The average cost for an LPN is projected at $67,395 which is an increase of 4% from the average current cost report data. This estimate of increased costs includes wages and benefits determined using the assumptions and data described in the county facility cost explanation. The total cost to facilities to add an estimated 2,374 FTE RNs is estimated to be $301,540,749. The total cost to facilities to add 26 FTE LPNs is estimated to be $1,752,277. The affected privately-owned facilities will also need to hire an estimated 5,988 FTE nurse aides in addition to the estimated 2,374 FTE RNs and estimated 26 FTE LPNs in order to meet the Department's proposal in the first rulemaking to require, in section 211.12(i), 4.1 direct resident care hours, per day. The average nurse aide salary is projected at $56,477 which is a 23% increase from the average current cost report data. The total estimated cost to add 5,988 FTE NAs is $338,128,429. The total increased cost to meet the requirements of both section 211.12(f.1)(5) and 211.12(i) therefore will be $641,421,455. According to data obtained from DHS, approximately 75.82%, or $486,325,747, 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 $252,889,388 and a state general fund investment of $233,436,359.

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

The Department's proposal in section 211.12(f.1)(4) to require one nurse aide per ten residents during the day, one nurse aide per ten residents during the evening and one nurse aide per fifteen residents overnight will not result in any costs beyond those already delineated above.

Cost of proposal to add qualified social worker.
As noted previously, the Department estimates that the annual cost to employ one full-time social worker, in the private sector, in the first year, will be approximately $73,216 on average, including wages and benefits. Assuming that the data provided to the Department in the 2019-2020 annual report remains unchanged, the Department estimates that the total cost to the 70 privately-owned MA facilities, with 120 beds or less, that do not employ either a full-time or part-time social worker, will be approximately $5,125,120, in the first year. According to data obtained from DHS, approximately 73%, or $3,741,338, 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 $1,945,496 and a state general fund investment of $1,795,842. The Department estimates a 5% increase in wages and benefits for each year thereafter.

The Department estimates that it will cost facilities, with 120 beds or less, $36,608 each to staff up from a part-time social worker to a full-time social worker. This assumes that the part-time social workers, currently employed, are earning half the salary of a full-time social worker. The total cost to the nine MA facilities is estimated to be $329,472. According to data obtained from DHS, approximately 73%, or $240,515, of the cost to the nine 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 $125,068 and a state general fund investment of $115,447. The Department estimates a 5% increase in wages and benefits for each year thereafter.

DMVA
DMVA will be affected by the Department's proposed nursing staff ratio in section 211.12(f.1)(5). DMVA operates six veterans' homes across the state with the capacity to serve 1,526 total residents and employs more than 2,000 clinical and professional staff. The proposed increase in RNs and LPNs, as proposed by the Department in section 211.12(f.1)(5) will require DMVA to employ an additional 166 RNs and 83 LPNs. The average cost to DMVA for an RN is $136,031.24 and for an LPN is $103,720.67. This estimate includes wages and benefits. The total cost to DMVA to add 166 RNs will be $22,581,185.84 and to add 83 LPNs will be $8,608,815.61, for a total cost of $31,189,918.45. DMVA will need to hire an additional 43 nurse aides in addition to the 166 RNs and 83 LPNs to meet the Department's proposal in the first proposed rulemaking to require, in section 211.12(i), 4.1 direct care resident hours, per day. The average cost to DMVA for a nurse aide, including wages and benefits, is $75.871.34 for a total cost of $3,262,467.62. The total cost to DMVA under the proposed amendments to meet the requirements of both section 211.12(f.1)(5) and 211.12(i) will be $34,452,469.07. Based on the number of eligible MA residents, about 35% of the total cost, an estimated $12 million, will be covered by the MA program; therefore, the Federal MA Program rate, estimated to be 52%, will apply to these costs, for an estimated $6.2 million. Applying the Federal share of approximately $6.2 million to the total costs of approximately $34 million needed to staff up to the 4.1 ratio results in an estimated increase of approximately $28 million in state funding ($5.8 million state fund for the MA program and $22.2 million DMVA share non-MA eligible residents).

DMVA will not be affected by the Department's proposal in section 211.16 (relating to social services) to require a facility to employ a qualified social worker on a full-time basis as all six veterans' homes already employ a licensed social worker on a full-time basis.

(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.

Long Term Care Nursing Facilities
All 689 licensed long-term care nursing facilities in the Commonwealth will be required to comply with this proposed rulemaking. These facilities provide care to more than 72,000 residents. The Department applied the North America Industry Classification System (NCAICS) standards to the long-term care nursing facilities identified above. Under the NCAICS, a long-term care facility is a small business if it has $35.5 million or less in total income annually. The Department does not maintain data on long-term care nursing facility annual income. According to the U.S. Small Business Administration, there are approximately 30.7 million small businesses, which account for 99.9% of all businesses in the United States. U.S. Small Business Administration, Office of Advocacy. 2019 Small Business Profile. Retrieved from: https://cdn.advocacy.sba.gov/wp-content/uploads/2019/04/23142610/2019-Small-Business-Profiles-States-Territories.pdf. The Department has no reason to dispute this assumption or to question whether the same percentage applies to long-term care nursing facilities in the Commonwealth. If any of the Commonwealth's 689 licensed long-term care nursing facilities are considered to be a small business, they will still be required to meet the requirements of the Department's long-term care nursing facilities regulations, as will any long-term care nursing facility that is not considered a small business. The Department's responsibility to the quality of care to residents in long-term care nursing facilities applies to all of those residents and is not altered by the fact that a long-term care nursing facility may be considered a small business.

(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.

Financial and Economic Impact and Benefits

Long-Term Care Nursing Facilities
Proposed elimination of sections that are duplicative of Federal requirements
The proposed amendments will apply to all 689 long-term care nursing facilities licensed by the Department. These facilities provide health services to more than 72,000 residents. The Department anticipates little to no financial or economic impact on these facilities as a result of the proposed elimination of sections that are duplicative of the Federal requirements. All but three of the 689 long-term care nursing facilities participate in either Medicare or MA and thus, are required already to comply with existing Federal requirements. The three long-term care nursing facilities that do not participate in Medicare or MA may be financially impacted if they do not already meet the minimum standards within the Federal requirements. However, any impact on these three facilities is outweighed by the need for consistency in the application of standards to all long-term care nursing facilities, regardless of whether they participate in Medicare or MA.

Cost of proposal to add qualified social worker.
Some long-term care nursing facilities will be financially impacted by the Department's proposal, in section 211.16, to require all facilities to employ a full-time qualified social worker. Currently, a full-time social worker is only required for facilities with more than 120 beds. To estimate how many facilities will be impacted, the Department pulled data from the most recent, available annual report, for

fiscal year 2019-2020. 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 annual report is obtained through an annual survey of facilities. The data therefore is dependent on self-reporting from the facilities who complete the survey. Based on a review of the report, the Department estimates that the proposal in section 211.16 will impact 91 privately-owned facilities.[7] Out of these 91 facilities, ten indicated that they only have a part-time social worker, and the remaining 81 reported that they do not have either a full-time or part-time social worker. Of the 81 facilities that reported they do not have either a full-time or part-time social worker, 70 participate in MA, 10 participate only in Medicare, and one is private pay only. Of the ten facilities that have only a part-time social worker, nine participate in MA and one is private pay only.

As noted previously, 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 estimates, based on the above, that the annual cost to employ one full-time social worker, in the private sector, in the first year, will be approximately $73,216 on average, including wages and benefits. Assuming that the data provided to the Department in the 2019-2020 annual report remains unchanged, the Department estimates that the total cost to the 70 privately-owned MA facilities, with 120 beds or less, that do not employ either a full-time or part-time social worker, will be approximately $5,125,120, in the first year. According to data obtained from DHS, approximately 73%, or $3,741,338, 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 $1,945,496 and a state general fund investment of $1,795,842.

The total estimated cost to the 10 Medicare-only facilities that do not employ either a full-time or part-time social worker is $73,216. The total estimated cost to the one private pay facility that does not employ either a full-time or part-time social worker is $73,216. The Department estimates a 5% increase in wages and benefits for each year thereafter.

The Department estimates that it will cost facilities with 120 beds or less $36,608 each to staff up from a part-time social worker to a full-time social worker. This assumes that the part-time social workers, currently employed, are earning half the salary of a full-time social worker. The total cost to the nine MA facilities is estimated to be $329,472. According to data obtained from DHS, approximately 73%, or $240,515, of the cost to the nine 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 $125,068 and a state general fund investment of $115,447. The total estimated cost to the one private pay facility that needs to staff up from a part-time social worker to a full-time social worker is $36,608. The Department estimates a 5% increase in wages and benefits for each year thereafter.

[7] DMVA indicated to the Department that the six veterans' homes that it operates will not be affected by the Department's proposal in section 211.16. In addition, out of the 20 county-owned facilities, nineteen 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 2019-2020 annual report. If this continues to be the case, there will be no impact to this facility.

The cost to facilities to employ a full-time social worker is outweighed by the need to have a full-time social worker on staff. 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.
Of the 689 facilities licensed by the Department, 620 facilities participate in MA. Six of these are operated by DMVA, 20 are county-owned, and the remaining 594 are privately-owned. The Department consulted with DMVA to determine the impact of the proposed increase to the nursing staff ratio in section 211.12(f.1)(5) as well as the proposed increase in the number of direct care nursing hours to 4.1 as proposed in the Department's first proposed rulemaking. The proposed increase in RNs and LPNs, as proposed by the Department in section 211.12(f.1)(5) will require DMVA to employ an additional 166 RNs and 83 LPNs. The average cost to DMVA for an RN is $136,031.24 and for an LPN is $103,720.67. This estimate includes wages and benefits. The total cost to DMVA to add 166 RNs will be $22,581,185.84 and to add 83 LPNs will be $8,608,815.61, for a total cost of $31,189,918.45. DMVA will need to hire an additional 43 nurse aides in addition to the 166 RNs and 83 LPNs to meet the Department's proposal in the first proposed rulemaking to require, in section 211.12(i), 4.1 direct care resident hours, per day. The average cost to DMVA for a nurse aide, including wages and benefits, is $75.871.34 for a total cost of $3,262,467.62. The total cost to DMVA under the proposed amendments to meet the requirements of both section 211.12(f.1)(5) and 211.12(i) will be $34,452,469.07. Based on the number of eligible MA residents, about 35% of the total cost, an estimated $12 million, will be covered by the MA program; therefore, the Federal MA Program rate, estimated to be 52%, will apply to these costs, for an estimated $6.2 million. Applying the Federal share of approximately $6.2 million to the total costs of approximately $34 million needed to staff up to the 4.1 ratio results in an estimated increase of approximately $28 million in state funding ($5.8 million state fund for the MA program and $22.2 million DMVA share non-MA eligible residents).

The Department consulted with DHS to determine the impact of the proposed increase in section 211.12(f.1)(5) to the twenty county-owned facilities and the 594 privately-owned facilities, that are not operated by DMVA. The proposed increase in RNs and LPNs, as proposed by the Department in section 211.12(f.1)(5), will require the 20 county-owned facilities that participate in MA[8], to employ an additional estimated 184 Full Time Equivalent (FTE) RNs but no LPNs. The average cost for an RN is projected to be $127,072, which is an increase of 28% from the average current cost report data. 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%). The 75th percentile wage was used as a proxy for expected wages in 2023 with increased demand from the 4.1 requirement along with trends in the labor market for RNs, LPNs and nurse aides and unchecked pressures on agency use and pricing. The total cost to county-owned facilities that participate in MA, to add 184 RNs at the increased salary assumption is estimated to be $23,381,248. The affected county-owned facilities will also need to hire an estimated 539 FTE nurse aides in addition to the 184 RNs in order to meet the Department's proposal in the first rulemaking to

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

require, in section 211.12(i), 4.1 direct resident care hours per day. The average cost for a nurse aide, including wages and benefits, is projected to increase to $56,477which is an increase of 23%, from the average salary paid as reported by facilities in the current cost report data reported to DHS. The cost to hire an additional 539 FTE nurse aides is projected to be $30,441,103. The total cost to meet the requirements of both section 211.12(f.1)(5) and 211.12(i) therefore will be $53,822,351. According to data obtained from DHS, approximately 84.51% or $45,485,269 of this cost will be covered by the MA program. The Federal MA Program rate, estimated to be 52%, will apply to MA payments made to fund these costs, for an estimated Federal match of $23,652,340 and a state general fund investment of $21,832,929.

The proposed increase in RNs and LPNs, as proposed by the Department in section 211.12(f.1)(5), is projected to require the 594 privately-owned facilities that participate in MA[9], to employ an additional 2,374 FTE RNs and 26 FTE LPNs. The average cost for an RN is projected at $127,072, which is an increase of 28% from the average current cost report data for privately owned facilities that participate in MA. The average cost for an LPN is projected at $67,395 which is an increase of 4% from the average current cost report data. This estimate of increased costs includes wages and benefits determined using the assumptions and data described in the county facility cost explanation. The total cost to facilities to add an estimated 2,374 FTE RNs is estimated to be $301,540,749. The total cost to facilities to add 26 FTE LPNs is estimated to be $1,752,277. The affected privately-owned facilities will also need to hire an estimated 5,988 FTE nurse aides in addition to the estimated 2,374 FTE RNs and estimated 26 FTE LPNs in order to meet the Department's proposal in the first rulemaking to require, in section 211.12(i), 4.1 direct resident care hours, per day. The average nurse aide salary is projected at $56,477 which is a 23% increase from the average current cost report data. The total estimated cost to add 5,988 FTE NAs is $338,128,429. The total increased cost to meet the requirements of both section 211.12(f.1)(5) and 211.12(i) therefore will be $641,421,455. According to data obtained from DHS, approximately 75.82%, or $486,325,747, 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 $252,889,388 and a state general fund investment of $233,436,359.

There are 62 facilities that participate only in Medicare. The proposed increase in RNs and LPNs, as proposed by the Department in section 211.12(f.1)(5), will require these 62 facilities, to employ an additional 258 FTE RNs and 3 FTE LPNs. This estimate is based on data obtained from the Department's 2019-2020 annual report. The average projected annual cost for an RN is $127,072 and the average projected annual cost for an LPN is $67,395. This estimate includes wages and benefits. The total cost to facilities to add approximately 258 FTE RNs, based on the same cost assumptions provided by DHS, will be approximately $32,784,576. The total cost to add 3 FTE LPNs will be approximately $202,186. The affected Medicare facilities will also need to hire 659 nurse aides in addition to the 258 RNs and 3 LPNs in order to meet the Department's proposal in the first rulemaking to require, in section 211.12(i), 4.1 direct resident care hours, per day. The average cost for a nurse aide, including wages and benefits, is $56,477. The total cost to add 659 nurse aides is approximately $37,218,412. The total cost for Medicare facilities to meet the requirements of both sections 211.12(f.1)(5) and 211.12(i) therefore will be $70,205,174. 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.

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

There are three private-pay facilities that do not participate in either Medicare or MA. The proposed increase in RNs and LPNs, as proposed by the Department in section 211.12(f.1)(5), will require the 3 privately-owned facilities, to employ an additional 3 FTE RNs, but no LPNs. This estimate is based on data obtained from the Department's 2019-2020 annual report. The average projected annual cost for an RN is $127,072. This estimate includes wages and benefits. The total cost to facilities to add 3 RNs is estimated to be $381,216. The affected facilities will also need to hire 8 nurse aides in addition to the 3 RNs in order to meet the Department's proposal in the first rulemaking to require, in section 211.12(i), 4.1 direct resident care hours, per day. The average cost for a nurse aide, including wages and benefits, is $56,477. The total cost to meet the requirements of both section 211.12(f.1)(5) and 211.12(i) therefore will be $833,031.

The Department's proposal in section 211.12(f.1)(4) to require one nurse aide per ten residents during the day, one nurse aide per ten residents during the evening and one nurse aide per fifteen residents overnight will not result in any costs beyond those already described above.
The Department applied the NCAICS standards to the long-term care nursing facilities identified above. Under the NCAICS, a long-term care facility is a small business if it has $35.5 million or less in total income annually. The Department does not maintain data on long-term care nursing facility annual income. According to the U.S. Small Business Administration, there are approximately 30.7 million small businesses, which account for 99.9% of all businesses in the United States. The Department has no reason to dispute this assumption or to question whether the same percentage applies to long-term care nursing facilities in the Commonwealth. If any of the Commonwealth's 689 licensed long-term care nursing facilities are considered to be a small business, they will still be required to meet the requirements of the Department's long-term care nursing facilities regulations, as will any long-term care nursing facility that is not considered a small business. The Department's responsibility to the quality of care to residents in long-term care nursing facilities applies to all of those residents and is not altered by the fact that a long-term care nursing facility may be considered a small business.

Department
The Department licenses long-term care nursing facilities, and thus, will be impacted by the proposed regulations. 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 proposed changes elimination of sections that are duplicative of the Federal requirements will streamline the survey process for long-term care nursing facilities. This, in turn, will create consistency and eliminate confusion in the application of the standards that apply to long-term care nursing facilities.

DHS

Cost to meet proposed nursing staff ratio.
The Department consulted with DHS to determine the impact of the proposed increase in section 211.12(f.1)(5) to the 20 county-owned facilities and the 594 privately-owned facilities, that are not operated by DMVA, and to determine the impact to the MA program. The proposed increase in RNs and LPNs, as proposed by the Department in section 211.12(f.1)(5), will require the 20 county-owned facilities that participate in MA[10] to employ an additional estimated 184 Full Time Equivalent (FTE) RNs but no LPNs. The average cost for an RN is projected to average $127,072, which is an increase of 28% from the average current cost report data. 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

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

recent benefit cost percentage (28%) and trended for inflation to 2023 (5%). The 75th percentile wage was used as a proxy for expected wages in 2023 with increased demand from the 4.1 requirement along with trends in the labor market for RNs, LPNs and nurse aides and unchecked pressures on agency use and pricing. The total cost to county-owned facilities that participate in MA, to add 184 RNs at the increased salary assumption is estimated to be $23,381,248. The affected county-owned facilities will also need to hire an estimated 539 FTE nurse aides in addition to the 184 RNs in order to meet the Department's proposal in the first rulemaking to require, in section 211.12(i), 4.1 direct resident care hours, per day. The average cost for a nurse aide, including wages and benefits, is projected to increase to $56,477 which is an increase of 23%, from the average salary paid as reported by facilities in the current cost report data reported to DHS. The cost to hire an additional 539 FTE nurse aides is projected to be $35.875,840. The total cost to meet the requirements of both section 211.12(f.1)(5) and 211.12(i) therefore will be $53,822,351. According to data obtained from DHS, approximately 84.51% or $55,546,733 of this cost will be covered by the MA program. The Federal MA Program rate, estimated to be 52%, will apply to MA payments made to fund these costs, for an estimated Federal match of $23,652,340 and a state general fund investment of $21,832,929.

The proposed increase in RNs and LPNs, as proposed by the Department in section 211.12(f.1)(5), is projected to require the 594 privately-owned facilities that participate in MA[11] to employ an additional 2,374 FTE RNs and 26 FTE LPNs. The average cost for an RN is projected at $127,072, which is an increase of 28% from the average current cost report data for privately owned facilities that participate in MA. The average cost for an LPN is projected at $67,395 which is an increase of 4% from the average current cost report data. This estimate of increased costs includes wages and benefits determined using the assumptions and data described in the county facility cost explanation. The total cost to facilities to add an estimated 2,374 FTE RNs is estimated to be $301,540,749. The total cost to facilities to add 26 FTE LPNs is estimated to be $1,752,277. The affected privately-owned facilities will also need to hire an estimated 5,988 FTE nurse aides in addition to the estimated 2,374 FTE RNs and estimated 26 FTE LPNs in order to meet the Department's proposal in the first rulemaking to require, in section 211.12(i), 4.1 direct resident care hours, per day. The average nurse aide salary is projected at $56,477 which is a 23% increase from the average current cost report data. The total estimated cost to add 5,988 FTE NAs is $338,128,429. The total increased cost to meet the requirements of both section 211.12(f.1)(5) and 211.12(i) therefore will be $641,421,455. According to data obtained from DHS, approximately 75.82%, or $486,325,747, 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 $252,889,388 and a state general fund investment of $233,436,359.

The Department's proposal in section 211.12(f.1)(4) to require one nurse aide per ten residents during the day, one nurse aide per ten residents during the evening and one nurse aide per fifteen residents overnight will not result in any costs beyond those already described above.

Cost of proposal to add qualified social worker.
As noted previously, the Department estimates that the annual cost to employ one full-time social worker, in the private sector, in the first year, will be approximately $73,216 on average, including wages and benefits. Assuming that the data provided to the Department in the 2019-2020 annual report remains unchanged, the Department estimates that the total cost to the 70 privately-owned MA facilities, with 120 beds or less, that do not employ either a full-time or part-time social worker, will be approximately $5,125,120, in the first year. According to data obtained from DHS, approximately 73%,

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

or $3,741,338, 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 $1,945,496 and a state general fund investment of $1,795,842. The Department estimates a 5% increase in wages and benefits for each year thereafter.

The Department estimates that it will cost facilities, with 120 beds or less, $36,608 each to staff up from a part-time social worker to a full-time social worker. This assumes that the part-time social workers, currently employed, are earning half the salary of a full-time social worker. The total cost to the nine MA facilities is estimated to be $329,472. According to data obtained from DHS, approximately 73%, or $240,515, of the cost to the nine 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 $125,068 and a state general fund investment of $115,447. The Department estimates a 5% increase in wages and benefits for each year thereafter.

DMVA
DMVA will be financially impacted by the proposed nursing staff ratio in section 211.12(f.1)(5). DMVA operates six veterans' homes across the state with the capacity to serve 1,526 total residents and employs more than 2,000 clinical and professional staff. The proposed increase in RNs and LPNs, as proposed by the Department in section 211.12(f.1)(5) will require DMVA to employ an additional 166 RNs and 83 LPNs. The average cost to DMVA for an RN is $136,031.24 and for an LPN is $103,720.67. This estimate includes wages and benefits. The total cost to DMVA to add 166 RNs will be $22,581,185.84 and to add 83 LPNs will be $8,608,815.61, for a total cost of $31,189,918.45. DMVA will need to hire an additional 43 nurse aides in addition to the 166 RNs and 83 LPNs to meet the Department's proposal in the first proposed rulemaking to require, in section 211.12(i), 4.1 direct care resident hours, per day. The average cost to DMVA for a nurse aide, including wages and benefits, is $75.871.34 for a total cost of $3,262,467.62. The total cost to DMVA under the proposed amendments to meet the requirements of both section 211.12(f.1)(5) and 211.12(i) will be $34,452,469.07. Based on the number of eligible MA residents, about 35% of the total cost, an estimated $12 million, will be covered by the MA program; therefore, the Federal MA Program rate, estimated to be 52%, will apply to these costs, for an estimated $6.2 million. Applying the Federal share of approximately $6.2 million to the total costs of approximately $34 million needed to staff up to the 4.1 ratio results in an estimated increase of approximately $28 million in state funding ($5.8 million state fund for the MA program and $22.2 million DMVA share non-MA eligible residents).

All six veterans' homes currently employ a licensed social worker on a full-time basis. Thus, there will be no financial impact to DMVA by the Department's proposal in section 211.16 (relating to social services) to require that a facility employ a qualified social worker on a full-time basis.

Public
The Department anticipates no financial or economic impact on the public as a result of the proposed regulations.

Residents of Long-Term Care Nursing Facilities
The Department is not able to determine the extent to which residents may be financially impacted by the proposed regulations. Various insurance options cover the costs residents pay for long-term nursing care, including Original Medicare, Medicare Supplement Insurance (Medigap), a Medicare Advantage Plan, long-term care insurance, MA, and out-of-pocket.

Most people with Medicare get their health care through Original Medicare, which is managed by the Federal government. For residents of long-term care nursing facilities, only short-term stays of up to 100 days are covered by Original Medicare. Original Medicare does not cover all services provided by a long-term care nursing facility. Original Medicare does not cover custodial care, such as assistance with getting in and out of bed, eating, bathing, dressing, and using the bathroom, if that is the only kind of care that is needed. Centers for Medicare & Medicaid Services. (2019). Medicare Coverage of Skilled Nursing Facility Care. Retrieved from https://www.medicare.gov/Pubs/pdf/10153-Medicare-Skilled-Nursing-Facility-Care.pdf.

Original Medicare will cover long-term nursing care if the resident has Medicare Part A, has had a qualifying hospital stay of 3 consecutive days or more and enters the facility within 30 days of leaving the hospital, the resident needs inpatient services which require the skill of professional personnel, and the resident needs skilled care on a daily basis and the services can only be given in a facility. Original Medicare pays the full cost of the first 20 days of a long-term care nursing facility stay. For days 21-100, Original Medicare pays all but a daily coinsurance, which is the resident's responsibility. In 2019, the coinsurance was up to $170.50 per day. For days beyond 100, Original Medicare pays nothing, and the resident is responsible for the full cost of covered services. *Id.*

Covered services and costs in a long-term care nursing facility may be different if the resident has Medigap, a Medicare Advantage Plan, MA, or long-term care insurance. Covered services and costs vary under these types of plans depending on the type of plan the resident has. *Id.* MA is managed by the state and provides benefits for residents with limited income and resources. Any costs not covered by the above resources would result in an out-of-pocket cost to the resident. Medicare.gov. How Can I Pay for Nursing Home Care? https://www.medicare.gov/what-medicare-covers/what-part-a-covers/how-can-i-pay-for-nursing-home-care.

Because the circumstances of each resident are unique with respect to the types of coverage they may have as well as to their length of stay and needs while in the facility, the Department is not able to estimate to what extent costs of a long-term care nursing stay, including costs for professional nursing staff, may be offset by Original Medicare, Medigap, a Medicare Advantage Plan, MA, or long-term care insurance. The Department is also not able to estimate how much a resident may pay out-of-pocket for such care, based on these variables.

Social Impact and Benefits

General Public and Residents of Long-Term Care Nursing Facilities
More than 72,000 individuals reside in the 689 long-term care nursing facilities licensed by the Department and will be affected by the proposed regulations. These residents, and their family members, will benefit from the proposed 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 Medical Assistance. 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 proposed increase in direct care hours provided by RNs and LPNs.

The Department anticipates little to no social impact on the other entities identified in this question.

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

The proposed amendments will apply to all 689 long-term care nursing facilities licensed by the Department. These facilities provide health services to more than 72,000 residents. The Department anticipates little to no costs for these facilities as a result of the proposed elimination of sections that are duplicative of the Federal requirements. All but three of the 689 long-term care nursing facilities participate in either Medicare or MA and thus, are required already to comply with existing Federal requirements. The three long-term care nursing facilities that do not participate in Medicare or MA may incur costs if they do not already meet the minimum standards within the Federal requirements. However, any costs to these three facilities are outweighed by the need for consistency in the application of standards to all long-term care nursing facilities, regardless of whether they participate in Medicare or MA.

The proposal in section 211.12(f.1)(5) to increase the minimum number of RNs and LPNs will result in costs to long-term care nursing facilities and the MA program. 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 level care for 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 proposing a higher rate of nurse aides 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 proposing higher staffing ratios for RNs and LPNs during the day 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 proposing a slightly lower ratio of nursing services personnel in the evening. Many of the activities listed above take place during the evening, but to a lesser extent. The Department is proposing to require one RN instead of an LPN during the night shift because there should always be an RN on duty to provide care to residents.

In proposed section 211.16, the Department is proposing to require a full-time social worker in all facilities, regardless of size. While there will be a cost to some facilities as a result of this proposal, the Department feels that this cost is strongly outweighed by the benefits of having a full-time social worker on staff. 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.

(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.

Proposed elimination of sections that are duplicative of Federal requirements
The Department anticipates little to no costs to the 689 licensed long-term care nursing facilities as a result of the proposed elimination of sections that are duplicative of the Federal requirements. All but three of the 689 long-term care nursing facilities participate in either Medicare or MA and thus, are required to comply with existing Federal requirements. The three long-term care nursing facilities that do not participate in Medicare or MA may be impacted if they do not already meet the minimum standards within the Federal requirements. However, any financial impact to the three facilities that do not participate in Medicare or MA is outweighed by the need for consistency in the application of standards to all long-term care nursing facilities, regardless of whether the facilities participate in Medicare or MA.

Cost of proposal to add qualified social worker.
Some long-term care nursing facilities will be affected by the Department's proposal, in section 211.16, to require all facilities to employ a full-time qualified social worker. Currently, a full-time social worker is only required for facilities with more than 120 beds. To estimate how many facilities will be impacted, the Department pulled data from the most recent, available annual report, for fiscal year 2019-2020. 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 annual report is obtained through an annual survey of facilities. The data therefore is dependent on self-reporting from the facilities who complete the survey. Based on a review of the report, the Department estimates that the proposal in section 211.16 will impact 91 privately-owned facilities.[12] Out of these 91 facilities, ten indicated that they only have a part-time social worker, and the remaining 81 reported that they do not have either a full-time or part-time social worker. Of the 81 facilities that reported they do not have either a full-time or part-time social worker, 70 participate in MA, 10 participate only in Medicare, and one is private pay only. Of the ten facilities that have only a part-time social worker, nine participate in MA and one is private pay only.

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%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 estimates, based on the above, that the annual cost to employ one full-time social worker, in the private sector, in the first year, will be approximately $73,216 on average, including wages and benefits. Assuming that the data provided to the Department in the 2019-2020 annual report remains unchanged, the Department estimates that the total cost to the 70 privately-owned MA facilities,

[12] DMVA indicated to the Department that the six veterans' homes that it operates will not be affected by the Department's proposal in section 211.16. In addition, out of the 20 county-owned facilities, nineteen 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 2019-2020 annual report. If this continues to be the case, there will be no impact to this facility.

with 120 beds or less, that do not employ either a full-time or part-time social worker, will be approximately $5,125,120, in the first year. According to data obtained from DHS, approximately 73%, or $3,741,338, 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 $1,945,496 and a state general fund investment of $1,795,842.

The total estimated cost to the 10 Medicare-only facilities that do not employ either a full-time or part-time social worker is $73,216. The total estimated cost to the one private pay facility that does not employ either a full-time or part-time social worker is $73,216. The Department estimates a 5% increase in wages and benefits for each year thereafter.

The Department estimates that it will cost facilities with 120 beds or less $36,608 each to staff up from a part-time social worker to a full-time social worker. This assumes that the part-time social workers, currently employed, are earning half the salary of a full-time social worker. The total cost to the nine MA facilities is estimated to be $329,472. According to data obtained from DHS, approximately 73%, or $240,515, of the cost to the nine 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 $125,068 and a state general fund investment of $115,447. The total estimated cost to the one private pay facility that needs to staff up from a part-time social worker to a full-time social worker is $36,608. The Department estimates a 5% increase in wages and benefits for each year thereafter.

Cost to meet proposed nursing staff ratio.
Of the 689 facilities licensed by the Department, 620 facilities participate in MA. Six of these are operated by DMVA, 20 are county-owned, and the remaining 594 are privately-owned. The Department consulted with DMVA to determine the impact of the proposed increase to the nursing staff ratio in section 211.12(f.1)(5) as well as the proposed increase in the number of direct care nursing hours to 4.1 as proposed in the Department's first proposed rulemaking. The proposed increase in RNs and LPNs, as proposed by the Department in section 211.12(f.1)(5) will require DMVA to employ an additional 166 RNs and 83 LPNs. The average cost to DMVA for an RN is $136,031.24 and for an LPN is $103,720.67. This estimate includes wages and benefits. The total cost to DMVA to add 166 RNs will be $22,581,185.84 and to add 83 LPNs will be $8,608,815.61, for a total cost of $31,189,918.45. DMVA will need to hire an additional 43 nurse aides in addition to the 166 RNs and 83 LPNs to meet the Department's proposal in the first proposed rulemaking to require, in section 211.12(i), 4.1 direct care resident hours, per day. The average cost to DMVA for a nurse aide, including wages and benefits, is $75.871.34 for a total cost of $3,262,467.62. The total cost to DMVA under the proposed amendments to meet the requirements of both section 211.12(f.1)(5) and 211.12(i) will be $34,452,469.07. Based on the number of eligible MA residents, about 35% of the total cost, an estimated $12 million, will be covered by the MA program; therefore, the Federal MA Program rate, estimated to be 52%, will apply to these costs, for an estimated $6.2 million. Applying the Federal share of approximately $6.2 million to the total costs of approximately $34 million needed to staff up to the 4.1 ratio results in an estimated increase of approximately $28 million in state funding ($5.8 million state fund for the MA program and $22.2 million DMVA share non-MA eligible residents).

The Department consulted with DHS to determine the impact of the proposed increase in section 211.12(f.1)(5) to the 20 county-owned facilities and the 594 privately-owned facilities, that are not operated by DMVA. The proposed increase in RNs and LPNs, as proposed by the Department in

section 211.12(f.1)(5), will require the 20 county-owned facilities that participate in MA[13] to employ an additional estimated 184 Full Time Equivalent (FTE) RNs but no LPNs. The average cost for an RN is projected to average $127,072, which is an increase of 28% from the average current cost report data. 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%). The 75th percentile wage was used as a proxy for expected wages in 2023 with increased demand from the 4.1 requirement along with trends in the labor market for RNs, LPNs and nurse aides and unchecked pressures on agency use and pricing. The total cost to county-owned facilities that participate in MA, to add 184 RNs at the increased salary assumption is estimated to be $23,381,248. The affected county-owned facilities will also need to hire an estimated 539 FTE nurse aides in addition to the 184 RNs in order to meet the Department's proposal in the first rulemaking to require, in section 211.12(i), 4.1 direct resident care hours, per day. The average cost for a nurse aide, including wages and benefits, is projected to increase to $56,477 which is an increase of 23%, from the average salary paid as reported by facilities in the current cost report data reported to DHS. The cost to hire an additional 539 FTE nurse aides is projected to be $30,441,103. The total cost to meet the requirements of both section 211.12(f.1)(5) and 211.12(i) therefore will be $53,822,351. According to data obtained from DHS, approximately 84.51%, or $45,485,269, of this cost will be covered by the MA program. The Federal MA Program rate, estimated to be 52%, will apply to MA payments made to fund these costs, for an estimated Federal match of $23,652,340 and a state general fund investment of $21,832,929.

The proposed increase in RNs and LPNs, as proposed by the Department in section 211.12(f.1)(5), is projected to require the 594 privately-owned facilities that participate in MA[14] to employ an additional 2,374 FTE RNs and 26 FTE LPNs. The average cost for an RN is projected at $127,072, which is an increase of 28% from the average current cost report data for privately owned facilities that participate in MA. The average cost for an LPN is projected at $67,395 which is an increase of 4% from the average current cost report data. This estimate of increased costs includes wages and benefits determined using the assumptions and data described in the county facility cost explanation. The total cost to facilities to add an estimated 2,374 FTE RNs is estimated to be $301,540,749. The total cost to facilities to add 26 FTE LPNs is estimated to be $1,752,277. The affected privately-owned facilities will also need to hire an estimated 5,988 FTE nurse aides in addition to the estimated 2,374 FTE RNs and estimated 26 FTE LPNs in order to meet the Department's proposal in the first rulemaking to require, in section 211.12(i), 4.1 direct resident care hours, per day. The average nurse aide salary is projected at $56,477 which is a 23% increase from the average current cost report data. The total estimated cost to add 5,988 FTE NAs is $338,128,429. The total increased cost to meet the requirements of both section 211.12(f.1)(5) and 211.12(i) therefore will be $641,421,455. According to data obtained from DHS, approximately 75.82%, or $486,325,747, 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 $252,889,388 and a state general fund investment of $233,436,359.

There are 62 facilities that participate only in Medicare. The proposed increase in RNs and LPNs, as proposed by the Department in section 211.12(f.1)(5), will require these 62 facilities, to employ an additional 258 FTE RNs and 3 FTE LPNs. This estimate is based on data obtained from the Department's 2019-2020 annual report. The average projected annual cost for an RN is $127,072 and

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

the average projected annual cost for an LPN is $67,395. This estimate includes wages and benefits. The total cost to facilities to add approximately 258 FTE RNs, based on the same cost assumptions provided by DHS, will be approximately $32,784,576. The total cost to add 3 FTE LPNs will be approximately $202,186. The affected Medicare facilities will also need to hire 659 nurse aides in addition to the 258 RNs and 3 LPNs in order to meet the Department's proposal in the first rulemaking to require, in section 211.12(i), 4.1 direct resident care hours per day. The average cost for a nurse aide, including wages and benefits, is $56,477. The total cost to add 659 nurse aides is approximately $37,218,412. The total cost for Medicare facilities to meet the requirements of both sections 211.12(f.1)(5) and 211.12(i) therefore will be $70,205,174. 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.

There are three private-pay facilities that do not participate in either Medicare or MA. The proposed increase in RNs and LPNs, as proposed by the Department in section 211.12(f.1)(5), will require the 3 privately-owned facilities, to employ an additional 3 FTE RNs, but no LPNs. This estimate is based on data obtained from the Department's 2019-2020 annual report. The average projected annual cost for an RN is $127,072. This estimate includes wages and benefits. The total cost to facilities to add 3 RNs is estimated to be $381,216. The affected facilities will also need to hire 8 nurse aides in addition to the 3 RNs in order to meet the Department's proposal in the first rulemaking to require, in section 211.12(i), 4.1 direct resident care hours, per day. The average cost for a nurse aide, including wages and benefits, is $56,477. The total cost to meet the requirements of both section 211.12(f.1)(5) and 211.12(i) therefore will be $833,031.

The Department's proposal in section 211.12(f.1)(4) to require one nurse aide per ten residents during the day, one nurse aide per ten residents during the evening and one nurse aide per fifteen residents overnight will not result in any costs beyond those already delineated above.

(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 20 county-owned long-term care nursing facilities which account for approximately 8 percent (8,706 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 16 counties: Berks, Bradford, Bucks, Chester, Clinton, Crawford, Cumberland, Delaware, Erie, Indiana, Lehigh, Monroe, Northampton, Philadelphia, Warren, and Westmoreland. All of the county-owned long-term care nursing facilities participate in either Medicare or MA. Because these facilities are already required to comply with Federal requirements, they will not incur a cost as a result of the Department's proposed elimination of sections that are duplicative of the Federal requirements.

There will be no cost to the county-owned long-term care nursing facilities as a result of the Department's proposal in section 211.16. Currently, a full-time social worker is only required for facilities with more than 120 beds. Out of the 20 county-owned facilities, nineteen 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 2019-2020 annual report. If this continues to be the case, there will be no impact to this facility.

The Department consulted with DHS to determine the impact of the proposed increase in section 211.12(f.1)(5) to the 20 county-owned facilities. The proposed increase in RNs and LPNs, as proposed by the Department in section 211.12(f.1)(5), will require the 20 county-owned facilities that participate in MA to employ an additional estimated 184 Full Time Equivalent (FTE) RNs but no LPNs. The average cost for an RN is projected to average $127,072, which is an increase of 28% from the average current cost report data. 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%). The 75th percentile wage was used as a proxy for expected wages in 2023 with increased demand from the 4.1 requirement along with trends in the labor market for RNs, LPNs and nurse aides and unchecked pressures on agency use and pricing. The total cost to county-owned facilities that participate in MA, to add 184 RNs at the increased salary assumption is estimated to be $23,381,248. The affected county-owned facilities will also need to hire an estimated 539 FTE nurse aides in addition to the 184 RNs in order to meet the Department's proposal in the first rulemaking to require, in section 211.12(i), 4.1 direct resident care hours, per day. The average cost for a nurse aide, including wages and benefits, is projected to increase to $56,477 which is an increase of 23%, from the average salary paid as reported by facilities in the current cost report data reported to DHS. The cost to hire an additional 539 FTE nurse aides is projected to be $30,441,103. The total cost to meet the requirements of both section 211.12(f.1)(5) and 211.12(i) therefore will be $53,822,351. According to data obtained from DHS, approximately 84.51% or $45,485,269 of this cost will be covered by the MA program. The Federal MA Program rate, estimated to be 52%, will apply to MA payments made to fund these costs, for an estimated Federal match of $23,652,340 and a state general fund investment of $21,832,929.

The Department's proposal in section 211.12211.12(f.1)(4) to require one nurse aide per ten residents during the day, one nurse aide per ten residents during the evening and one nurse aide per fifteen residents overnight will not result in any costs beyond those already described above.

(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.

Department

The Department licenses long-term care nursing facilities, and thus, will be impacted by the proposed regulations. 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 proposed changes elimination of sections that are duplicative of the Federal requirements will streamline the survey process for long-term care nursing facilities. This, in turn, will create consistency and eliminate confusion in the application of the standards that apply to long-term care nursing facilities.

DHS

Cost to meet proposed nursing staff ratio.

The Department consulted with DHS to determine the impact of the proposed increase in section 211.12(f.1)(5) to the 20 county-owned facilities and the 594 privately-owned facilities, that are not operated by DMVA, and to determine the impact to the MA program. The proposed increase in RNs and LPNs, as proposed by the Department in section 211.12(f.1)(5), will require the 20 county-owned facilities that participate in MA[15] to employ an additional estimated 184 Full Time Equivalent (FTE)

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

RNs but no LPNs. The average cost for an RN is projected to average $127,072, which is an increase of 28% from the average current cost report data. 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%). The 75th percentile wage was used as a proxy for expected wages in 2023 with increased demand from the 4.1 requirement along with trends in the labor market for RNs, LPNs and nurse aides and unchecked pressures on agency use and pricing. The total cost to county-owned facilities that participate in MA to add 184 RNs at the increased salary assumption is estimated to be $23,381,248. The affected county-owned facilities will also need to hire an estimated 539 FTE nurse aides in addition to the 184 RNs in order to meet the Department's proposal in the first rulemaking to require, in section 211.12(i), 4.1 direct resident care hours, per day. The average cost for a nurse aide, including wages and benefits, is projected to increase to $56,477 which is an increase of 23%, from the average salary paid as reported by facilities in the current cost report data reported to DHS. The cost to hire an additional 539 FTE nurse aides is projected to be $30,441,103. The total cost to meet the requirements of both section 211.12(f.1)(5) and 211.12(i) therefore will be $53,822,351. According to data obtained from DHS, approximately 84.51%, or $45,485,269, of this cost will be covered by the MA program. The Federal MA Program rate, estimated to be 52%, will apply to MA payments made to fund these costs, for an estimated Federal match of $23,652,340 and a state general fund investment of $21,832,929.

The proposed increase in RNs and LPNs, as proposed by the Department in section 211.12(f.1)(5), is projected to require the 594 privately-owned facilities that participate in MA[16] to employ an additional 2,374 FTE RNs and 26 FTE LPNs. The average cost for an RN is projected at $127,072, which is an increase of 28% from the average current cost report data for privately owned facilities that participate in MA. The average cost for an LPN is projected at $67,395, which is an increase of 4% from the average current cost report data. This estimate of increased costs includes wages and benefits determined using the assumptions and data described in the county facility cost explanation. The total cost to facilities to add an estimated 2,374 FTE RNs is estimated to be $301,540,749. The total cost to facilities to add 26 FTE LPNs is estimated to be $1,752,277. The affected privately-owned facilities will also need to hire an estimated 5,988 FTE nurse aides in addition to the estimated 2,374 FTE RNs and estimated 26 FTE LPNs in order to meet the Department's proposal in the first rulemaking to require, in section 211.12(i), 4.1 direct resident care hours, per day. The average nurse aide salary is projected at $56,477, which is a 23% increase from the average current cost report data. The total estimated cost to add 5,988 FTE NAs is $338,128,429. The total increased cost to meet the requirements of both section 211.12(f.1)(5) and 211.12(i) therefore will be $641,421,455. According to data obtained from DHS, approximately 75.82%, or $486, 325,747, 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 $252,889,388 and a state general fund investment of $233,436,359.

The Department's proposal in section 211.12(f.1)(4) to require one nurse aide per ten residents during the day, one nurse aide per ten residents during the evening and one nurse aide per fifteen residents overnight will not result in any costs beyond those already delineated above.

Cost of proposal to add qualified social worker.
As noted previously, the Department estimates that the annual cost to employ one full-time social worker, in the private sector, in the first year, will be approximately $73,216 on average, including

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

wages and benefits. Assuming that the data provided to the Department in the 2019-2020 annual report remains unchanged, the Department estimates that the total cost to the 70 privately-owned MA facilities, with 120 beds or less, that do not employ either a full-time or part-time social worker, will be approximately $5,125,120, in the first year. According to data obtained from DHS, approximately 73%, or $3,741,338, 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 $1,945,496 and a state general fund investment of $1,795,842. The Department estimates a 5% increase in wages and benefits for each year thereafter.

The Department estimates that it will cost facilities, with 120 beds or less, $36,608 each to staff up from a part-time social worker to a full-time social worker. This assumes that the part-time social workers, currently employed, are earning half the salary of a full-time social worker. The total cost to the nine MA facilities is estimated to be $329,472. According to data obtained from DHS, approximately 73%, or $240,515, of the cost to the nine 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 $125,068 and a state general fund investment of $115,447. The Department estimates a 5% increase in wages and benefits for each year thereafter.

DMVA
DMVA operates six veterans' homes across the state with the capacity to serve 1,526 total residents and employs more than 2,000 clinical and professional staff. The proposed increase in RNs and LPNs, as proposed by the Department in section 211.12(f.1)(5) will require DMVA to employ an additional 166 RNs and 83 LPNs. The average cost to DMVA for an RN is $136,031.24 and for an LPN is $103,720.67. This estimate includes wages and benefits. The total cost to DMVA to add 166 RNs will be $22,581,185.84 and to add 83 LPNs will be $8,608,815.61, for a total cost of $31,189,918.45. DMVA will need to hire an additional 43 nurse aides in addition to the 166 RNs and 83 LPNs to meet the Department's proposal in the first proposed rulemaking to require, in section 211.12(i), 4.1 direct care resident hours, per day. The average cost to DMVA for a nurse aide, including wages and benefits, is $75.871.34 for a total cost of $3,262,467.62. The total cost to DMVA under the proposed amendments to meet the requirements of both section 211.12(f.1)(5) and 211.12(i) will be $34,452,469.07. Based on the number of eligible MA residents, about 35% of the total cost, an estimated $12 million, will be covered by the MA program; therefore, the Federal MA Program rate, estimated to be 52%, will apply to these costs, for an estimated $6.2 million. Applying the Federal share of approximately $6.2 million to the total costs of approximately $34 million needed to staff up to the 4.1 ratio results in an estimated increase of approximately $28 million in state funding ($5.8 million state funds for the MA program and $22.2 million DMVA share non-MA eligible residents).

All six veterans' homes currently employ a licensed social worker on a full-time basis. Thus, there will be no cost to DMVA by the Department's proposal in section 211.16 (relating to social services) to require that a facility employ a qualified social worker on a full-time basis.

(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.

The Department's proposed amendment to section 201.19 will require a facility to maintain certain employee personnel records, as proposed in paragraphs (1) through (9). Proposed paragraphs (1)

through (7) are currently in the Department's interpretive guidelines for section 201.19. Facilities, therefore, are already maintaining this information. Proposed paragraph (8), which requires a criminal background check, is already required by OAPSA. Proposed paragraph (9) will be a new paperwork requirement. Proposed paragraph (9) will require a facility, in the event that an employee has a conviction, to include in the employee's personnel record a determination of suitability for employment in the position to which the employee is assigned. The Department is not proposing any particular format for this determination and does not believe this requirement will be overburdensome to facilities. Indeed, a facility should benefit from having all of the information proposed in paragraphs (1) through (9) in the event that a question arises regarding an employee at the facility.

The Department's proposed amendment to section 201.24(e) will require 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 is proposing that 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 with the proposed amendment.

The Department's proposed amendment to section 211.5(e) (relating to medical records) will require a long-term care nursing facility to provide to the Department, within 30 days of closure, 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 proposed addition of section 211.9(j.1) will require a facility to have written policies and procedures for the disposition of medications. The Department proposes that these policies and procedures align with Federal guidance found in *Appendix PP* and address the following: (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 State and Federal requirements, local ordinances and standards of practice. This should not impose any burden on those facilities that participate in Medicare or Medical Assistance as they are already following this guidance. In addition, existing sections 211.9(i) and (j) already requires all facilities licensed by the Department, including those that do not participate in Medicare or Medical Assistance, to have policies in place regarding the disposition of medications that are similar to those being proposed in section 211.9(j.1). Therefore, only a minor update to existing policies and procedures should be required for the three facilities that do not participate in Medicare or Medical Assistance.

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

There are no new forms required for implementation of this proposed rulemaking.

(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 2021-2022	FY +1 Year 2022-2023[17]	FY +2 Year 2023-2024	FY +3 Year 2024-2025	FY +4 Year 2025-2026	FY +5 Year 2026-2027
SAVINGS:	**$**	**$**	**$**	**$**	**$**	**$**
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: [18]						
Regulated Community[19]	0	$68,800,312	$137,600,623	$144,480,654	$151,704,687	$159,289,922
Local Government[20]	0	$1,810,878	$3,621,755	$3,802,843	$3,992,985	$4,192,634
State Government[21]	0	$73,644,225	$147,288,450	$154,652,872	$162,385,516	$170,504,792
Total Costs[22]	0	$129,687,860	$259,375,720	$272,344,506	$285,961,731	$300,259,818

[17] The Department estimates that the costs for fiscal year 2022-2023 will be half of the full year costs for fiscal year 2023-2024. The Department plans to publish the regulations in final form by the end of calendar year 2022. If the regulations go into effect on publication, then they will be effective for approximately half of fiscal year 2022-2023.

[18] The costs for this proposed rulemaking do not include the cost to hire additional nurse aides. The cost for nurse aides is included in the first proposed package of long-term care nursing facility regulations (number 10-221), which includes the proposed increase to 4.1 hours of direct care per resident per day.

[19] The cost to the regulated community includes the costs to all facility types to hire social workers, RNs and LPNs ($396,975,306), minus the portion of those costs the Department estimates will be covered by Medicaid and, in the case of DMVA, by the Federal portion of the MA program ($259,374,683).

[20] The cost to local government includes the costs to county-owned facilities to hire social workers, RNs and LPNs ($23,381,248), minus the portion of those costs the Department estimates will be covered by Medicaid ($19,759,493).

[21] The cost to state government includes the costs to DMVA facilities to hire social workers, RNs and LPNs ($31,189,918), minus the federal portion of those costs covered by the Federal MA program ($5,676,565), plus the state portion of the cost to the MA program for private and county-owned Medicaid facilities to hire social workers, RNs and LPNs ($121,775,097).

[22] 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,

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 2018-2019	FY -2 2019-2020	FY -1 2020-2021	Current FY 2021-2022
Quality Assurance (DOH)	$23,009,000.	$22,513,000.	$23,093,000.	$24,393,000.
DMVA (Veterans Homes)	$82,862,759.	$80,914,283.	$76,166,619.	$78,092,277.
DHS (MA/ Community Health Choices)	$693,766,000	$2,328,939,000	$3,166,060,000	$4,247,238,000

(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.

See answer to Question 15. The Department is unable to identify which long-term care nursing facilities may be small businesses. The proposed regulations will apply to all long-term care nursing facilities irrespective of whether they are considered a small business. The Department's responsibility to the health and welfare of all residents in long-term care nursing facilities is not altered by the fact that a long-term care nursing facility may be a small business.

(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 total cost is a sum of the cost to the regulated community ($137,600,623) plus the state portion of the costs to the Medicaid program ($121,775,097).

The Department's proposed amendment to section 201.19 (relating to personnel records) will require a facility to maintain certain employee personnel records, as proposed in paragraphs (1) through (9). Proposed paragraphs (1) through (7) are currently in the Department's interpretive guidelines for section 201.19. Facilities, therefore, are already maintaining this information. Proposed paragraph (8), which requires a criminal background check, is already required by OAPSA. Proposed paragraph (9) would be a new paperwork requirement. Proposed paragraph (9) will require a facility, in the event that an employee has a conviction, to include in the employee's personnel record a determination of suitability for employment in the position to which the employee is assigned. The Department is not proposing any particular format for this determination and does not believe this requirement will be overburdensome to facilities. Indeed, a facility should benefit from having all of the information proposed in paragraphs (1) through (9) in the event that a question arises regarding an employee at the facility.

The Department's proposed amendment to section 201.24(e) will require 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 is proposing that 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 with the proposed amendment.

The Department's proposed amendment to section 211.5(e) (relating to medical records) will require a long-term care nursing facility to provide to the Department, within 30 days of closure, 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 proposed addition of section 211.9(k) will require a facility to have written policies and procedures for the disposition of medications. The Department proposes that these policies and procedures align with Federal guidance found in *Appendix PP* and address the following: (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 State and Federal requirements, local ordinances and standards of practice. This should not impose any burden on those facilities that participate in Medicare or Medical Assistance as they are already following this guidance. In addition, existing sections 211.9(i) and (j) already requires all facilities licensed by the Department, including those that do not participate in Medicare or Medical Assistance, to have policies in place regarding the disposition of medications that are similar to those being proposed in section 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 Medical Assistance.

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

See answer to Question 15. The Department is unable to identify which long-term care nursing facilities may be small businesses. The proposed regulations will apply to all long-term care nursing facilities irrespective of whether they are considered a small business. The Department's responsibility to the health and welfare of all residents in long-term care nursing facilities is not altered by the fact that a long-term care nursing facility may be a small business.

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

The Department did not identify any less costly alternative that will be consistent with public health and safety.

(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 to meet the particular needs of any groups or persons. The proposed regulations will apply to all long-term care nursing facilities in the Commonwealth.

(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.

No alternative regulatory provisions were considered for this proposed rulemaking.

(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) Less stringent compliance or reporting requirements were not considered.
b) Less stringent schedules or deadlines for compliance or reporting were not considered.
c) Consolidation or simplification of compliance or reporting requirements were not considered.
d) The establishment of performance standards for small businesses were not considered.
e) The exemption of small business from all or any part of the proposed regulations were not considered.

The proposed regulations will apply to all long-term care nursing facilities regardless of whether those facilities are considered a small business. The Department's responsibility to the health and welfare of all long-term care nursing residents is not altered by the fact that a long-term care nursing facility may be a small business.

(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.

Fiscal impact information was obtained from DHS and DMVA to determine the impact to those agencies as discussed throughout the RAF.

The Department also relied on the following sources to determine fiscal impact to long-term care nursing facilities, as described throughout the RAF.

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

Center for Workforce Information & Analysis. (2021). Occupational Wages. Retrieved from: https://www.workstats.dli.pa.gov/Products/Occupational%20Wages/Pages/default.aspx.

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

A. The length of the public comment period:

30 days after 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. Notice of that meeting was published in the *Pennsylvania Bulletin* on December 21, 2019.

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

D. The expected effective date of the final-form regulation:

Upon publication of the final rulemaking in the *Pennsylvania Bulletin*. The Department intends to set the same effective date for all four rulemaking packages.

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

Upon publication of the final rulemaking in the *Pennsylvania Bulletin*.

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. These proposed amendments 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.

CDL-1

FACE SHEET
FOR FILING DOCUMENTS
WITH THE LEGISLATIVE REFERENCE BUREAU

(Pursuant to Commonwealth Documents Law)

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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: Amy M. Elliott (DEPUTY ATTORNEY GENERAL) Digitally signed by Amy M. Elliott DN: cn=Amy M. Elliott, o=Pennsylvania Office of Attorney General, ou=Chief Deputy Attorney General, email=aelliott@attorneygeneral.gov, c=US Date: 2022.05.10 08:52:27 -04'00'	DEPARTMENT OF HEALTH (AGENCY)	BY:
5/10/22 DATE OF APPROVAL	DOCUMENT/FISCAL NOTE NO. 10-224	April 4, 2022 DATE OF APPROVAL
☐ Check if applicable Copy not approved. Objections attached.	DATE OF ADOPTION: 3/11/2022	(Deputy General Counsel) (Chief Counsel, Independent Agency) (Strike inapplicable title)
	BY: Keara Klinepeter Keara Klinepeter	☐ 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 PROPOSED 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

LONG-TERM CARE NURSING FACILIITES

The Department of Health (Department), after consultation with the Health Policy Board, proposes to amend 28 Pa. Code §§ 201.18—201.21, 201.24—201.31, 207.2, 209.3, 211.2—211.17 to read as set forth in Annex A.

The Department initially decided to submit proposed amendments to Title 28, Part IV, Subpart C (relating to long-term care facilities) in five separate packages. The Department has since decided, in response to concerns raised during the public comment period for the previous packages, to reduce the number of proposed packages from five to four by combining what it intended to propose in its fourth and fifth packages. Therefore, this is the fourth, and last, set of amendments to be proposed to Title 28, Part IV, Subpart C.

The Department will begin drafting the corresponding four final-form rulemaking packages after the public has had the opportunity, through the separate public comment periods provided for in each package, to review and comment on all four proposed rulemaking packages. The Department is also planning to hold meetings with stakeholders after each public comment period has ended. The first of these meetings, to discuss proposed groups 1 and 2, took place on December 15, 2021. Additional meetings will be scheduled to discuss proposed groups 3 and 4 after the public comment period has ended for each of those groups. The Department intends to submit all four final-form regulatory packages to the House Health Committee, Senate Health and Human Services Committee, and the Independent Regulatory Review Commission (IRRC) together on the same day, so that all four final-form regulatory packages can be reviewed together as a whole.

The contents for this fourth, and last, proposed rulemaking are as follows:

Proposed Rulemaking 4

§ 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.

§ 201.26. Power of attorney.

§ 201.27. Advertisement of special services.

§ 201.29. Resident's rights.

§ 201.30. Access requirements.

§ 201.31. Transfer agreement.

§ 207.2. Administrator's responsibility.

§ 209.3. Smoking.

§ 211.2. Physician services.

§ 211.3. Oral and telephone orders.

§ 211.4. Procedure in event of death.

§ 211.5. Clinical 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.

§ 211.12. Nursing services.

§ 211.15. Dental services.

§ 211.16. Social services.

§ 211.17. Pet therapy.

The contents for previously submitted proposed rulemakings were as follows:

Proposed Rulemaking 1

§ 201.1. Applicability.

§ 201.2. Requirements.

§ 201.3. Definitions.

§ 211.12(i). Nursing Services.

Proposed Rulemaking 2

§ 201.23. Closure of facility.

Chapter 203. Application of Life Safety Code for Long-Term Care Nursing Facilities.

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

Chapter 205. Physical Environment and Equipment Standards for Long-Term Care Nursing Facilities.

§ 207.4. Ice containers and storage.

Proposed Rulemaking 3

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

§ 201.12a. Evaluation of application for license of a new facility or change in ownership. (new)

§ 201.12b. Opportunity for public comment.

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

§ 201.13a. License renewal.

§ 201.14. Responsibility of licensee.

§ 201.15. Restrictions on license.

§ 201.17. Location.

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

§ 209.1. Fire department service.

§ 209.7. Disaster preparedness.

§ 209.8. Fire drills.

§ 211.1. Reportable diseases.

I. Background and Need for Amendments

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%. Pennsylvania also has a higher percentage of older adults when compared to other states. In 2017, Pennsylvania 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 (aged 65 or older) for every 100-working age Pennsylvanians (15 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. 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 today has an almost 70% chance of needing some type of long-term nursing care during the remainder of their lifetime. 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. Currently, there are approximately 73,000 Pennsylvanians residing in 689 long-term care nursing facilities licensed by the Department.

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. This proposed rulemaking is necessary to improve the quality of care delivered to residents, increase resident safety and minimize procedural burdens on health care practitioners who provide care to residents in long-term care nursing facilities.

The Department began the process of updating the current long-term care 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 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. Upon completion of the LTC Work Group's discussions, the Department conducted an internal review of the recommended changes. While the Department accepted most of the language and substantive changes proposed by the LTC Work Group and attempted to incorporate them in this proposed rulemaking, the Department is proposing additional changes to language and additional substantive changes, as well.

During 2019 and 2020, the Department conferred with other agencies that would be potentially affected by the proposed regulatory changes, to seek their input on provisions within their substantive expertise. These agencies included the Department of Aging, DHS and DMVA. The Department received recommendations from these agencies regarding the draft proposed regulations and made additional changes to the proposed regulations to enhance resident safety and quality of care.

The Department in its first and second proposed rulemakings addressed inconsistencies between State and Federal requirements for long-term care nursing facilities licensed in this Commonwealth. In the first proposed rulemaking, the Department proposed to expand the adoption of the Federal requirements to include all of the requirements set forth in 42 CFR Part 483, Subpart B (relating to requirements for long-term care facilities). The purpose of that amendment was to create consistency in the application of State and Federal requirements to long-term care nursing facilities in the Commonwealth. In the second proposed rulemaking, the Department proposed to amend existing regulations pertaining to the closure of a long-term care

nursing facility to eliminate duplication between existing State requirements and Federal requirements. The Department also proposed in that rulemaking to update requirements for alterations, renovations, or construction of long-term care nursing facilities.

In the third proposed rulemaking, the Department shifted its focus to the requirements that a long-term care nursing facility must meet for licensure, as well as safety requirements and requirements for infection prevention and control. The amendments in that proposed rulemaking included: eliminating provisions that are duplicative of the Federal requirements and updating requirements for the application for licensure of new facilities and changes in ownership for existing facilities.

In this fourth, and last, proposed rulemaking, the Department proposes amendments to the remaining sections of regulations pertaining to long-term care nursing facilities. These proposed amendments include additional elimination of provisions that are duplicative and that conflict with the Federal requirements. Other proposed amendments include increasing the number of registered nurses (RNs), licensed practical nurses (LPNs) and nurse aides required under section 211.12 (relating to nursing services), adding a requirement that facilities have a full-time qualified social worker regardless of 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.

II. Description of Proposed Amendments

§ 201.18. Management.

Subsection (a).

The Department proposes to delete this subsection to eliminate duplication and avoid conflict with the Federal requirements for long-term care nursing facilities. Under 42 CFR

483.70(d) (relating to administration), 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.

Subsection (b).

The Department proposes to add 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 proposes to add 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).

Subsection (c).

The Department proposes to replace "provide the information required in § 201.12 (relating to application for license) and prompt reports of changes which would affect the accuracy of the information required" with "report to the Department within 30 days changes to the information that was submitted with the facility's application for licensure under § 201.12 (relating to application for license of a new facility or change in ownership)" to clarify the governing body's responsibility with respect to the information submitted under section 201.12. It is a prospective owner's responsibility to submit the information required under section 201.12 for the application for licensure, rather than the governing body. Once an application for licensure is approved, the governing body becomes responsible for reporting to the Department any changes to the information that was submitted with the application for licensure. The Department is proposing to require that changes be reported within 30 days to align with 28 Pa. Code § 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.

Subsection (d).

The Department proposes to delete the first sentence in subsection (d) to eliminate duplication and avoid conflict with the Federal requirements. Under 42 CFR 483.70(d)(1), a facility is required to have a governing body that is legally responsible for establishing and implementing policies regarding the management and operation of the facility. In the second sentence of subsection (d), the Department proposes to add a cross-reference to the requirement in 42 CFR 483.70(d)(1) for clarity. The Department also proposes to delete the phrase "shall be made available to the members of the governing body, which shall ensure that they are operational." This phrase is unnecessary and redundant given that the governing body is responsible for establishing and implementing policies for the management and operation of the facility, under the Federal requirements. In the third sentence, the Department proposes to replace the term "responsible persons" with the term "resident representatives." The term "responsible person" is an outdated term that is no longer used and has been replaced, throughout the regulations, 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.

Subsection (d.1)

This proposed subsection is new. The Department proposes to move the requirement from the first sentence of existing subsection (e) to this new subsection with some minor

changes. The Department proposes to replace 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 proposes to retain the requirement that the administrator be currently licensed and registered in this Commonwealth and that the administrator be employed full time. The Department is proposing to remove 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 proposes new language, in subsection (d.1), to permit a facility with 25 beds or less to share an administrator provided that the Department is informed of this arrangement, there is a plan in the event of an emergency when the administrator is not working, and there is a readily available method for residents to contact the administrator should they find it necessary. The existing language limiting the sharing of an administrator to two facilities is moved from subsection (e) to this subsection.

The Department has received multiple requests for exception under existing subsection (e), particularly from facilities that provide transitional care, have few residents, and a lot of resident turnover. In these cases, the facilities would like to share an administrator with other facilities within their network to save money. Permitting facilities with 25 beds or less to share an administrator addresses these concerns and will provide flexibility for those facilities that do not have a need for a full-time administrator. Adding the requirements in paragraphs (1) through (4), *i.e.*, requiring the Department to be informed, having a plan in the event of an emergency when the administrator is not working, having a readily available method of contacting the administrator, and requiring the director of nursing to have sufficient knowledge and experience to compensate for the time that the administrator is not in the facility, will ensure the health and safety of residents when a facility chooses to employ a part-time administrator.

Subsection (d.2)

This proposed subsection is new. The Department proposes to move the requirement in the fourth sentence of subsection (e) into this subsection with no substantive changes. The Department proposes to move this requirement to its own subsection for clarity and ease of readability.

Subsection (e)

As noted above, the Department proposes to delete the requirement in the first sentence of this subsection and move it to proposed subsection (d.1), with amendments. The Department proposes to delete the next two sentences. The ability of a facility to share an administrator is contemplated through the addition of the language in proposed subsection (d.1) which will permit facilities with 25 beds or less to have a part-time administrator if the requirements in subsection (d.1) (1) through (4) are met. As noted above, the Department also proposes to delete the requirement in the fourth sentence and move it into subsection (d.2).

The Department proposes to retain the last sentence in subsection (e), as well as paragraphs (1) through (7). The Department proposes to add a new paragraph (2.a). The Department proposes to move into paragraph (2.a) the existing language from section 207.2(a) (relating to administrator's responsibility), requiring an administrator to ensure satisfactory housekeeping and maintenance of the buildings and grounds. The Department is proposing this amendment so that the responsibilities of the administrator are all together in one place in the regulations. In paragraph (5), the Department proposes to replace the term "employe" with the term "employee" for correct usage and spelling of that term. The Department does not propose any amendments to paragraphs (1), (2), (3), (4), (6) or (7).

Subsection (f).

The Department proposes to remove 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. A facility's responsibility for resident funds is addressed in the Federal requirements at 42 CFR 483.10(f)(10) and (11) (relating to resident rights). The Department also proposes to replace the term "responsible person" with the term "resident representative" for consistency in the use of that term throughout the regulations.

Subsection (g).

The Department does not propose any amendments to this subsection.

Subsection (h).

The Department proposes to replace the term "resident's responsible person" with "resident representative" for consistency in the use of that term throughout the regulations. The Department proposes to delete the last sentence requiring a facility to provide residents with access to their money within three business days in the form requested, cash or check, by the resident. The Department proposes to replace this sentence with a requirement that a facility provide the resident with cash, if requested, within one day of the request, or with a check, if requested, within three days of the request. The proposed requirement that a facility provide a resident with cash, if requested, within one day is new. Based on discussions with the LTC Work Group, the Department believes that facilities typically have enough cash on hand, or have the ability to obtain cash quickly, and therefore, should be able to provide a resident with cash, if requested, within one day. The Department proposes no amendment to the existing requirement that a check be provided, if requested, within three days because specific personnel are often needed to process a check and these personnel may not be onsite every day.

§ 201.19. Personnel records.

The Department proposes to change the name of this section from "personnel policies and procedures" to "personnel records." This section requires a facility to maintain certain types of personnel records, not to create policies and procedures for personnel records. Therefore, the term "personnel records" more accurately describes the requirements of this section.

The Department also proposes to replace the term "employe" with the term "employee" to reflect the current usage and spelling of that term. The Department proposes to add the word "facility" before the word "employee" to clarify that this section applies to employees of the facility and not, for example, employees of another agency that the facility may utilize to provide care or services to residents. The Department proposes to replace the word "sufficient" with the words "the following" and to delete "to support placement in the position to which assigned" after the word "information." The Department proposes these amendments to accommodate the addition of several new proposed requirements in paragraphs (1) through (9) of this section.

The Department proposes in paragraphs (1) through (9) to require a facility to keep in its personnel records, for each facility employee: (1) the employee's job description, educational background and employment history; (2) employee performance evaluations; (3) documentation of 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 is free from communicable diseases or conditions listed at 28 Pa. Code § 27.155 (relating to restrictions on health care practitioners); (5) records of such pre-employment health examinations and of subsequent health services rendered to the facility's employees as are necessary to ensure that all employees are physical able to perform their duties; (6) documentation of the employee's orientation to the facility and the employee's position prior to or within one week of the employee's start date; (7) documentation of the employee's completion of required trainings; (8)

a criminal history record; and (9) in the event of a conviction, a determination of the employee's suitability for employment in the position to which the employee is assigned. Proposed paragraphs (1) through (4) and (6) through (7) are currently in the Department's interpretive guidelines for section 201.19. Facilities, therefore, are already maintaining this information. Nonetheless, the Department is proposing to include these guidelines in regulation to make it clear that facilities are expected to include these items in employee personnel records. Department of Health. Interpretive Guidelines. Retrieved from: https://www.health.pa.gov/topics/Documents/Laws%20and%20Regulations/interpretive_guidelines_for_state_regs.pdf.

Proposed paragraph (5) is an expansion of the Department's inclusion of "health status" that is currently in the above-referenced guidance. Because the use of the term "health status" is vague, the Department is proposing to clarify in regulation that a facility is required to maintain records of pre-employment health examinations and subsequent health services rendered to the facility's employees as are necessary to ensure that all employees are physically able to perform their duties. This requirement mirrors a requirement that exists for hospitals in 28 Pa. Code § 103.36 (relating to personnel records). For this requirement, the Department is not concerned with what specific conditions an employee may have but is only looking to see if the facility is maintaining this information. It is not the Department's intent to determine who can and cannot perform certain duties due to a medical or health condition. Rather, it is up to each individual facility to determine what to do with this information, *e.g.*, provide restrictions for the employee or limit contact with residents, depending on specific circumstances and in accordance with applicable laws. Requiring a facility to maintain the types of records identified in paragraphs (1)

through (7) will assist both the facility and the Department if a concern arises regarding an employee at the facility.

The Department is proposing to add paragraph (8) to align with the Older Adult Protective Services Act (OAPSA), which requires a criminal history background check for individuals applying for employment in a long-term care nursing facility. 35 P.S. § 10225.502. The Department is proposing to add paragraph (9) 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, but proposes to require that a facility document its determination, where an employee has a conviction, to demonstrate that the employee's background was considered should a concern arise regarding the employee's suitability for employment.

§ 201.20. Staff development.

Subsection (a).

The Department proposes to delete "training related to problems, needs and rights of the residents." The Department proposes to move the requirement that a facility provide, at a minimum, annual in-service training from subsection (c), to add a cross-reference to the Federal training requirements at 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 proposes to delete from subsection (c) those requirements that are duplicative of the Federal requirements in 42 CFR 483.95, and to move from subsection (c) those topics that are not

covered under 42 CFR 483.95. For additional clarity and ease of readability, the Department proposes to place these training topics into an enumerated list.

The topics proposed for deletion 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 proposes to retain, and move 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 proposes to retain these two training requirements to ensure the health and safety of residents. The Department also proposes to retain, and move 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 proposes to retain 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* (NFPA 101 *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 NFPA 101 *Life Safety Code*, all facility personnel are to be instructed in their role in the use of and response to fire alarms.

Subsection (b).

The Department proposes to replace the term "employe" with the term "employee" for current usage and spelling of that term. The Department proposes to delete the second sentence

of this subsection because training on the prevention of resident abuse and reporting of abuse is covered under the Federal requirements at 42 CFR 483.95(c).

Subsection (c).

The Department proposes to delete this subsection in light of the proposed amendments to subsection (a), as described above.

Subsection (d).

The Department proposes one minor, grammatical amendment to this subsection. The Department proposes to delete the word "the" between the words "at" and "staff development programs."

§ 201.21. Use of outside resources.

Subsections (a).

The Department proposes to delete 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 such a facility.

Subsection (b).

The Department proposes to delete 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.

Subsection (c).

The Department proposes to delete this subsection to eliminate duplication and avoid conflict with the Federal requirements. Under 42 CFR 483.70(g)(2), the arrangement or agreement for outside services must be in writing.

Subsection (d).

The Department proposes to delete subsection (d) and replace it with a new subsection (e), described below.

Subsection (e).

Proposed subsection (e) is new and will replace the requirement in existing subsection (d) regarding outside resources that supply temporary employees to a facility. The Department proposes to require in this new subsection that 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 at 28 Pa. Code § 27.155 and that the employees are physically able to perform their assigned duties. The Department is proposing this amendment to ensure that employees obtained from outside resources, such as agency staff, are able to care for residents. As with proposed sections 201.19(4) and 201.19(5), 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 employees being provided are able to work with residents. It would be up to the outside agency to comply with applicable laws pertaining to the sharing of personal information.

§ 201.24. Admission policy.

Subsection (a).

The Department proposes to delete this subsection to eliminate duplication and to avoid conflict with the Federal requirements. As discussed previously, the term "responsible person"

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 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. The ability of a resident representative to exercise the rights of a resident are addressed in 42 CFR 483.10(b). Under 42 CFR 483.10(b), 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.

Subsection (b).

The Department proposes to delete this subsection to eliminate duplication and avoid conflict with the Federal requirements. Under 42 CFR 483.15(a)(2)(i) (relating to admission, transfer, and discharge rights), a facility must not request or require residents or potential residents from waiving their rights under the Federal requirements, or applicable State, Federal or local licensing or certification laws. Under 42 CFR 483.15(a)(2)(iii), a facility must not request or require residents or potential residents to waive facility liability for losses of personal property.

Subsection (c) and (d).

The Department does not propose any amendments to subsections (c) or (d).

Subsection (e).

This proposed subsection is new and goes above and beyond 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, to develop

and adhere to procedures implementing those policies. The Department proposes to require a facility to include the following in its policies and procedures: (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; (2) orientation of the resident to the facility and location of essential services and key personnel to include the dining room, nurses' workstations, and offices for the social worker and grievance or compliance officer; (3) a description of facility routines to include 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); and (5) assistance to the resident, if needed, in creating a homelike environment and settling personal possessions in the room to which the resident has been assigned. The Department, under the act, has the authority to promulgate rules and regulations necessary to carry out the purposes and provisions of the act. 35 P.S. § 448.803. One of the stated purposes of the act is to assure that citizens receive humane, courteous, and dignified treatment. 35 P.S. § 448.102. 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.

Subsection (f).

This proposed subsection is new and will require that 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. The Department proposes to permit another individual, identified by the governing body, to stand in the shoes of the facility's social worker to perform these tasks as the social worker may not always be available at the time of a resident's admission. The Department also proposes to require that the coordination of introductions, orientation and discussions occur within two 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.

§ 201.25. Discharge policy.

The Department proposes to delete 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 requirements of these plans include, among other things, ensuring that the discharge needs of the resident are identified and arrangements for the resident's care following discharge.

§ 201.26. Resident representative.

The Department proposes to replace the words "power of attorney" in the title and body of this section. 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 proposes to remove the slash mark and replace it with a comma to make owner and operator two words for stylistic reasons. The Department proposes to replace the word "employe" with "employee" for current usage and spelling of that term. The Department proposes another grammatical change by replacing the word "having" with the word "with" for ease of readability. The Department also proposes to add to the end of this subsection an

exception for family members of residents who are employed in the facility. The Department proposes to allow family members who are employed in the facility to serve as resident representatives, so long as there is no conflict of interest. This amendment was proposed by the LTC Work Group, and the Department agrees that a resident should have the best person acting on their behalf, regardless of that person's employment within the facility. The addition of "so long as there is no conflict of interest" is proposed to ensure that residents are protected from possible financial exploitation from having a family member employee serve as their resident representative.

§ 201.29. Resident's rights.

Subsection (a).

The Department proposes to add a sentence requiring 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 proposes this requirement as part of its efforts to promote more resident-centered environments in long-term care nursing facilities. The residents of a facility live there and are subject to the policies and procedures of the facility. Therefore, they should be allowed to have some say in how the facility operates. Including residents in the development and implementation of policies and procedures regarding resident rights will provide residents with this ability.

Subsections (b) and (c).

The Department proposes no amendments to subsections (b) and (c).

Subsection (d).

The Department proposes to delete this subsection to eliminate duplication and avoid conflict with the Federal requirements. Under 42 CFR 483.95(b), 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 set forth in 42 CFR 483.10.

Subsection (e).

The Department proposes to delete this subsection to eliminate duplication and avoid conflict with the Federal requirements. Under 42 CFR 483.10(g)(18), a facility is required to inform a 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, including charges for services not covered by Medicare or Medical Assistance, or by the per diem rate of the facility. A facility is also required under 42 CFR 483.10(g)(18)(i) and (ii), to provide notice when changes in coverage are made to items and services covered by Medicare or Medical Assistance, and at least 60 days prior to the implementation of changes to charges for other items and services offered by the facility. The 60-day notice under the Federal requirements is more stringent and thus, is more protective of residents than the language that currently exists in subsection (e). The return of security deposits is covered by 42 CFR 483.10(g)(18)(iii), which requires a facility to refund any deposit or charges already paid, less the facility per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge requirements. Facility requirements for the handling of resident funds are also addressed in 42 CFR 483.10(f)(10) and (11).

Subsection (f).

The Department proposes to delete 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. 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. 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. Although existing subsection (f) refers to the bed-hold policy in terms of discharge, and the Federal requirements refer to a bed-hold in the context of a transfer, the Department considers the term "discharge" to be synonymous with "transfer" in this context because conceptually, a bed-hold is only necessary in the case of a temporary absence. The last two sentences of subsection (f), pertaining to documentation, are addressed in 42 CFR 483.15(c)(2), which requires documentation of the transfer or discharge in the resident's medical

record and that appropriate information regarding the resident be communicated to the receiving health care institution or provider.

Subsection (g).

The Department proposes to delete the first sentence of this subsection to eliminate duplication and avoid conflict with the Federal requirements. The Federal requirements pertaining to the transfer and discharge of residents are in 42 CFR 483.15. Under 42 CFR 483.15(c)(7), a facility must provide and document preparation and orientation to residents to ensure a safe and orderly transfer or discharge from the facility. Under 42 CFR 483.15(c)(2), a facility is required to document the transfer or discharge in the resident's medical record and communicate appropriate information regarding the resident to the receiving health care institution or provider, including all necessary information to ensure a safe and effective transition of care. Where a transfer occurs because the facility cannot meet the needs of the resident, the facility must document its attempts to meet the resident needs and the service that is available at the receiving facility to meet the resident's needs. The Department proposes to retain the second sentence in this subsection, with minor amendments. Specifically, the Department proposes to replace the term "resident's responsible person" with "resident representative" for consistency in the use of that term throughout the regulations. The Department also proposes to replace "MA" with "Medical Assistance" for clarity.

Subsection (h).

The Department proposes to delete 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).

The Department proposes to delete this subsection to eliminate duplication and to avoid conflict with the Federal requirements. Under 42 CFR 483.10(b), 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.

Subsection (j).

The Department proposes to delete subsection (j) 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. The right to personal privacy encompasses accommodations, medical treatment, communications (oral, written and telephone), personal care, and visits and meetings with family and resident groups.

Subsection (k).

The Department proposes to delete 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.

Subsection (l).

The Department proposes to delete 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.

Subsection (m).

The Department proposes to delete this subsection. Existing subsection (a), which the Department proposes to retain, addresses the requirement that a facility have policies and procedures related to resident rights. Thus, there is no need to retain this subsection.

Subsection (n).

The Department proposes no amendments to the first sentence of this subsection. The Department proposes to delete the second sentence in this subsection to eliminate duplication and to avoid conflict with the Federal requirements. Under 42 CFR 483.10(g)(16), a facility must provide a notice of rights and services to residents prior to or upon admission and also, during the residents' stay. 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. The Department proposes to replace the word "clinical" with the word "medical" in the last sentence for consistency in the use of the term "medical record" throughout the regulations to describe a resident's medical record.

Subsection (o).

The Department proposes to replace the term "nursing home" with the term "facility" for consistency in the use of that term throughout this subpart, and as defined in section 201.3 (relating to definitions). The remaining amendments proposed by the Department, to this subsection, align with the Federal requirements and Federal guidance found in *Appendix PP – Guidance to Surveyors for Long-Term Care Facilities* from the Centers of Medicare & Medicaid Services (CMS) *State Operations Manual*. Under 42 CFR 483.10(c)(6), a resident has the right to participate in or refuse to participate in experimental research. *Appendix PP* expands upon this as follows:

> The resident has the right to refuse to participate in experimental research. A resident being considered for participation in experimental research must be fully informed of the nature of the experimental research (for example, medication or other treatment) and the possible consequences of participating. The resident must provide informed consent prior to participation and initiation of experimental research. If the resident is incapable of understanding the situation and of realizing the risks and benefits of the proposed research, but a resident representative gives consent, facility staff have a responsibility to ensure that the consent is properly obtained and that essential measures are taken to protect the resident from harm or mistreatment. The resident (or his or her representative if the resident lacks health care decision-making capacity) must have the opportunity to refuse to participate both before and during the experimental research activity.

Appendix PP defines experimental research as the development, testing and use of a clinical treatment, such as an investigational drug or therapy that has not yet been approved by the U.S. Food and Drug Administration (FDA) or medical community as effective and conforming to accepted medical practice. Commentators, and IRRC, requested in prior proposed rulemakings that the Department expressly add into regulation any guidance that it wishes to adopt from *Appendix PP*. The Department proposes to expressly add the above guidance from *Appendix PP* into regulation because it provides greater protection to residents than the Federal requirement alone. This protection is necessary as residents who are being considered for experimental research are already vulnerable and need to be fully informed of the nature of the research and the possible consequences for participating in the research in order to make a decision.

Subsection (p).

This proposed subsection is new. The Department proposes to add this subsection 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. The Department's proposal to include race, color, familial status, religious creed, ancestry, age, sex, national origin, handicap or disability, use of guide or support animals because of the blindness, deafness or physical handicap of the user or because the user is a handler or trainer of support or guide animals in this subsection mirrors existing protections under the Pennsylvania Human Relations Act (PHRA). The PHRA prohibits places of public accommodation from discriminating against individuals on the basis of race, color, familial status, religious creed, ancestry, age, sex, national origin, handicap or disability, use of guide or support animals because of the blindness, deafness or physical handicap of the user or because the user is a handler or trainer of support or guide animals. 43 P.S. § 955(i).

Further, the Department is proposing to clarify that discrimination in the provision of health care based on sexual orientation, gender identity and expression is also prohibited. Currently, Federal and State law do not specifically prohibit discrimination based on sexual orientation or gender identity, though the Federal requirements for long-term care nursing facilities do provide some protections for same-sex spouses and residents based on sexual orientation and gender identity. *See* 42 CFR 483.10(b)(3); 42 CFR 483.10(f)(4)(vi)(B) and (C). In 2018, the Pennsylvania Human Relations Commission (PHRC), the entity charged with enforcing the PHRA, released guidance stating that its interpretation of the term "sex" in the PHRA "may refer to sex assigned at birth, sexual orientation, transgender identity, gender transition, gender identity, and/or gender expression." PHRC. Pennsylvania Human Relations Commission Guidance on Discrimination on the Basis of Sex under the Pennsylvania Human Relations Act. Retrieved from https://www.phrc.pa.gov/AboutUs/Documents/APPROVED%20Sex%20Discrimination%20Gui

dance%20PHRA.pdf. The result of that guidance is that the PHRC will accept filing of complaints arising out of discrimination based on sex assigned at birth, sexual orientation, transgender identity, gender transition, gender identity or gender expression in places of public accommodation. As mentioned, long-term care nursing facilities are places of public accommodation under both Federal and State law and therefore, would be subject to the PHRC guidance.

Further, the Department's proposal in subsection (p) is consistent with its duty and authority under the act to ensure that "all citizens receive humane, courteous, and dignified treatment." 35 P.S. § 448.102. That duty cannot be met if the Department allows or remains silent on discrimination against any class of persons, especially persons that otherwise have not been afforded clear protections under the law. Section 804 of the act further prohibits any provider from discriminating on the basis of sex. 35 P.S. § 448.804. Consistent with the PHRC guidance, discrimination on the basis of "sex" would include discrimination based on sex assigned at birth, sexual orientation, transgender identity, gender transition, gender identity or gender expression. The Department is proposing to make clear to long-term care nursing facilities the Department's interpretation of this statutory provision, which is consistent with the text of the statute and the intent and purpose of the act.

§ 201.30. Access requirements.

The Department proposes to delete 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), 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. 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 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.

§ 201.31. Transfer agreement.

The Department proposes to delete this section to eliminate duplication and avoid conflict with the Federal requirements at 42 CFR 483.70(j). Under 42 CFR 483.70(j), a facility is required to have in effect a written transfer agreement with one or more hospitals that are approved for participation under Medicare or Medical Assistance. The transfer agreement must reasonably assure that residents will be transferred to the hospital with timely admission to the hospital when transfer is medically appropriate and that all medical and other information needed for the care and treatment of residents will be exchanged between the providers. The facility is also required to attempt in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible.

§ 207.2. Administrator's responsibility.

The Department proposes to delete this section. As discussed previously, the Department proposes to move the requirement in existing subsection (a), pertaining to the administrator's responsibility for housekeeping and maintenance, to section 201.18(e)(2.a) (relating to management). Thus, there is no need to retain this requirement here. The Department proposes to delete 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. Residents being cared for at home would not typically have services provided by multiple

people. Prohibiting nursing services personnel from performing any housekeeping duties can contribute to residents feeling as though they are institutionalized regardless of what their environment looks like. Properly trained staff should be allowed to provide primary care for residents that covers a broad range of tasks.

§ 209.3. Smoking.

The Department proposes to delete this section to eliminate duplication and avoid conflict with the Federal requirements. Under 42 CFR 483.90(i)(5), 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 NFPA 101 *Life Safety Code*, which has been adopted in the Federal requirements in 42 CFR 483.90(a), also addresses requirements for smoking policies at 18.7.4 and 19.7.4.

§ 211.2. Medical director.

As explained below, the Department proposes to delete subsections from this section, pertaining to physicians, to eliminate duplication and to avoid confusion with the Federal requirements. The Department proposes to retain and amend subsections of this section that pertain to the medical director. As a result of these amendments, the Department proposes to change the title of this section from "physician services" to "medical director" to reflect the proposed contents of this section more accurately.

Subsection (a).

The Department proposes to delete 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.

Subsection (b).

The Department proposes to delete 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. 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.

Subsection (c).

The Department proposes to amend 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). 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 proposes to retain 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 proposes to add, 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 four 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 proposes to delete 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.

Subsection (d).

The Department proposes to delete this subsection 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.

§ 211.3. Verbal and telephone orders.

The Department proposes to replace 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).

The Department proposes to replace "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 proposes the deletion of 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), 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 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 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 at 63 P.S. § 218.6, and in regulation at 49 Pa. Code, Chapter 21, Subchapter H (relating to clinical nurse specialists). The Department proposes to delete the last sentence allowing written orders to be faxed, as this is duplicative of existing language in subsection (d), which the Department proposes to keep with amendments, as described below.

Subsection (b).

The Department proposes to replace "a physician's oral" with the word "verbal" for consistency with the proposed amendments to subsection (a). The Department proposes to replace "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 proposes to add "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 proposes to delete the requirement that verbal, and telephone, orders be dated and countersigned with the original signature of the physician or physician's delegee within seven days and replace this with the requirement, currently in subsection (c), that verbal, and telephone, orders be dated and countersigned within 48 hours. The Department proposes this amendment as 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.

Subsection (c).

The Department proposes to delete this subsection. As noted above, the Department proposes to move the 48-hour requirement from the first sentence of this subsection into subsection (b). The Department proposes to delete the second sentence of this subsection, pertaining to Schedule II medications. Dispensation of controlled substances is covered under Federal law. *See* 21 CFR 1306.11.

Subsection (d).

The Department proposes to replace the word "oral" with the word "verbal" for consistency in terminology. The Department proposes to replace "medication or treatment" with "care, treatment or medication" for consistency with the proposed amendments to subsection (b), as described above. The Department proposes to replace 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 proposes to replace the word "received" with the word "sent" for grammatical reasons. The Department also proposes to add "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).

The Department proposes, throughout this subsection, to replace the words "an oral" with the words "a verbal" for consistency in terminology. In paragraph (2), the Department proposes to replace "practitioner" with "physician, or physician's delegee authorized under 42 CFR 483.30(e)" for consistency in terminology. In paragraph (4), the Department proposes to add 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).

The Department proposes to replace 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.

Subsection (b).

The Department proposes only one amendment to this subsection. The Department proposes to replace 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 proposes to amend the title of this section from "clinical records" to "medical records." The Department proposes this amendment to align with the use of this term in the Federal requirements throughout 42 CFR Part 483, Subpart B, to refer to a resident's medical records.

Subsection (a).

The Department proposes to delete subsection (a) to eliminate duplication and to avoid conflict with the Federal requirements at 42 CFR 483.10(h)(3)(ii). 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.

Subsection (b).

The Department proposes to delete subsection (b) to eliminate duplication and to avoid conflict with the Federal requirements. Under 42 CFR 483.10(h)(3), a resident has the right to secure and confidential personal and medical records, and under 42 CFR 483.10(h)(3)(i), has the right to refuse the release of personal and medical records except as provided under 42 CFR 483.70(i)(2) or other applicable Federal or State laws. Under 42 CFR 483.70(i)(2), a facility is required to keep information contained in a resident's medical records confidential except when the records are released to the resident or resident representative, for treatment, payment or health care operations, for public health activities, or as required by law.

Subsection (c).

The Department proposes to delete subsection (c) to eliminate conflict with the Federal requirements at 42 CFR 483.70(i)(4), which requires medical records to be retained for the period of time required by State law or for five years from the date of discharge when there is no State law requirement, or in the case of a minor, for three years after the resident reaches legal age under State law.

Subsection (d).

The Department proposes one minor amendment in this subsection. The Department proposes to replace the word "clinical" with "medical" for consistency in terminology.

Subsection (e).

The Department proposes to replace 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 proposes to add the word "resident" before medical records for clarity. The Department also proposes to replace 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, will ensure that residents will be able to access their medical records after the facility closes.

Subsection (f).

The Department proposes to replace the word "clinical" with the word "medical" for consistency in the use of the term "medical record." The Department proposes to delete the

words "at a minimum, the" at the beginning of this subsection and add a cross-reference to 42 CFR 483.70(i)(5) to clarify that the items listed in this subsection are required in addition to the items in the Federal requirements. The Department also proposes to replace the language after the word "include" with a delineated list that includes the items that are presently in subsection (f). The Department proposes this amendment for clarity and ease of readability.

Subsection (g).

The Department proposes to delete subsection (g) to eliminate duplication and avoid conflict with the Federal requirements. Under 42 CFR 483.70(i)(1), a facility must maintain medical records in accordance with accepted professional standards and practices. 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 conducted by the State, progress notes from physicians, nurses and other licensed professionals, and laboratory, radiology and other diagnostic services reports.

Subsection (h).

The Department proposes to delete subsection (h) to eliminate duplication and avoid conflict with the Federal requirements. 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).

The Department proposes to replace the word "clinical" with the word "medical" for consistency in the use of the term "medical record." The Department also proposes one minor grammatical change by replacing the comma following the word "utilized" with a semi-colon.

§ 211.6. Dietary services.

Subsection (a).

The Department proposes to add language to this subsection to require that menus not only be planned but also posted in the facility or distributed to residents at least two weeks in advance. This requirement goes above and beyond the Federal requirements for facilities under 42 CFR 483.60 (relating to food and nutrition services). The Department proposes this requirement as part of its efforts to promote more resident-centered environments in long-term care nursing facilities. Requiring that menus be posted or distributed to residents contributes to a more resident-centered environment by allowing residents and their visitors to view and plan meals in advance.

Subsection (b).

The Department proposes to delete this subsection to eliminate duplication and avoid conflict with the Federal requirements. Under 42 CFR 483.60, 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. Facilities should utilize the emergency plan developed under 42 CFR 483.73 to determine how much food is needed in the event of an emergency. 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 the facility. Instead, facilities should utilize the emergency plan developed under 42 CFR 483.73 to determine how much food is needed in the event of an emergency.

Subsection (c).

The Department proposes to delete 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 to providing sufficient support personnel to safely carry out the functions of the food and nutrition service, 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).

Subsection (d).

The Department proposes to delete 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.

Subsection (e).

The Department proposes to delete 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). 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).

Subsection (f).

The Department proposes only minor amendments to this subsection. Specifically, the Department proposes to replace "an employe" with "employees" and "employes" with "employees." The Department proposes these two changes for grammatical reasons and for consistency in the usage and spelling of the term "employees."

§ 211.7. Physician assistants and certified registered nurse practitioners.

The Department proposes to delete 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, 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 in statute at 63 P.S. § 422.13 and in regulation at 49 Pa. Code, Chapter 18, Subchapter D. The scope of practice for certified registered nurse practitioners is set forth in statute at 63 P.S. § 218.2, and in regulation at 49 Pa. Code, Chapter 21, Subchapter C. The scope of practice for clinical nurse specialists is set forth in statute at 63 P.S. § 218.6, and in regulation at 49 Pa. Code, Chapter 21, Subchapter H.

The Department proposes to retain the requirements in subsections (b)(2) through (b)(4) as the Federal requirements do not cover posting and notification requirements for supervising

physicians. The Department proposes one minor amendment to subsection (b)(2). The Department proposes to replace the term "nursing station" with the term "workstation." As noted in the Department's other proposed 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. **§ 211.8. Use of restraints.**

Subsection (a).

The Department proposes to delete this subsection to eliminate duplication and avoid conflict with the Federal requirements. Under 42 CFR 483.10(e)(1), a resident has the right to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms. A facility, under 42 CFR 483.12(a)(2) (relating to freedom from abuse, neglect, and exploitation), is required to ensure that residents are free from physical or chemical restraints imposed for discipline or convenience and that are not required to treat a resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.

Subsection (b).

The Department proposes to delete this subsection. As noted previously, under 42 CFR 483.12(a)(2), when restraints are used, a facility must use the least restrictive alternative for the least amount of time. In addition, any restraint to a resident that results in injury to the resident would be considered to be abuse as defined in the Federal requirements at 42 CFR 483.5 and prohibited by 42 CFR 483.12(a)(1).

Subsection (c).

The Department proposes to delete this subsection, which requires removal of restraints for a specified time period. The Department is 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. The Department proposes to replace subsection (c) with new language in subsection (c.1) below.

Subsection (c.1).

The Department proposes this new subsection as a replacement for existing subsection (c) to require that, if restraints are used, a facility ensure that appropriate interventions are in place to safely and adequately respond to resident needs. Physical or chemical restraints are permitted by the Federal requirements, but only in limited circumstances. When used, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. The Department is proposing to add the language in subsection (c.1) to clarify that a facility is required to have appropriate interventions in place, when restraints are used, to protect the health and safety of residents. Depending on the type of restraint, these interventions would include, for example, turning and repositioning residents, providing distractions while the resident is in restraints, checking the skin of the resident underneath the restraint, and supervising the resident to ensure that the resident is not harmed while in restraints.

Subsection (d).

The Department proposes to delete the words "a signed, dated, written" because orders for restraints may be either written or verbal. The Department also proposes to replace 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 to describe

the type of individual who may provide medical orders. The Department proposes to delete the last two sentences of this subsection. As noted previously, physical or chemical restraints are permitted by the Federal requirements, but only in limited circumstances. When used, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.

Subsection (e).

The Department proposes to add "or physician's delegee authorized under 42 CFR 483.30(e)" after the word "physician" for consistency in the use of terminology as described previously.

Subsection (f).

The Department proposes no amendments to this subsection.

§ 211.9. Pharmacy services.

Subsection (a).

The Department proposes to retain the requirement in paragraph (1) with minor stylistic amendments. The Department proposes to delete 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 section 201.3.

Subsection (b).

The Department proposes to replace "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).

The Department proposes no amendments to this subsection.

Subsection (d).

The Department proposes to add the words "both prescription and non-prescription" after the word "medications" to make it clear 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 will enable 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 proposes to delete the word "written" before the word "orders" because orders may be written or verbal. The Department also proposes to add "or the physician's delegee authorized under 42 CFR 483.30(e)" for consistency in the use of this term throughout the regulation, and because these individuals may also provide medication orders.

Subsection (e).

The Department proposes to delete this subsection. It is not necessary to retain this requirement given the proposed amendment to subsection (d), to require a written order for both prescription and non-prescription medications.

Subsection (f).

The Department proposes only one amendment to this subsection. In paragraph (1), the Department proposes to replace 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).

The Department proposes to delete 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.

Subsection (i) and (j).

The Department proposes to delete subsections (i) and (j) and add a new subsection (j.2), pertaining to the disposition of medications, as described below.

Subsection (j.1).

Proposed subsection (j.1) is new. The Federal requirements for pharmacy services do not directly address the disposition of medications. The Department, therefore, proposes to add language in 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 proposes to require 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 State and Federal requirements, local ordinances and standards of practice. These requirements align with Federal guidance found in section F755 of *Appendix PP*. Commentators, and IRRC, requested in prior proposed rulemakings that the Department expressly add into regulation any guidance that it wishes to adopt from *Appendix PP*. The Department proposes to expressly add the above guidance from *Appendix PP* into regulation because it provides greater protection to residents than the Federal requirement. Proper procedures for the disposition of medications are vital for the health and safety of residents.

Subsection (k).

The Department proposes no amendments to this subsection.

Subsection (l).

The Department proposes to move 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 proposes to add "security" and "inventory tracking" to the policies and procedures that a facility is required to have for the emergency medication kit. The Department proposes this addition 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 proposes to delete 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 proposes, in paragraph (2), to require 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 proposes a grammatical change from the word "pre-scribe" to "prescribe." The Department also proposes to correct the citation to the Pharmacy Act from 63 P.S. §§ 390.1—390.13 to 63 P.S. §§ 390-1—390-13.

The Department proposes to delete paragraph (4). As noted, the Department proposes to move the phrase "readily available to staff" to the first sentence of this subsection. The Department proposes to delete 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 proposes to require, in paragraph (1), that the facility have 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).

The Department proposes to delete 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). 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). The Department proposes to retain 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.

Subsections (b) through (d).

The Department proposes no amendments to subsections (b) through (d).

§ 211.11. Resident care plan.

The Department proposes to delete this section to eliminate duplication and to avoid conflict with the Federal requirements. 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, 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.

§ 211.12. Nursing services.

Subsection (a).

The Department proposes to delete this subsection to eliminate duplication and to avoid conflict with the Federal requirements. Under 42 CFR 483.35(a)(1), a facility is required to 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.

Subsection (b).

The Department proposes to delete this subsection to eliminate duplication and to avoid conflict with the Federal requirements. Under 42 CFR 483.35(b)(2), except when waived, a facility is required to designate a RN to serve as the director of nursing on a full-time basis.

Subsection (c).

The Department proposes only one amendment to this subsection. The Department proposes to replace the word "staff" with the word "personnel" for consistency in the use of the term "nursing services personnel" throughout the regulations.

Subsection (d).

The Department proposes only one amendment to this subsection. The Department proposes 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.

Subsection (e).

The Department proposes to delete this subsection to eliminate duplication and to avoid conflict with the Federal requirements. Charge nurses are responsible for overseeing nursing activities within the facility. Under 42 CFR 483.35(a)(2), unless waived, a facility is required to designate a licensed nurse to serve as a charge nurse on each tour of duty.

Subsection (f).

The Department proposes to delete this subsection. The Department proposes new minimum staffing ratios, to replace the requirements in paragraph (1). These new staffing ratios are outlined in proposed subsection (f.1). The new proposed staffing ratios also render paragraph (2) obsolete, as the Department's proposal does not contemplate an LPN being responsible for overseeing total nursing activities within a facility on the night tour of duty. The Department is proposing to require one RN instead of an LPN during the night shift because there should always be an RN on duty to provide care to residents. Residents do not stop needing the higher level of care provided by an RN during the night. An LPN does not have the same level of education or training as an RN, and the scope of practice for an RN is more extensive than an LPN. For example, an LPN cannot complete an assessment of a resident. If someone were to fall in the middle of the night shift, an RN would have to be called in or the resident would have to wait until the next shift for an assessment to be performed. Requiring an RN at all times ensures resident safety.

Subsection (f.1).

This proposed subsection is new. The Department proposes to move the requirements in subsections (g) to new proposed paragraph (3), subsection (h) to new proposed paragraph (2), and subsection (j) to new proposed paragraph (1) to this subsection for clarity and ease of readability. The Department proposes in new paragraph (4) to require a minimum of one nurse aide per ten residents during the day, one nurse aide per ten residents during the evening, and one nurse aide per fifteen residents overnight. This requirement is being proposed to clarify the expected distribution of nurse aides over the course of three shifts, to ensure that the same level of nurse aide coverage is provided to residents during the day and evening, and to ensure that adequate staffing is being provided throughout the course of a 24-hour period. Adding this

requirement will also improve the ability of residents and their families to determine whether the regulations are being followed.

The Department proposes in new paragraph (5) to require a facility to provide 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. The Department proposes to add a chart with a breakdown for facilities with one to 540 residents to assist facilities in determining the actual number of RNs and LPNs required under paragraph (1). The Department proposes to add clarifying language for facilities with more than 540 residents to make it clear that those facilities will need to calculate and provide additional RNs and LPNs in accordance with the ratios established by this subsection.

The Federal requirements do not specify a minimum number of direct care hours to be provided to residents, nor do the requirements specify a minimum number or type of nursing services personnel for resident care. CMS, however, in a 2001 study, found that a minimum of 4.1 hours of direct care per resident day would improve the quality of care provided to a resident, and that anything below that amount "could result in harm and jeopardy to residents." Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities, 80 Fed. Reg. 42168, 42202 (July 16, 2015). In the Department's first proposed rulemaking, the Department proposed, in subsection (i) to require a minimum of 4.1 direct care hours to align with the CMS study. In the 2001 study, CMS identified a pattern of incremental benefits in increased staffing until a threshold was reached, where no significant quality improvements were observed. This threshold occurred when 2.8 hours of care per resident day were provided by nurse aides, .75 hours of care per resident day were provided by RNs and .55 hours of care per resident day were provided by other licensed staff, *i.e.*, LPNs. Feuerberg, Marvin. CMS. (December 2001). Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes. Overview of the Phase

II Report: Background, Study Approach, Findings, and Conclusions. Retrieved from: https://www.justice.gov/sites/default/files/elderjustice/legacy/2015/07/12/Appropriateness_of_Minimum_Nurse_Staffing_Ratios_in_Nursing_Homes.pdf.

The Department considered the breakdown of RNs, LPNs and nurse aides recommended by CMS, but ultimately determined that a somewhat lower breakdown is more feasible in this Commonwealth, given the funding concerns shared by facilities in response to the Department's first proposed rulemaking as well as the ongoing nurse staffing challenges and shortages in this Commonwealth and nationally. The Department, therefore, is proposing to require fewer RNs and LPNs than those recommended by CMS, but to require more nurse aides, proportionally, to achieve the 4.1 hours of direct care per resident per day proposed in section 211.12(i) of the Department's first proposed rulemaking.

Based on the experience and expertise of Department staff with first-hand knowledge of the administration of long-term care nursing facilities, the Department determined that the lowest acceptable level of nursing services personnel would be 2 RNs and 1 LPN per 60 residents during the day shift, 1 RN and 1 LPN per 60 residents during the evening shift, and 1 RN per 60 residents during the night shift, so that there is always an RN on duty. Therefore, per resident day, a minimum of 4 RNs and a minimum of 2 LPNs would be required per 60 residents, with nurse aides making up the remaining number of staff needed to meet the minimum 4.1 hours of direct care required by proposed section 211.12(i). By contrast, at the staffing levels recommended in the CMS study, a minimum of 6 RNs and 4 LPNs would be required per day,

per 60 residents, with nurse aides making up the remaining number of nursing services personnel needed to meet the minimum 4.1 hours of direct care.[1]

It is important to note that, despite being somewhat lower than what was recommended by CMS, the nursing staff ratios proposed by the Department represent a significant increase from current minimum requirements, which the Department believes will result in improvements in resident care and reduced professional nurse staff workloads. Lower staffing levels have been associated with high turnover rates and burnout among professional nurse staff, which leads to a greater risk of resident safety errors, reduction in quality measures and adverse outcomes overall, ultimately increasing health care costs. This in turn leads to poor outcomes for residents. Kolonoski, Ann. (2021). "A Call to the CMS: Mandate Adequate Professional Nurse Staffing in Nursing Homes." 121 *The American Journal of Nursing* 3.; Harrington, Charlene. (2016). "The Need for Higher Minimum Staffing Standards in U.S. Nursing Homes." 9 *Health Services Insights* 13. 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. Shin, Juh Hyun and Bae, Sung-Heui. (2012). "Nurse Staffing, Quality of Care, and Quality of Life in U.S. Nursing Homes, 1996-2011." 38 Journal of Gerontological Nursing 46. Requiring a proportionally higher rate of nurse aides, as proposed by the Department, will also 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.

[1] The Department reached this conclusion by multiplying the minimum proposed hours per resident day by 60 residents and dividing by 8 to represent 8-hour shifts. For example, for RNs, the Department multiplied .75 hours per resident day times 60 and divided by 8, to determine that the CMS staffing equivalent would be 6 RNs per resident day.

In addition, the Department is proposing higher staffing ratios for RNs and LPNs during the day 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 proposing a slightly lower ratio of nursing services personnel in the evening. Many of the activities listed above take place during the evening, but to a lesser extent. The Department is proposing to require one RN instead of an LPN during the night shift because there should always be an RN on duty to provide care to residents. Residents do not stop needing the higher level of care provided by an RN during the night. An LPN does not have the same level of education or training as an RN, and the scope of practice for an RN is more extensive than an LPN. For example, an LPN cannot complete an assessment of a resident. If someone were to fall in the middle of the night shift, an RN would have to be called in or the resident would have to wait until the next shift for an assessment to be performed. Requiring an RN at all times ensures resident safety.

Subsection (f.2).

The Department proposes in this new subsection to add language that will prohibit a facility from substituting a nurse aide for an LPN or RN and substituting an LPN for an RN to meet the minimum nursing staff ratio. However, a facility may substitute an RN for a nurse aide or an LPN to meet the ratio. Nurse aides are not able to perform the work of an LPN or RN based on their education and training. Likewise, LPNs are not able to perform the work of an RN based on their education and training. However, LPNs and RNs can perform the work of a nurse aide and could be substituted for a nurse aide. Likewise, an RN can perform all of the

work of an LPN based on their education and training, and thus, could be used as a substitute where an LPN is required to meet the minimum nursing staff ratio.

Subsection (g).

As noted previously, the Department proposes to delete this subsection and to move the requirements of this subsection to proposed subsection (f.1).

Subsection (h).

As noted previously, the Department proposes to delete this subsection and to move the requirements of this subsection to proposed subsection (f.1).

Subsection (i).

Proposed amendments to subsection (i) were discussed and explained in the Department's first proposed rulemaking, which was published in the *Pennsylvania Bulletin* on July 31, 2021. *See* 51 Pa.B. 4074 (July 31, 2021). The Department is presently reviewing and considering public comments that were submitted in response to that proposed rulemaking to determine if further amendments are needed in the final-form regulation.

Subsection (i.1).

This proposed subsection is new. The Department proposes to add a requirement that only direct resident care provided by nursing service personnel 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 would count toward the 4.1 number of direct care hours that were proposed by the Department in subsection (i) in its first proposed rulemaking. Section (i.1) goes above and beyond the Federal requirements for direct care staffing, as the Federal requirements contemplate that direct care may be provided by additional individuals, including therapists. *See* 42 CFR § 483.70(q)(2)(i). Direct care refers to

assisting a resident, through interpersonal contact, with care and services that allow the resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being. 42 CFR § 483.70(q)(1). Direct care typically involves assisting residents with tasks such as grooming and dressing themselves, exercise, eating, changing soiled clothing, repositioning, and providing toileting assistance. 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.

Subsection (j).

As noted previously, the Department proposes to delete this subsection and to move the requirements of this subsection to proposed subsection (f.1).

Subsection (k).

The Department proposes to delete 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 certified nurse aides.

Subsection (l).

The Department proposes to delete this subsection. The Department proposed, in its first proposed rulemaking, to add language to subsection (i) requiring a facility to have, during each shift in each 24-hour period, a sufficient number of nursing 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. It is therefore not necessary to retain the language in subsection (l).

§ 211.15. Dental services.

The Department proposes to delete this section to eliminate duplication and to avoid conflict with the Federal requirements. Under 42 CFR 483.55 (relating to dental services), a facility is required to provide or obtain from an outside resource routine and emergency dental services. A facility is required to assist residents in making dental appointments and arranging transportation to and from dental services locations. 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 three days.

§ 211.16. Social services.

Subsection (a).

The Department proposes to delete the first sentence of this subsection and to replace the phrase "facilities with a resident census of more than 120 residents" with "a facility." The effect of this proposed amendment will be to require that all facilities have a full-time qualified social worker, regardless of size. This exceeds the Federal requirements at 42 CFR 483.70(p) which only require a full-time qualified social worker for facilities with more than 120 beds. The Department, under the act, has the authority to promulgate rules and regulations necessary to carry out the purposes and provisions of the act. 35 P.S. § 448.803. One of the stated purposes of the act is to assure that citizens receive humane, courteous, and dignified treatment. 35 P.S. § 448.102. The Department believes strongly 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 social workers to assist with their care planning and to provide psychosocial support.

Subsection (b).

The Department proposes to delete this subsection in light of the proposed changes to subsection (a) as described above, which will require all facilities to have a full-time qualified social worker, regardless of size.

§ 211.17. Pet therapy.

The Department proposes to rephrase 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 proposes grammatical changes to paragraphs (2), (3), (4) and (6) for ease of readability. In paragraphs (4) and (6), the Department proposes to change the word "pets" to "animals" for consistency in the use of terms throughout this section. The Department proposes to delete paragraph (5) and replace it with proposed 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 proposes to add 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. Proposed paragraph (7) is new and will 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.

III. Fiscal Impact and Paperwork Requirements

Fiscal Impact

Commonwealth - 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 proposed elimination of sections, as described above, that are duplicative of the Federal requirements will streamline the survey process for long-term care nursing facilities. This, in turn, will create consistency and eliminate confusion in the application of standards that apply to long-term care nursing facilities.

Commonwealth – DHS.

Cost to meet proposed nursing staff ratio.

The Department consulted with DHS to determine the effect of the proposed increase in section 211.12(f.1)(5) to the 20 county-owned facilities and the 594 privately-owned facilities, that are not operated by DMVA, and to determine the effect on the Medical Assistance ("MA") program. The proposed increase in RNs and LPNs, as proposed by the Department in section 211.12(f.1)(5), will require the 20 county-owned facilities that participate in MA to employ an additional estimated 184 Full Time Equivalent (FTE) RNs but no LPNs. The average cost for an RN is projected to average $127,072, which is an increase of 28% from the average current cost

report data provided by county owned facilities. 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%). The 75th percentile wage was used as a proxy for expected wages in 2023 with consideration of increased demand from the 4.1 requirement along with trends in the labor market for RNs, LPNs and nurse aides and unchecked pressures on agency use and pricing. The total cost to county-owned facilities that participate in MA to add 184 RNs at the increased salary assumption is estimated to be $23,381,248. The affected county-owned facilities will also need to hire an estimated 539 FTE nurse aides in addition to the 184 RNs in order to meet the Department's proposal in the first rulemaking to require, in section 211.12(i), 4.1 direct resident care hours per resident per day. The average cost for a nurse aide, including wages and benefits, is projected to increase to $56,477 which is an increase of 23%, from the average salary paid as reported by facilities in the current cost report data reported to DHS. The cost to hire an additional 539 FTE nurse aides is projected to be $30,441,103. The total cost to meet the requirements of both section 211.12(f.1)(5) and 211.12(i) therefore will be $53,822,351. According to data obtained from DHS, approximately 84.51% or $45,485,269 of this cost will be covered by the MA program. The Federal MA Program rate, estimated to be 52%, will apply to MA payments made to fund these costs, for an estimated Federal match of $23,652,340 and a state general fund investment of $21,832,929.

The proposed increase in RNs and LPNs, as proposed by the Department in section 211.12(f.1)(5), is projected to require the 594 privately-owned facilities that participate in MA to employ an additional 2,374 FTE RNs and 26 FTE LPNs. The average cost for an RN is

projected at $127,072, which is an increase of 28% from the average current cost report data for privately owned facilities that participate in MA. The average cost for an LPN is projected at $67,395 which is an increase of 4% from the average current cost report data. This estimate of increased costs includes wages and benefits determined using the assumptions and data described in the county facility cost explanation. The total cost to facilities to add an estimated 2,374 FTE RNs is estimated to be $301,540,749. The total cost to facilities to add 26 FTE LPNs is estimated to be $1,752,277. The affected privately-owned facilities will also need to hire an estimated 5,988 FTE nurse aides in addition to the estimated 2,374 FTE RNs and estimated 26 FTE LPNs in order to meet the Department's proposal in the first rulemaking to require, in section 211.12(i), 4.1 direct resident care hours per resident per day. The average nurse aide salary is projected at $56,477 which is a 23% increase from the average current cost report data. The total estimated cost to add 5,988 FTE NAs is $338,128,429. The total increased cost to meet the requirements of both section 211.12(f.1)(5) and 211.12(i) therefore will be $641,421,455. According to data obtained from DHS, approximately 75.82%, or $486,325,747, 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 $252,889,388 and a state general fund investment of $233,436,359.

The Department's proposal in section 211.12(f.1)(4) to require one nurse aide per ten residents during the day, one nurse aide per ten residents during the evening, and one nurse aide per fifteen residents overnight will not result in any costs beyond those already delineated above.

Cost of proposal to add qualified social worker.

The Department estimates that the annual cost to employ one full-time social worker in the private sector, in the first year, will be approximately $73,216 on average, including wages

and benefits. Assuming that the data provided to the Department in the 2019-2020 annual report remains unchanged, the Department estimates that the total cost to the 70 privately-owned MA facilities, with 120 beds or less, that do not employ either a full-time or part-time social worker, will be approximately $5,125,120 in the first year. According to data obtained from DHS, approximately 73%, or $3,741,338, 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 $1,945,496 and a state general fund investment of $1,795,842. The Department estimates a 5% increase in wages and benefits for each year thereafter.

The Department estimates that it will cost facilities with 120 beds or less $36,608 each to staff up from a part-time social worker to a full-time social worker. This assumes that the part-time social workers, currently employed, are earning half the salary of a full-time social worker. The total cost to the ten MA facilities is estimated to be $329,472. According to data obtained from DHS, approximately 73%, or $240,515, of the cost to the ten 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 $125,068 and a state general fund investment of $115,447. The Department estimates a 5% increase in wages and benefits for each year thereafter.

Commonwealth – DMVA.

Cost to meet proposed nursing staff ratio.

DMVA operates six veterans' homes across the state with the capacity to serve 1,526 total residents and employs more than 2,000 clinical and professional staff. The proposed increase in RNs and LPNs, as proposed by the Department in section 211.12(f.1)(5) will require DMVA to employ an additional 166 RNs and 83 LPNs. The average cost to DMVA for an RN is $136,031.24 and for an LPN is $103,720.67. This estimate includes wages and benefits. The

total cost to DMVA to add 166 RNs will be $22,581,185.84 and to add 83 LPNs will be $8,608,815.61, for a total cost of $31,189,918.45. DMVA will need to hire an additional 43 nurse aides in addition to the 166 RNs and 83 LPNs to meet the Department's proposal in the first proposed rulemaking to require, in section 211.12(i), 4.1 direct care resident hours, per day. The average cost to DMVA for a nurse aide, including wages and benefits, is $75.871.34 for a total cost of $3,262,467.62. The total cost to DMVA under the proposed amendments to meet the requirements of both section 211.12(f.1)(5) and 211.12(i) will be $34,452,469.07. Based on the number of eligible MA residents, about 35% of the total cost, an estimated $12 million, will be covered by the MA program; therefore, the Federal MA Program rate, estimated to be 52%, will apply to these costs, for an estimated $6.2 million. Applying the Federal share of approximately $6.2 million to the total costs of approximately $34 million needed to staff up to the 4.1 ratio results in an estimated increase of approximately $28 million in state funding ($5.8 million state funds for the MA program and $22.2 million DMVA share non-MA eligible residents).

Cost of proposal to add qualified social worker.

DMVA operates six veterans' homes across the state with the capacity to serve 1,526 total residents and employs more than 2,000 clinical and professional staff. All six veterans' homes currently employ a licensed social worker on a full-time basis. Thus, DMVA would not be impacted by the Department's proposal in section 211.16 (relating to social services) to require that a facility employ a qualified social worker on a full-time basis.

Regulated community.

Cost of proposal to adopt Federal requirements.

The Department anticipates little to no financial impact on the 689 licensed long-term care nursing facilities as a result of the proposed elimination of sections that are duplicative of the Federal requirements. All but three of the 689 long-term care nursing facilities participate in either Medicare or Medical Assistance and thus, are required to comply with existing Federal requirements. The three long-term care nursing facilities that do not participate in Medicare or Medical Assistance may be impacted if they do not already meet the minimum standards within the Federal requirements. However, any financial impact to the three facilities that do not participate in Medicare or Medical Assistance is outweighed by the need for consistency in the application of standards to all long-term care nursing facilities, regardless of whether the facilities participate in Medicare or Medical Assistance.

Cost to meet proposed nursing staff ratio.

The Department consulted with DMVA to determine the impact of the proposed increase to the nursing staff ratio in section 211.12(f.1)(5) as well as the proposed increase in the number of direct care nursing hours to 4.1 as proposed in the Department's first proposed rulemaking. The proposed increase in RNs and LPNs, as proposed by the Department in section 211.12(f.1)(5) will require DMVA to employ an additional 166 RNs and 83 LPNs. The average cost to DMVA for an RN is $136,031.24 and for an LPN is $103,720.67. This estimate includes wages and benefits. The total cost to DMVA to add 166 RNs will be $22,581,185.84 and to add 83 LPNs will be $8,608,815.61, for a total cost of $31,189,918.45. DMVA will need to hire an additional 43 nurse aides in addition to the 166 RNs and 83 LPNs to meet the Department's proposal in the first proposed rulemaking to require, in section 211.12(i), 4.1 direct care resident hours, per day. The average cost to DMVA for a nurse aide, including wages and benefits, is $75.871.34 for a total cost of $3,262,467.62. The total cost to DMVA under the proposed

amendments to meet the requirements of both section 211.12(f.1)(5) and 211.12(i) will be $34,452,469.07. Based on the number of eligible MA residents, about 35% of the total cost, an estimated $12 million, will be covered by the MA program; therefore, the Federal MA Program rate, estimated to be 52%, will apply to these costs for an estimated $6.2 million. Applying the Federal share of approximately $6.2 million to the total costs of approximately $34 million needed to staff up to the 4.1 ratio results in an estimated increase of approximately $28 million in state funding ($5.8 million state fund for the MA program and $22.2 million DMVA share non-MA eligible residents).

The Department consulted with DHS to determine the impact of the proposed increase in section 211.12(f.1)(5) to the 20 county-owned facilities and the 594 privately-owned facilities, that are not operated by DMVA. The proposed increase in RNs and LPNs, as proposed by the Department in section 211.12(f.1)(5), will require the 20 county-owned facilities, that participate in MA, to employ an additional estimated 184 Full Time Equivalent (FTE) RNs but no LPNs. The average cost for an RN is projected to average $127,072, which is an increase of 28% from the average current cost report data. 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%). The 75th percentile wage was used as a proxy for expected wages in 2023 with increased demand from the 4.1 requirement along with trends in the labor market for RNs, LPNs and nurse aides and unchecked pressures on agency use and pricing. The total cost to county-owned facilities that participate in MA, to add 184 RNs at the increased salary assumption is estimated to be $23,381,248. The affected county-owned facilities will also need to hire an estimated 539 FTE

nurse aides in addition to the 184 RNs in order to meet the Department's proposal in the first rulemaking to require, in section 211.12(i), 4.1 direct resident care hours, per day. The average cost for a nurse aide, including wages and benefits, is projected to increase to $56,477, which is an increase of 23%, from the average salary paid as reported by facilities in the current cost report data reported to DHS. The cost to hire an additional 539 FTE nurse aides is projected to be $30,441,103. The total cost to meet the requirements of both section 211.12(f.1)(5) and 211.12(i) therefore will be $53,822,351. According to data obtained from DHS, approximately 84.51%, or $45,485,269, of this cost will be covered by the MA program. The Federal MA Program rate, estimated to be 52%, will apply to MA payments made to fund these costs, for an estimated Federal match of $23,652,340 and a state general fund investment of $21,832,929.

The proposed increase in RNs and LPNs, as proposed by the Department in section 211.12(f.1)(5), is projected to require the 594 privately-owned facilities that participate in MA to employ an additional 2,374 FTE RNs and 26 FTE LPNs. The average cost for an RN is projected at $127,072, which is an increase of 28% from the average current cost report data for privately owned facilities that participate in MA. The average cost for an LPN is projected at $67,395, which is an increase of 4% from the average current cost report data. This estimate of increased costs includes wages and benefits determined using the assumptions and data described in the county facility cost explanation. The total cost to facilities to add an estimated 2,374 FTE RNs is estimated to be $301,540,749. The total cost to facilities to add 26 FTE LPNs is estimated to be $1,752,277. The affected privately-owned facilities will also need to hire an estimated 5,988 FTE nurse aides in addition to the estimated 2,374 FTE RNs and estimated 26 FTE LPNs in order to meet the Department's proposal in the first rulemaking to require, in section 211.12(i), 4.1 direct resident care hours, per day. The average nurse aide salary is projected at

$56,477, which is a 23% increase from the average current cost report data. The total estimated cost to add 5,988 FTE NAs is $338,128,429. The total increased cost to meet the requirements of both section 211.12(f.1)(5) and 211.12(i) therefore will be $641,421,455. According to data obtained from DHS, approximately 75.82%, or $486,325,747, 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 $252,889,388 and a state general fund investment of $233,436,359.

There are 62 facilities that participate only in Medicare. The proposed increase in RNs and LPNs, as proposed by the Department in section 211.12(f.1)(5), will require these 62 facilities, to employ an additional 258 FTE RNs and 3 FTE LPNs. This estimate is based on data obtained from the Department's 2019-2020 annual report. The average projected annual cost for an RN is $127,072 and the average projected annual cost for an LPN is $67,395. This estimate includes wages and benefits. The total cost to facilities to add approximately 258 FTE RNs, based on the same cost assumptions provided by DHS, will be approximately $32,784,576. The total cost to add 3 FTE LPNs will be approximately $202,186. The affected Medicare facilities will also need to hire 659 nurse aides in addition to the 258 RNs and 3 LPNs in order to meet the Department's proposal in the first rulemaking to require, in section 211.12(i), 4.1 direct resident care hours per resident per day. The average cost for a nurse aide, including wages and benefits, is $56,477. The total cost to add 659 nurse aides is approximately $37,218,412. The total cost for Medicare facilities to meet the requirements of both sections 211.12(f.1)(5) and 211.12(i) therefore will be $70,205,174. 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.

There are three private-pay facilities that do not participate in either Medicare or MA. The proposed increase in RNs and LPNs, as proposed by the Department in section 211.12(f.1)(5), will require the 3 privately-owned facilities to employ an additional 3 FTE RNs, but no LPNs. This estimate is based on data obtained from the Department's 2019-2020 annual report. The average projected annual cost for an RN is $127,072. This estimate includes wages and benefits. The total cost to facilities to add 3 RNs is estimated to be $381,216. The affected facilities will also need to hire 8 nurse aides in addition to the 3 RNs in order to meet the Department's proposal in the first rulemaking to require, in section 211.12(i), 4.1 direct resident care hours, per day. The average cost for a nurse aide, including wages and benefits, is $56,477. The total cost to meet the requirements of both section 211.12(f.1)(5) and 211.12(i), therefore, will be $833,031.

The Department's proposal in section 211.12(f.1)(4) to require one nurse aide per ten residents during the day, one nurse aide per ten residents during the evening, and one nurse aide per fifteen residents overnight will not result in any costs beyond those already delineated above.

Cost of proposal to add full-time qualified social worker.

Some long-term care nursing facilities will be affected by the Department's proposal, in section 211.16, to require all facilities to employ a full-time qualified social worker. Currently, a full-time social worker is only required for facilities with more than 120 beds. To estimate how many facilities will be impacted, the Department pulled data from the most recent, available annual report, for fiscal year 2019-2020. 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 annual report is obtained through an annual survey of

facilities. The data therefore is dependent on self-reporting from the facilities who complete the survey. Based on a review of the report, the Department estimates that the proposal in section 211.16 will impact 91 privately-owned facilities.[2] Out of these 91 facilities, ten indicated that they only have a part-time social worker, and the remaining 81 reported that they do not have either a full-time or part-time social worker. Of the 81 facilities that reported they do not have either a full-time or part-time social worker, 70 participate in MA, 10 participate only in Medicare, and one is private pay only. Of the ten facilities that have only a part-time social worker, nine participate in MA and one is private pay only.

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%of an employer's cost for compensation, in the private sector.

The Department estimates, based on the above, that the annual cost to employ one full-time social worker in the private sector, in the first year, will be approximately $73,216 on average, including wages and benefits. Assuming that the data provided to the Department in the 2019-2020 annual report remains unchanged, the Department estimates that the total cost to the 70 privately-owned MA facilities with 120 beds or less, that do not employ either a full-time or part-time social worker, will be approximately $5,125,120 in the first year. According to data

[2] DMVA indicated to the Department that the six veterans' homes that it operates will not be affected by the Department's proposal in section 211.16. In addition, out of the 20 county-owned facilities, nineteen 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 2019-2020 annual report. If this continues to be the case, there will be no impact to this facility.

obtained from DHS, approximately 73%, or $3,741,338, 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 $1,945,496 and a state general fund investment of $1,795,842. The total estimated cost to the ten Medicare-only facilities that do not employ either a full-time or part-time social worker is $73,216. The total estimated cost to the one private pay facility that does not employ either a full-time or part-time social worker is $73,216. The Department estimates a 5% increase in wages and benefits for each year thereafter.

The Department estimates that it will cost facilities with 120 beds or less $36,608 each to staff up from a part-time social worker to a full-time social worker. This assumes that the part-time social workers, currently employed, are earning half the salary of a full-time social worker. The total cost to the nine MA facilities is estimated to be $329,472. According to data obtained from DHS, approximately 73%, or $240,515, of the cost to the nine 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 $125,068 and a state general fund investment of $115,447. The total estimated cost to the one private pay facility that needs to staff up from a part-time social worker to a full-time social worker is $36,608. The Department estimates a 5% increase in wages and benefits for each year thereafter.

The Department believes that the costs to facilities to employ a full-time social worker is strongly outweighed by the need to have a full-time social worker on staff. 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.

Local government.

Cost of proposal to adopt Federal requirements.

There are currently 20 county-owned long-term care nursing facilities which account for approximately 8 percent (8,706 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 16 counties: Berks, Bradford, Bucks, Chester, Clinton, Crawford, Cumberland, Delaware, Erie, Indiana, Lehigh, Monroe, Northampton, Philadelphia, Warren, and Westmoreland. All of the county-owned long-term care nursing facilities participate in either Medicare or Medical Assistance. Because these facilities are already required to comply with Federal requirements, they will not incur a cost as a result of the Department's proposed elimination of sections that are duplicative of the Federal requirements.

Cost to meet proposed nursing staff ratio.

The Department consulted with DHS to determine the impact of the proposed increase in section 211.12(f.1)(5) to the 20 county-owned facilities. The proposed increase in RNs and LPNs, as proposed by the Department in section 211.12(f.1)(5), will require the 20 county-owned facilities that participate in MA to employ an additional estimated 184 Full Time Equivalent (FTE) RNs but no LPNs. The average cost for an RN is projected to average $127,072, which is an increase of 28% from the average current cost report data. 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%). The 75th percentile wage was used as a proxy for expected wages in 2023 with increased demand from the 4.1 requirement along with trends in the labor market for RNs, LPNs and nurse aides and unchecked pressures on agency use and pricing. The total cost to county-owned facilities that participate in MA, to add 184 RNs at the increased salary assumption is estimated to be $23,381,248. The affected county-owned facilities will also need to hire an estimated 539 FTE nurse aides in addition to the 184 RNs in order to meet the Department's proposal in the first rulemaking to require, in section 211.12(i), 4.1 direct resident care hours, per day. The average cost for a nurse aide, including wages and benefits, is projected to increase to $56,477 which is an increase of 23%, from the average salary paid as reported by facilities in the current cost report data reported to DHS. The cost to hire an additional 539 FTE nurse aides is projected to be $30,441,103. The total cost to meet the requirements of both section 211.12(f.1)(5) and 211.12(i) therefore will be $53,822,351. According to data obtained from DHS, approximately 84.51% or $45,485,269 of this cost will be covered by the MA program. The Federal MA Program rate, estimated to be 52%, will apply to MA payments made to fund these costs, for an estimated Federal match of $23,652,340 and a state general fund investment of $21,832,929.

Cost of proposal to add full-time qualified social worker.

There will be no cost to the county-owned long-term care nursing facilities as a result of the Department's proposal in section 211.16. Currently, a full-time social worker is only required for facilities with more than 120 beds. Out of the 20 county-owned facilities, nineteen 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 2019-2020 annual report. If this continues to be the case, there will be no impact to this facility.

General public and Residents of Long-Term Care Nursing Facilities.

There is expected to be no cost to the general public. More than 72,000 individuals reside in the 689 long-term care nursing facilities licensed by the Department and will be affected by the proposed regulations. These residents, and their family members, will benefit from the proposed 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 Medical Assistance. 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 proposed increase in direct care hours provided by RNs, LPNs, and nurse aides.

The Department is not able to determine the extent to which residents may be financially affected by the proposed regulations. Various insurance options cover the costs residents pay for long-term nursing care, including Original Medicare, Medicare Supplement Insurance (Medigap), a Medicare Advantage Plan, long-term care insurance, MA, and out-of-pocket.

Most people with Medicare get their health care through Original Medicare, which is managed by the Federal government. For residents of long-term care nursing facilities, only short-term stays of up to 100 days are covered by Original Medicare. Original Medicare does not cover all services provided by a long-term care nursing facility. Original Medicare does not cover custodial care, such as assistance with getting in and out of bed, eating, bathing, dressing, and using the bathroom, if that is the only kind of care that is needed. Centers for Medicare &

Medicaid Services. (2019). Medicare Coverage of Skilled Nursing Facility Care. Retrieved from https://www.medicare.gov/Pubs/pdf/10153-Medicare-Skilled-Nursing-Facility-Care.pdf.

Original Medicare will cover long-term nursing care if the resident has Medicare Part A, has had a qualifying hospital stay of 3 consecutive days or more and enters the facility within 30 days of leaving the hospital, the resident needs inpatient services which require the skill of professional personnel, and the resident needs skilled care on a daily basis and the services can only be given in a facility. Original Medicare pays the full cost of the first 20 days of a long-term care nursing facility stay. For days 21-100, Original Medicare pays all but a daily coinsurance, which is the resident's responsibility. In 2019, the coinsurance was up to $170.50 per day. For days beyond 100, Original Medicare pays nothing, and the resident is responsible for the full cost of covered services. *Id.*

Covered services and costs in a long-term care nursing facility may be different if the resident has Medigap, a Medicare Advantage Plan, MA, or long-term care insurance. Covered services and costs vary under these types of plans depending on the type of plan the resident has. Id. MA is managed by the state and provides benefits for residents with limited income and resources. Any costs not covered by the above resources would result in an out-of-pocket cost to the resident. Medicare.gov. How Can I Pay for Nursing Home Care? https://www.medicare.gov/what-medicare-covers/what-part-a-covers/how-can-i-pay-for-nursing-home-care.

Because the circumstances of each resident are unique with respect to the types of insurance coverage they may have as well as to their length of stay and needs while in the facility, the Department is not able to estimate to what extent costs of a long-term care nursing stay, including costs for professional nursing staff, may be offset by Original Medicare,

Medigap, a Medicare Advantage Plan, MA, or long-term care insurance. The Department is also not able to estimate how much a resident may pay out-of-pocket for such care, based on these variables.

Paperwork Requirements

The Department's proposed amendment to section 201.19 (relating to personnel records) will require a facility to maintain certain employee personnel records, as proposed in paragraphs (1) through (9). Proposed paragraphs (1) through (7) are currently in the Department's interpretive guidelines for section 201.19. Facilities, therefore, are already maintaining this information. Proposed paragraph (8), which requires a criminal background check, is already required by OAPSA. Proposed paragraph (9) would be a new paperwork requirement. Proposed paragraph (9) will require a facility, in the event that an employee has a conviction, to include in the employee's personnel record a determination of suitability for employment in the position to which the employee is assigned. The Department is not proposing any particular format for this determination and does not believe this requirement will be overburdensome to facilities. Indeed, a facility should benefit from having all of the information proposed in paragraphs (1) through (9) in the event that a question or concern arises regarding an employee at the facility.

The Department's proposed amendment to section 201.24(e) will require 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 is proposing that 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 with the proposed amendment.

The Department's proposed amendment to section 211.5(e) (relating to medical records) will require a long-term care nursing facility to provide to the Department, within 30 days of closure, 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 proposed addition of section 211.9(j.1) will require a facility to have written policies and procedures for the disposition of medications. The Department proposes that these policies and procedures align with Federal guidance found in *Appendix PP* and address the following: (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 State and Federal requirements, local ordinances and standards of

practice. This should not impose any burden on those facilities that participate in Medicare or Medical Assistance as they are already following this guidance. In addition, existing sections 211.9(i) and (j) already requires all facilities licensed by the Department, including those that do not participate in Medicare or Medical Assistance, to have policies in place regarding the disposition of medications that are similar to those being proposed in section 211.9(j.1). Therefore, only a minor update to existing policies and procedures should be required for the three facilities that do not participate in Medicare or Medical Assistance.

IV. 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, 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)).

V. Effectiveness/Sunset Date

The final-form regulations will become effective upon their publication in the *Pennsylvania Bulletin* as final regulations. A sunset date will not be imposed. The Department will monitor the regulations and update them as necessary.

VI. Regulatory Review

Under section 5(a) of the Regulatory Review Act (71 P. S. § 745.5(a)), on May 11, 2022, the Department submitted a copy of this proposed rulemaking and a copy of a Regulatory Analysis Form to the Independent Regulatory Review Commission (IRRC) and to the Chairpersons of the Senate Health and Human Services Committee and the House Health Committee. A copy of this material is available to the public upon request.

Under section 5(g) of the Regulatory Review Act, IRRC may convey any comments, recommendations, or objections to the proposed rulemaking within 30 days of the close of the public comment period. The comments, recommendations or objections must specify the regulatory review criteria which have not been met. The Regulatory Review Act specifies detailed procedures for the review of comments, recommendations or objections that are raised prior to final publication of this rulemaking by the Department, the General Assembly, and the Governor.

VII. Contact Person

Interested persons are invited to submit comments, suggestions or objections to the proposed regulations within 30 days after publication of this notice in the *Pennsylvania Bulletin*. The Department prefers that comments, suggestions or objections be submitted via email at: RA-

DHLTCRegs@pa.gov. Persons without access to email may submit comments, suggestions or objections to Lori Gutierrez, Director, Office of Policy, at the following address: 625 Forster Street, Rm. 814, Health and Welfare Building, Harrisburg, PA 17120, (717) 317-5426. 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 ATT&T Relay Service at (800)654-5984[TT]. Persons who require an alternative format of this document may contact Lori Gutierrez at the above email, address or telephone number so that necessary arrangements can be made. Comments should be identified as pertaining to proposed rulemaking 10-224 (Long-term care nursing facilities, Proposed Rulemaking 4).

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.

* * * * *

§ 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 set forth in 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.

(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 section § 201.12 (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 necessary. 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:

(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 to contact the administrator should they find it necessary.

(4) The director of nursing services has adequate knowledge and experience 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 schedule shall be publicly posted in the facility.

(e) [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 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.a) Ensuring 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.

(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 one day of the request or a check, if requested, within three days 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] 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.

(3) Documentation of 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 at 28 Pa. Code § 27.155 (relating to restrictions on health care practitioners).

(5) Records of such 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.

(6) Documentation of the employee's orientation to the facility and the employee's assigned position prior to or within one week of the employee's start date.

(7) Documentation of the employee's completion of required trainings.

(8) A criminal history record.

(9) In the event of a conviction prior to or following employment, a determination by the facility of the employee's suitability for initial or continued employment in the position to which the employee is assigned.

§ 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).

(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.]

(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).**

(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 at 28 Pa. Code § 27.155 (relating to restrictions on health care practitioners) and are physically able to perform their assigned duties.

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§ 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 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:

(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 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 shall occur within two hours of a resident's admission.

§ 201.25. [Discharge policy.

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.] **(Reserved).**

§ 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 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.

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§ 201.29. Resident rights.

(a) The governing body of the facility shall establish written policies regarding the rights and responsibilities of residents and, through the administrator, 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 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.

(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.

(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.

(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 U.S. Food and Drug Administration (FDA) or medical community as effective and conforming to medical practice.

(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.

§ 201.30. [Access requirements.

(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.]

(Reserved).

§ 201.31. [Transfer agreement.

(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.] **(Reserved).**

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CHAPTER 207. HOUSEKEEPING AND MAINTENANCE STANDARDS FOR LONG-TERM CARE NURSING FACILITIES

HOUSEKEEPING AND MAINTENANCE

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§ 207.2. [Administrator's responsibility.

(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.] **(Reserved).**

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CHAPTER 209. FIRE PROTECTION AND SAFETY PROGRAMS FOR LONG-TERM CARE NURSING FACILITIES

FIRE PROTECTION AND SAFETY

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§ 209.3. [Smoking.

(a) Policies regarding smoking shall be adopted. The policies shall include provisions for the protection of the rights of the 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.

(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.

(f) Ash trays of noncombustible material and safe design shall be provided in areas where smoking is permitted.

(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.

(2) Development of written policies which are approved by the governing body that delineate the responsibilities of attending physicians.] **(Reserved).**

§ 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, 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 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).**

(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).**

(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).**

(e) [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 to safely and adequately respond to resident needs.

(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.

§ 211.9. Pharmacy services.

(a) Facility policies shall ensure that[:

(1) Facility] 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).

(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:

(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.

(5) A method of disposition to prevent diversion or accidental exposure consistent with applicable State and Federal 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, security, [and] 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, shall reflect an awareness of, and provision for, meeting the total medical 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.

(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.]

(Reserved).

§ 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 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:

(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 one nursing services personnel on duty, per 20 residents.

(4) A minimum of one nurse aide per ten residents during the day, one nurse aide per ten residents during the evening and one nurse aide per fifteen 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 7LPNs	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 above ratios.

(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).

(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).**

* * * * *

(i.1) Only direct resident care provided by nursing service personnel shall 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.

(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.] **(Reserved).**

§ 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.

(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:

(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

May 11, 2022

Mr. David Sumner
Executive Director
Independent Regulatory Review Commission
14th Floor, 333 Market Street
Harrisburg, PA 17101

Re: Department of Health – Proposed 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

Dear Mr. Sumner:

Enclosed are proposed regulations for review by the Senate Health & Human Services Committee (Committee) in accordance with the Regulatory Review Act (71 P.S. §§ 745.1-745.15).

The Department, in this proposed rulemaking, is proposing amendments to eliminate provisions of the existing long-term care nursing facility regulations that are duplicative and conflict with Federal requirements. Other proposed amendments include increasing the number of registered nurses (RNs), licensed practical nurses (LPNs) and nurse aides required under section 211.12 (relating to nursing services), adding a requirement that facilities have a full-time qualified social worker regardless of 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.

Section 5(d) of the Regulatory Review Act, 71 P.S. § 745.5(d), provides that the Committee may, at any time prior to the submittal of the regulation in final form, convey to the proposing agency and the Independent Regulatory Review Commission its comments, recommendations and objections to the proposed regulations and provide the agency with any pertinent staff reports. The Department expects the proposed regulations to be published on May 28, 2022. A 30-day public comment period is provided.

As required by Section 5(c) of the Regulatory Review Act, 71 P.S. § 745.5(c), the Department will provide to the Committee a copy of any comment received pertaining to the proposed regulations, within 5 business days of receipt. The Department will also provide the Committee with any assistance it requires to facilitate a thorough review of the proposed 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: Maureen Bereznak
To: Smith, Pamela (Health); Kathy Rapp; Michael Siget; Lori Clark
Subject: RE: Proposed Long-Term Care Nursing Facilities Regulations # 10-224
Date: Wednesday, May 11, 2022 8:50:14 AM

These regulations have been received by the House Health Committee. Thank you.

Maureen Bereznak
Research Analyst
House Health Committee (R)
PA House of Representatives
330 Ryan Office Building, State Capitol
Phone: 717-772-2471
Fax: 717-705-1862

From: Smith, Pamela (Health) <pamesmith@pa.gov>
Sent: Wednesday, May 11, 2022 8:41 AM
To: Kathy Rapp <Klrapp@pahousegop.com>; Michael Siget <Msiget@pahousegop.com>; Lori Clark <Lclark@pahousegop.com>; Maureen Bereznak <Mberezna@pahousegop.com>
Subject: Proposed Long-Term Care Nursing Facilities Regulations # 10-224
Importance: High

Good morning,

Attached is a proposed regulatory package from the Department of Health for long-term care nursing facilities.

The Regulatory Review Act requires delivery of the proposed regulatory package to the Standing Committees of the General Assembly, the Legislative Reference Bureau (LRB) and the Independent Regulatory Review Commission (IRRC) **on the same day**, with IRRC receiving the package last. Confirmation of receipt by the Standing Committees and LRB is required for delivery to IRRC.

Please respond as soon as possible to this email indicating that you have received the attached proposed regulatory package so that I can deliver the package to IRRC **today, May 11, 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: Proposed Long-Term Care Nursing Facilities Regulations #10-224
Date: Wednesday, May 11, 2022 9:41:36 AM

Received. Thanks!

From: Smith, Pamela (Health) <pamesmith@pa.gov>
Sent: Wednesday, May 11, 2022 8:41 AM
To: Frankel, Dan <DFrankel@pahouse.net>; Fricke, Erika L. <EFricke@pahouse.net>
Subject: Proposed Long-Term Care Nursing Facilities Regulations #10-224
Importance: High

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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: Haywood, Senator Art
To: Smith, Pamela (Health); Freeman, Clarissa
Subject: Re: Proposed Long-Term Care Nursing Facilities Regulations # 10-224
Date: Wednesday, May 11, 2022 9:18:15 AM

Thanks

Art Haywood's phone
State Senator

From: Smith, Pamela (Health) <pamesmith@pa.gov>
Sent: Wednesday, May 11, 2022 8:40:16 AM
To: Haywood, Senator Art <art.haywood@pasenate.com>; Freeman, Clarissa <clarissa.freeman@pasenate.com>
Subject: Proposed Long-Term Care Nursing Facilities Regulations # 10-224

■ EXTERNAL EMAIL ■

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Phone: 717.783.2500 | Fax: 717.705.6042
www.health.state.pa.us

From: Bradbury, Joan
To: Smith, Pamela (Health)
Cc: Brooks, Senator Michele
Subject: RE: Proposed Long-Term Care Nursing Facilities Regulations # 10-224
Date: Wednesday, May 11, 2022 1:41:51 PM

Received. Thank you Pam,
Joan

Joan Bradbury
Executive Director
Senate Health & Human Services Committee
Office of Senator Michele Brooks
168 Main Capitol Building
717-787-1475 (direct)

From: Smith, Pamela (Health) <pamesmith@pa.gov>
Sent: Wednesday, May 11, 2022 8:40 AM
To: Brooks, Senator Michele <mbrooks@pasen.gov>; Bradbury, Joan <jbradbury@pasen.gov>
Subject: Proposed Long-Term Care Nursing Facilities Regulations # 10-224
Importance: High

Good morning,

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The Regulatory Review Act requires delivery of the proposed regulatory package to the Standing Committees of the General Assembly, the Legislative Reference Bureau (LRB) and the Independent Regulatory Review Commission (IRRC) **on the same day**, with IRRC receiving the package last. Confirmation of receipt by the Standing Committees and LRB is required for delivery to IRRC.

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Thanks,
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Phone: 717.783.2500 | Fax: 717.705.6042

www.health.state.pa.us

PRIVILEGED AND CONFIDENTIAL ATTORNEY-CLIENT COMMUNICATION
ATTORNEY WORK PRODUCT

From: Bulletin
To: Smith, Pamela (Health)
Cc: Leah Brown; Code&Bulletin
Subject: [External] RE: Proposed Long-Term Care Nursing Facilities Regulations # 10-224 (LRB)
Date: Wednesday, May 11, 2022 10:14:03 AM

ATTENTION: This email message is from an external sender. Do not open links or attachments from unknown sources. To report suspicious email, forward the message as an attachment to CWOPA_SPAM@pa.gov.

Good morning Pam:
Thank you for sending PRM 10-224. Someone from our office will contact you regarding the publication date in the *Pennsylvania Bulletin*. Take care and have a nice day.

Corinne Marut
Editorial Assistant
Legislative Reference Bureau
Pennsylvania Code & Bulletin Office
647 Main Capitol Building
Harrisburg, PA 17120-0033
717-783-1530
cmarut@palrb.us

From: Smith, Pamela (Health) <pamesmith@pa.gov>
Sent: Wednesday, May 11, 2022 9:48 AM
To: Bulletin <bulletin@palrb.us>
Cc: Leah Brown <lbrown@palrb.us>
Subject: Proposed Long-Term Care Nursing Facilities Regulations # 10-224 (LRB)
Importance: High

Good morning,

Attached is a proposed regulatory package from the Department of Health for long-term care nursing facilities. The entire package is attached as a .pdf with Word versions of the Annex and Preamble.

The Regulatory Review Act requires delivery of the proposed regulatory package to the Standing Committees of the General Assembly, the Legislative Reference Bureau (LRB) and the Independent Regulatory Review Commission (IRRC) **on the same day**, with IRRC receiving the package last. Confirmation of receipt by the Standing Committees and LRB is required for delivery to IRRC.

Please respond as soon as possible to this email indicating that you have received the attached proposed regulatory package so that I can deliver the package to IRRC **today, May 11, 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: Bulletin
To: Smith, Pamela (Health)
Cc: Leah Brown
Subject: [External] Re: Proposed Long-Term Care Nursing Facilities Regulations # 10-224 (LRB)
Date: Wednesday, May 11, 2022 11:18:17 AM

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Hello Pam!

Thank you for sending the PRM that we discussed earlier this week! As advised, we will publish this in the May 28th issue of the Pa. Bulletin. I will be in touch if I have any questions!

Have a great rest of your week!

Leah

From: Smith, Pamela (Health) <pamesmith@pa.gov>
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