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June 26, 2022

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Director, Office of Policy
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Health and Welfare Building Harrisburg, PA 17120
VIA EMAIL to: RA-DHLTCRegs@pa.gov

Re: Rulemaking 10-224 (Long-Term Care Facilities, Proposed Rulemaking 4) 28 PA Code Sections 201.18-21, 201.24-31, 207.2, 209.3, 211.2-211.17
Deadline: June 27, 2022

To Whom It May Concern:

Thank you for the opportunity to comment on the Department's fourth package of proposed nursing home licensing regulations. Community Legal Services (CLS) provides free legal assistance to low-income Philadelphia residents in civil matters affecting the most essential human needs, including housing, employment, public benefits, access to health care and long term supports and services. Our Health & Independence Unit provides legal advice and representation to nursing home residents concerning residents' rights and quality of care. We also engage in policy advocacy in this area. We write with the following comments and to express support for the comments submitted by our advocacy partners at CARIE.

First and most importantly, we continue to strongly support increasing nursing care hours to 4.1 per resident per day. We also support the provisions in this package to increase staffing ratios. The problem of poor quality of care in nursing facilities has been both shameful and well known for decades. However, with the arrival of the COVID-19 pandemic, the inadequate staffing levels, training and infection control present in many nursing facilities contributed to a catastrophic loss of life that finally drew public attention to the need to improve care in these facilities. Myriad reports and academic studies have established that nursing staffing levels are the key to quality care in nursing facilities and that staffing levels below 4.1 hours per resident per day result in adverse care outcomes. Pennsylvania's nursing home regulations are being revised for the first time in more than 20 years – if we do not act now, it is unlikely that this morally imperative improvement will occur in the foreseeable future.

The industry argues that it cannot recruit the workers needed to comply with the proposed staffing increases. However, the current inadequate staffing levels are part of the reason that

nursing facilities struggle to attract workers. Nursing staff do not want to work in jobs where they are overworked, and they become demoralized that they cannot meet residents' needs of residents because of inadequate staffing ratios. Improving staffing levels, together with higher wages and benefits, will make these jobs more attractive and reduce turnover.

An increase in Medicaid payment rates is likely needed to pay for adequate staffing levels, wages and benefits. However, we need greater transparency concerning how public funds are spent by nursing facilities in order to know the funding level needed. Nursing facilities are increasingly being purchased by private entities whose business model is characterized by complex corporate structures and related-party arrangements which make it impossible to tell whether a facility is breaking even, losing money or making a profit for its corporate parent. In order to generate more transparency to inform funding decisions, we again strongly urge the Department to require each facility to submit an annual consolidated financial cost report, to include any parent organization or related entities providing goods or services to the facility.

In addition to the comments offered by CARIE et al., we offer the following additional specific comments on package 4:

§201.18 Management:

We recommend as an addition to 201.18(d.1)(3) that there be a readily available method for resident representatives, as well as residents, to contact the administrator.

§201.20 Staff Development:

Under this proposal, required dementia-related training would be limited to "dementia management" and "care of the cognitively impaired". 42 CFR §483.95(c)(3), (g)(1), (g)(3). This requirement should be expanded to include an understanding of Alzheimer's and other dementias, best care practices including person-centered care, restraint-free care and social engagement, and communication with people with dementia.

LGBTQ cultural competency and implicit bias should be added as areas of training.

We also recommend adding provisions requiring that training be provided by knowledgeable trainers and in a manner which will effectively convey information and result in learning of the material. We have heard of "training" that was provided by having nursing facility staff walk from table to table picking up literature on various topics, and signing at each table that "training" was provided. This is of course completely unacceptable, so we urge the Department to add this requirement. In addition, we suggest adding the training method and format to the written records of training programs which must be maintained under §201.20(d). We also urge the Department to add a requirement that competency or learning be demonstrated after training.

We urge you not to delete training on abuse from the orientation at §201.20(b). Although the federal training requirements at 42 CFR §483.95 include this topic, they do not require it to be

taught at an orientation. Training on the prevention and reporting of abuse (and facility-specific procedures) are cardinal areas which must be taught to staff immediately upon starting to work in a facility.

§201.21 Use of Outside Services

The preamble states that much of this section is being deleted because it is covered by 42 CFR §483.70(g). However, subsections (a) and (c) are not addressed by this federal provision. Subsection 483.70(g) applies to a "qualified professional person". Would this include certified nurse aides? If not, the current §201.21(a) is needed to require the facility to ensure that such personnel meets all necessary licensure and certification requirements. Subsection (c) should also be retained, since the federal provision is less broad. With the proliferation of service provision by related entities, written records including the financial arrangements and charges of the outside source are especially important.

§201.24 Admission Policy

Consistent with our recommendations in *Separate and Unconscionable*[1], the report CLS and CARIE released in 2021 on the racial and ethnic disparities present in our nursing facilities, we urge you to add protections against discriminatory treatment in this section. Please note that the federal admissions policy regulations, at 42 CFR §483.15(a)(5), provide that "[s]tates or political subdivisions may apply stricter admissions standards under State or local laws than are specified in this section, to prohibit discrimination against individuals entitled to Medicaid." We strongly urge the Department to utilize this flexibility to ameliorate discrimination against and segregation of Medicaid recipients, which overlaps with racial and ethnic inequities in long term care facilities. We recommend adoption of the provisions outlined in CARIE's comments, including those requiring facilities to:

- Create and apply a written admissions policy which is compliant with the Americans with Disabilities Act and prohibits discrimination in violation of the Pennsylvania Human Relations Act or federal law or based on payment source;
- Retain a record of all referrals, requests, inquiries and applications for admission, including racial and demographic information, referral source, date and disposition, which records shall be submitted to the Department annually with the civil rights compliance questionnaire; and
- Provide a written notice when an applicant is denied admission.

We urge you not to delete the second sentence of subsection (a), which provides that a resident is not required to name a responsible person if the resident is capable of managing their own affairs. This protection does not appear in the federal regulations and is important, as we have seen facilities attempt to require residents who have capacity to execute a power of attorney for

[1] https://clsphila.org/seniors/racial-disparities-in-nursing-homes/

the convenience of the facility. We have also seen facilities refuse to honor the wishes of a resident who has capacity, instead deferring to the instructions of the resident's agent under power of attorney.

We also object to the removal of subsection (b), which prohibits facilities from obtaining a release from liabilities or legal duties except as part of a formal settlement in litigation. The preamble states that this provision is duplicative of 42 CFR §483.15(a)(2)(iii), but that federal provision only covers liability for losses of personal property, not other types of liability or duties under the licensing regulations. Facilities should not be allowed to seek or obtain releases from liability for, e.g., harm caused by poor care or from the duty to comply with all federal and state requirements.

We applaud the addition of subsection (e) which will require the orientation of new residents to facilities. The timely review of immediate care orders and discussion of the resident's customary routines and preferences are important for a good start to the resident's stay, as are orientation to the facility and help settling in to the room.

We agree with CARIE that residents would considerably benefit from the Department requiring facilities to use a Department-approved standard admissions agreement and detailing what must be included in the agreement. CLS and CARIE have previously recommended language that would add this requirement to the regulations, and it is restated in CARIE's comments.

§201.25 Discharge policy

We urge you not to delete this section. Discharges are one of the most frequent resident rights problem areas. We have frequently seen facilities seeking to discharge residents to unsafe settings or without all of the services or equipment they need. The regulations governing discharges have been an important tool when we advocate for our clients in these situations. While the preamble says that this section is duplicative of 42 CFR §483.21(c), that federal provision does not state as clearly as §201.25 does that the discharge plan must "ensure that the resident has a program of continuing care after discharge from the facility" and that the plan must be "in accordance with each resident's needs." The federal provision, by contrast, focuses on the discharge planning process rather than the plan itself. It does not explicitly say that the plan must include all of the services or equipment necessary to meet the resident's needs, but rather merely requires those needs to be identified and the plan to include "any arrangements that have been made" for the resident's post-discharge care. The clearer statement by §201.25 is needed in order to ensure adequate discharge planning.

§201.29 Resident Rights

The preamble explains that the Department proposes to delete subsection (d) because of duplication with 42 CFR §483.95(b), but the provisions are not duplicative. While the federal provision requires that staff be educated on residents' rights and care requirements, §201.29(d)

requires that staff be trained and involved in the implementation of the facility's *policies and procedures* regarding the rights and responsibilities of residents.

Subsection (e) contains additional protections, beyond those in 42 CFR §483.10(g)(18), which should be retained. Most importantly, subsection (e) prohibits facilities from requiring a security deposit from residents receiving Medicaid. This explicit prohibition does not appear in federal §483.10. The federal regulations also do not require that the written contract indicate how a deposit will be used and the terms for its return.

We **very strongly urge you** not to delete from subsection (g) the requirement that "the resident is transferred to an appropriate place that is capable of meeting the resident's needs". For years, we and other advocates, including long term care ombudsmen from throughout the state, have regularly seen nursing facilities attempt and sometimes succeed in discharging residents to homeless shelters, hotel rooms, boarding homes and other settings where their needs cannot be met. While the transfer/discharge federal regulation cited in the preamble addresses the situation where a resident is transferred to another nursing facility (by requiring the facility to document the service available at the receiving facility to meet the specific needs that the facility claims it cannot meet), it does not address transfers to other settings. The current regulation at §201.29(g) is the clearest protection for nursing home residents against being transferred to non-nursing facility settings where their needs will not be met. For this reason, it is imperative that it be retained.

Subsection (i) contains several elements which are not present in the analogous federal regulation, including the requirement that a resident "be encouraged and assisted" to exercise their rights as a resident and a citizen. The federal regulation also does not require that the telephone number of the local legal services program be provided to residents and posted.

The preamble states that subsection (m) is not necessary because its content is contained in subsection (a). However, subsection (a) does not require that a facility's policies and procedures reflect the residents' rights in this section, only that policies regarding rights be developed and adhered to. We suggest editing subsection (a) to add that a facility's policies and procedures must be consistent with state and federal requirements concerning residents' rights.

We suggest clarifying that the list of residents' rights which must be posted pursuant to subsection (n) includes both the rights listed in both the state and federal regulations.

While we appreciate the addition in subsection (o) of language from Appendix PP on experimental research or treatment, there are several important components which were left out and should be added. The first sentence currently says that the resident or resident representative can consent, but this should be edited to provide that the resident representative can give consent only if the resident is unable to understand the situation and the risks and benefits of the proposed research. If the resident has capacity, only the resident should be able to provide consent for experimental research or treatment. Additional language should be added from Appendix PP providing that where 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.

We applaud the addition of subsection (p), especially recognizing residents' right to care without discrimination on the basis of sexual orientation and gender identity or expression. Older LGBTQ adults and those experiencing disability must be able to access long term services and supports and should not be subjected to discrimination or mistreatment. Nor should they be forced to return to the closet in order to receive the services they need. This provision is an important step forward and we strongly support its inclusion.

We urge you to add an important protection for nursing home residents in the area of involuntary transfers and discharges. While residents have the right, pursuant to federal regulation, to appeal a notice of involuntary discharge, the Department of Human Services has through subregulatory means inexplicably placed the burden of proof in such hearings on the nursing home resident. 55 Pa. Code Chapter 1181 Appendix N. Pennsylvania appears to be nearly alone among states in imposing this burden on the resident. It makes no sense, since the nursing facility, as the moving party, rather than the resident, possesses the information as to why it believes the resident should be discharged and the evidence, if any, supporting the discharge. This puts the resident in the untenable position of trying to prove at a hearing why they should not be discharged in the absence of having been provided with information about the basis for or evidence supporting the discharge. And since this information is revealed by the nursing home only at the time of the hearing, it is impossible for the resident to prepare an effective defense.

Moreover, it is self-evident that nursing home residents are a particularly vulnerable population who are especially ill-equipped to bear the burden of proof, since they are likely to be impeded by some or all of the following: mobility limitations, cognitive impairment, isolation, lack of knowledge of their rights or hearing procedures, lack of telephone service, inability to access the Internet, and/or lack of even paper and writing implements. We have seen this placement of the burden of proof result in bad outcomes for nursing home residents, especially where – as is usually the case – they do not have access to legal counsel. And the stakes in these appeals are very high for the nursing home resident, who is at risk of being discharged to a place where their most basic needs may not be met. Transfer trauma is also a very real risk which can result in a nursing home resident's health decline or even death. We therefore strongly urge you to add a provision clarifying that the burden of proof in involuntary transfer and discharge appeals is on the nursing facility.

§201.30 Access

Two elements of §201.30 are not included in the federal regulations and should be preserved. The first is subsection (a)'s prohibition on the facility question an attorney, ombudsman staff or agency representatives about the reason for their visit to a resident. The second is subsection (b)'s requirement that a person not enter the living area of a resident without identifying themselves to the resident and receiving permission to enter.

§201.31 Transfer agreement

This section should be amended to provide that residents have the right to choose which hospital they are admitted to and that nursing facilities must work with the resident's Community HealthChoices, Medicare Advantage or other insurance plan to determine whether the resident's chosen hospital is in network and arrange for transfer there.

We are also concerned that the federal regulations (at 42 CFR §483.70(j)(2)) which the Department deems duplicative provide that a nursing facility shall be considered to have a transfer agreement in effect if it attempts in good faith to enter an agreement with a hospital sufficiently close to make transfer feasible. It is clearly unacceptable for a nursing facility to lack an agreement permitting it to transfer its residents for hospital care when needed, even if the nursing facility has tried in good faith but failed to obtain such an agreement. For this reason, the current provisions at §201.30 which require there to be a transfer agreement without exception should be retained in order to protect Pennsylvania nursing home residents.

§207.2 Administrator's responsibility

We find the Department's reasoning for eliminating subsection (b) puzzling. Except perhaps in a Greenhouse setting which comes close to replicating a true homelike atmosphere, it is not clear how having nursing personnel performing housekeeping tasks would make an environment more homelike. Nursing personnel, who are often understaffed relative to residents' nursing needs, are needed to provide nursing care and should not be diverted to performing housekeeping tasks.

§209.3 Smoking

There are several aspects of §209.3 which are not included in the federal regulations and should be retained, including the requirement that smoking policies be posted in a conspicuous place and legible format and the requirement that adequate supervision while smoking be provided for residents who need it. We assume that the safety requirements in subsections (e) through (g) are included in the NFPA requirements; if they are not, they should be retained.

We are also concerned for the rights of residents who smoke. After smoking for decades, it is extremely difficult for residents to give up this habit and the addiction to nicotine. We have repeatedly seen residents who were denied the ability to smoke, even outside the facility. Some were threatened with eviction when they violated poorly implemented smoking policies or resorted to smoking secretly. For this reason, we urge the Department to make provision for residents who smoke, as well as those who are non-smokers. In recommendations previously submitted by CLS, CARIE and partner organizations, we recommended the following language: "(h) Smoking policies may prohibit smoking, however, these policies may only be implemented prospectively for residents such that residents admitted to the facility under an earlier smoking policy that permitted smoking must be grandfathered from any change in smoking policy and the resident's smoking must be accommodated." Beyond grandfathering residents admitted under an earlier smoking policy, we recommend that smoking policies permit residents to smoke in

designated or outdoor areas and that supervision be provided for those who need it. At a minimum, smoking policies should be communicated with residents before their admission so that they can decide whether the facility will meet their needs.

§211.2 Medical Director

We welcome the requirement that medical directors complete at least four hours annual of CME pertinent to medical director or post-acute or long term care. However, we are very concerned about the deletion of the portion of subsection (c) which provides that the medical director may serve on a full or part time basis depending on the needs of the residents and facility. Although the preamble states that this is covered by 42 CFR §483.70(f), that federal regulation permits a medical director to serve on a consultant basis and does not include the language requiring the consideration of resident and facility needs in deciding the level of medical director presence. The two regulations are not duplicative; instead, deferring to the federal provision would lower the standard for medical director coverage in Pennsylvania by allowing it to be provided on a consultant basis. Professional oversight in nursing facilities is crucial to quality of care and needed now more than ever, as the acuity of residents' needs has increased since the current Pennsylvania regulations were enacted. We therefore strongly urge you to retain the current language in the second sentence of subsection (c).

§211.5 Medical records

There are at least two components of the provisions which the Department proposes to delete which differ from or are not specifically included in the federal regulations, including the requirement that written consent be obtained for release of information in subsection (b) and the requirement that records be retained for 7 years (versus 5 years in the federal regulations).

Subsection (e) provides that when a facility closes, a resident's records may be transferred with them to a receiving health care facility in lieu of the facility being required to store those records. We suggest that the facility should be responsible for storing *all* residents' records, including those in which the original or a copy was sent to the receiving facility. If the original version of the resident's records is sent to the receiving facility, the closing facility can store a copy. As records become increasingly electronic, it should not present a difficulty for the closing facility to retain copies of each resident's records.

We suggest adding to the list of items that must be included in the resident's medical record all plans of care (not just the most recent – 42 CFR §483.70(i)(5) requires only "the plan of care"). These records may be needed to determine what a resident's needs and services were at a particular point in time or to track changes. We also urge you to add reports, investigations and action taken concerning injuries, since this information is being eliminated with the deletion of subsection (g).

§211.6 Dietary services

We have concerns about eliminating subsection (b). It is not clear whether facilities will all interpret 42 CFR §483.73 (concerning emergency plan) as requiring them to have sufficient food on hand. And how will compliance be determined?

We are also concerned that subsection (b) serves a secondary purpose of ensuring that sufficient food is available even in non-emergency circumstances: there have been instances where a facility experiencing financial trouble ran out of food and staff was forced to purchase food out of the own pockets to feed hungry residents.
See https://www.inquirer.com/philly/business/skyline-healthcare-collapse-nursing-home-operator-golden-living-20180508.html.

We also note that resident counseling is included as a dietary consultant service in subsection (d) but not in the 42 CFR §483.60.

§211.8 Use of restraints

We agree with CARIE's comments that state requirements concerning restraints should be expanded, not reduced. We are especially concerned about the substitution of proposed subsection (c.1) in place of subsection (c). While we agree that facilities must ensure that "appropriate interventions" are in place, this language is overly vague. Facilities should be required to continue to comply with the requirement to remove physical restraints at least 10 minutes out of every 2 hours during normal waking hours and change the resident's position. While we understand the Department's concern that the subsection (c) requirements will become the ceiling, we fear that residents will not be released from restraints even for 10 minutes every two hours if subsection (c) is removed, given the vagueness of the language in new subsection (c.1). This section should provide that additional appropriate interventions must be utilized in addition to the baseline articulated in subsection (c). If there are more up to date interventions which are best practices, they should also be set forth in this section.

§211.11 Resident care plan

We support the recommendations in CARIE's comments for expansion of this section and would particularly like to lift up the following recommended language to ensure accessibility and better incorporate person centeredness into care planning:

(f) The resident or their representative is the center of the interdisciplinary team's person centered service planning process. The process should maximize the decision-making and participation of residents at all levels of cognitive functioning. Residents who have a legal guardian must have the opportunity to address any concerns.

(g) The person-centered planning process must be conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who do not speak English.

(h) At a minimum, Person-Centered service plans must:
i. Include preferences around social interaction, with specific planning focused on supporting the resident during periods of prolonged isolation
ii. Ensure human dignity
iii. Reflect the individuality, values, and cultural considerations of the resident
iv. Identify any unmet needs while including clear language as to how staff can provide proper support to meet these needs
v. Identify and support ongoing opportunities for meaningful engagement, support interests and preferences, and allow for choice.

We are also concerned that it is often difficult for resident representatives and other family members or individuals who the resident chooses to include in care planning to participate for several reasons, including facility failure to invite them and unwillingness to schedule the care planning meeting for times when these individuals are available. Their presence can be crucial to bringing out important care issues and supporting the resident in this process. We therefore recommend the addition of a provision requiring facilities to invite the resident's representative and other people of their choosing and to document this in the medical record. We also recommend requiring facilities to flexibly cooperate with requests for scheduling or rescheduling to permit the resident's representative or other people of their choosing to attend.

We also recommend adopting a requirement that Medical Assistance recipients' Community HealthChoices managed care plan service coordinators be included in care planning meetings, with the resident's consent. These service coordinators are responsible for monitoring and ensuring that residents receive the nursing facility services they need, and this important function cannot be meaningfully carried out without their involvement in the care planning process.

§211.12 Nursing services

We object to the elimination of subsections (b) and (e). While the preamble states that they are duplicative of 42 CFR §§483.35(a)(2) and (b)(2), those federal regulations allow the requirement to be waived, while these extremely important requirements are mandatory under Pennsylvania's current regulations. In addition, §483.35(a)(2) requires only a licensed nurse, while Pennsylvania's provision requires an RN. These provisions should therefore be retained.

We are pleased to see the improved ratios for nurse staffing, although we reiterate our support for the ratios and care hours articulated in CARIE's recommendations. As stated above, nursing staff levels are at the core of quality care, and improvements to Pennsylvania's required staffing levels are desperately needed.

We are confused by the meaning of subsection (f.1)(3): isn't this requirement that one nursing services personnel must be on duty per 20 residents inconsistent with (f.1)(4)'s requirement that at least one nurse aide (which is a subset of nursing services personnel) must be on duty per 10 or 15 residents (depending on the time of day)?

We strongly support the addition of subsection (i.1), providing that only direct resident care provided by nursing service personnel may be counted toward the number of hours of general nursing care required. While ancillary staff such as therapists and social workers are also important, they provide different services from general nursing care. There is no substitute for actual nursing care in fulfilling the purposes of these staffing provisions: meeting residents' most basic and essential personal and nursing care needs.

We urge you not to delete subsection (l), since some facilities may require an increase in nursing staffing from the minimum based on specific situations in their facility.

We also urge you to require that nurse staffing data be posted online as well as at the facility, so that resident representatives, family members, Community HealthChoices service coordinators and the public can monitor them even if they are unable to be in the facility each day.

§211.15 Dental services

While 42 CFR §483.55 requires facilities to have a policy concerning responsibility and charges for lost or damaged dentures, §211.15(b) requires the facility to assure that dentures are retained by the resident and to mark dentures for each resident. This protection is in addition to and not duplicative of the federal regulations, so we suggest retaining it.

§211.16 Social services

We applaud the proposed requirement that all nursing facilities employ a full-time social worker. In our legal representation of nursing home residents, we frequently see complicated and difficult social issues which require social work intervention. Nursing facility residents are a more diverse population than in earlier times. They include significant numbers of younger people with disabilities and individuals with behavioral health or substance use disorder histories, who have complex and varied psychosocial needs.

Social work needs are especially common in implementing safe discharges and transitions to the community, which are an important priority in assuring that individuals are served in the least restrictive setting. In a recent CLS case where the nursing facility (which has fewer than 120 residents) lacked a social worker, a resident was trapped against his will in the facility indefinitely because there was no one to navigate finding him the dialysis services he needed in the community.

Additional sections needed:

We support CARIE's comments concerning additional areas in which regulations should be promulgated, particularly the need for standards for dementia or memory care units. The Commonwealth's personal care home regulations added standards for these units nearly 20 years ago, and the need is equally strong in the nursing facility context. We support the recommended language provided by CARIE in their comments.

Thank you for your work in revising these important regulations and for your consideration of these comments. If you have any questions, please feel free to contact me at pwalz@clsphila.org or (215) 227-4798.

Sincerely,

p/w

Pamela Walz, Supervising Attorney
Health & Independence Unit

cc: Independent Regulatory Review Commission at irrchelp@irrc.state.pa.us