3343

From:	Kathy Cubit
To:	Abbott, Meaghan; Krak, Natalie; Piechowicz, Tara; Gutierrez, Lori; Boss, Rachel; Rodack, Kristen; Heuss, Faith; Roberts, Kate
Cc:	Diane Menio
Subject:	[External] Re: Reg Meeting with CARIE/DOH/GO
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Diane and I want to thank you for meeting with us yesterday. We appreciate Gov. Wolf's continued commitment and your efforts to update PA's nursing home regulations before the end of his Administration. We understand the challenges ahead and are glad to help advance this mutual goal. One issue we neglected to mention is that to ensure support from the advocacy community, especially with the compromise made with staffing, there will need to be improvements made to resident rights and not deleting sections where current state regulations improve upon federal requirements as described in our comments for the fourth package. We look forward to future conversations and working with you.

Thanks again,
Kathy

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June 21, 2022

Lori Gutierrez
Director - Office of Policy
625 Forster Street, Room 814
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 provide comments about Pennsylvania's proposed nursing home regulations. These comments were a collaborative effort among several consumer advocacy organizations including Center for Advocacy for the Rights and Interests of Elders (CARIE), Pennsylvania Council on Independent Living, Pennsylvania Health Law Project (PHLP), and SeniorLAW Center who are signatories, and others who will be submitting separate comments. Collectively, we counsel and represent and/or advocate for long-term care residents and their family caregivers.

We are pleased to see that the Department of Health is continuing its update of the nursing home licensing regulations. The residents and loved ones we represent are long overdue for improvements in the quality of their care and their surroundings. COVID-19 had a tragically devastating impact on nursing home residents and staff. Moreover, it laid bare gross deficiencies and unconscionable racial disparities in the quality of nursing home care. There can be no doubt that the current regulations are insufficient to protect the lives of residents. Considerable changes are necessary and comprehensive reform is essential.

As we have noted throughout our comments on the prior proposed regulations packages, comprehensive reform must include the following important priorities:

- **Systemic Changes to Direct Care Staffing** to increase direct care staffing hours and direct care staffing to resident ratios, as well as to adjust direct care staffing upwards from the minimum as needed to address individuals' assessed needs, overall resident acuity, and other facility-specific factors (such as physical layout features or operation of specialized units).

- **Improvements in Training Requirements** including minimum training hours for direct care and other staff with specific articulated training areas and demonstration of competency.
- **Infection Prevention and Control Requirements** that ensure each nursing home has full-time expert staff on-site to prevent and control infections.
- **Emergency and Pandemic Preparedness Planning Requirements** so that nursing homes must meaningfully plan for how to address emergencies and to prepare for pandemics or other outbreaks.
- **Application for Licensure and for Change of Ownership Procedures** that ensure that the application to operate or purchase a nursing home requires a thorough evaluation of the applicant's experience, expertise, and financial capacity to provide high quality of care.
- **Transparency in ownership, cost reporting, and spending on direct care** such that audited, consolidated cost reporting from the parent organization down to the nursing home and inclusive of all related parties is essential.
- **Residents' Rights Improvements** to update regulations that are over 20 years old and do not protect all residents from discrimination or ill treatment.

While some of the packages address some of these important areas, we have raised concerns in all packages that more changes are needed to achieve a safe, equitable system that provides high-quality care and protects and ensures residents' rights. This package is the most concerning of the four, as can be seen in our extensive comments below and in the mark-up of the proposed regulations that we have attached.

OVERARCHING CONCERNS ABOUT THE DEPARTMENT'S APPROACH TO REVISING THE REGULATIONS, APPLICABLE TO ALL FOUR PACKAGES:

Overall, the proposed revisions of the regulations reflect a massive and sometimes incomplete or unjustified deferral to the federal regulations and other external documents when

1) this is not necessary,
2) this is confusing for the regulated nursing facilities,
3) this inhibits transparency for residents and the public,
4) this is done in a way that deletes portions of existing state regulations that permissibly improved upon what was in the federal regulations, and
5) this means the Department is passing up opportunities to do better, to clarify, or to enhance what is in the federal regulations.

We have raised this red flag on each of the prior packages of proposed regulations: that the proposed regulations reflect an overreliance on the federal regulations as a substitute for meaningful state requirements. None of the proposed changes in those packages, however, has as deleterious an effect as can be found in this fourth package of Department-deleted sections has on residents, their rights, and admissions and discharge protections. We are very disappointed by the extensive, unnecessary deletions of existing state regulations. We strenuously urge that the Department not delete existing requirements but, instead make them consistent with the federal requirements, cross-reference the applicable federal

requirements, and then clarify, expand, or improve upon the federal requirements. This is critically important for ensuring high-quality nursing facility services for residents across the Commonwealth, regardless of payor source.

OVERARCHING COMMENTS ABOUT PACKAGE 4

This package of regulations makes some positive steps towards addressing outstanding concerns, but also removes some very important protections. We are very concerned about this package. We offer the following comments.

This package includes many missed opportunities through overreliance on the federal regulations. We object to these more specifically below but, our overarching reasons for opposing this approach are that:

1) **All facilities, regulators/surveyors, and the public need to know what the complete set of rules are for nursing homes.** Shifting the onus to facilities, regulators/surveyors, and the public to know to sum total of requirements that nursing homes must meet is unacceptable.
2) **The state has failed to undertake or actually removed state opportunities to tailor the federal regulations to Pennsylvania, make them more specific, or strengthen them.** The state has the authority to expand or improve upon federal requirements. Despite knowing of problems that the federal regulations do not fully address, the Department fails to exercise its authority to do better for Pennsylvanians. This is disappointing.
3) **All facilities must comply with the requirements of 42 CFR 483 if the state is going to cross reference it, not just the facilities participating in Medicare and/or Medicaid.** We are concerned that since the federal regulations found at 42 CFR 483 establish conditions of participation for the Medicare and/or Medicaid program, facilities that are solely private pay are not bound by these requirements. While there are not many in Pennsylvania, they do exist. The Department's intention to extend the federal regulations to these facilities through cross referencing the federal regulations may not be adequate to ensure the federal regulations apply and possibly may not sustain any legal challenges. We also question how likely these facilities are to be familiar with both the federal regulations and all applicable interpretative guidance documents.
4) **The removal diminishes the Pennsylvania regulations because they already improved upon the federal regulations.** The Department occasionally proposes to entirely delete a section (because of federal regulations it feels are duplicative), but the state regulations had already expanded or improved upon the federal requirement and the consequence is that the proposed regulations are taking away extra improvements by reverting to the federal regulations. The Department's justifications for these removals simply cite to the federal requirement and fail to note that this justification actually only covers part of what the Department proposes to delete.

COMMENTS ON SPECIFIC SECTIONS

In the remainder of this comment letter, we detail our specific package 4 concerns by section.

Comments on Section 201.18 – Management

More details should be provided about the governing body's responsibilities and the section on the governing body of a nursing home should not be deleted. We object to the deletion of (a). We believe it should be strengthened, not deleted. We had previously recommended adding language clarifying and expanding on the responsibilities of the governing body and we continue to recommend that again here in the tracked changes additions we offer to this section. We also do not think the affirmative requirement for governing bodies to adopt effective administrative and resident care policies and bylaws governing operation of the facility in accordance with legal requirements that was in (d) should have been deleted.

Personal property must be required to be returned within 10 days of discharge or death as some facilities currently delay or simply do not return property at all. Because there have been instances of facilities not returning property of discharged or deceased residents at all, or delaying returning property for extended periods of time, we had previously recommended adding language requiring that property be returned within 10 days and we continue to recommend that again here in the tracked changes additions we offer to this section.

While we support some of the new additions to this section, we recommend additional revisions to undo propose deletions and to add a few.

- We support the affirmative requirement for facilities to report changes in their governing body to the Department within 30 days. Transparency is critically needed.
- We like the additions to what had previously been in (e). In addition to the requirement that the administrator's schedule should be posted in the facility, we recommend that it should also be available on the facility's website for residents and families to be able to have transparency into when the administrator will be on-site. We propose language recommending this. In furtherance of the goal of transparency, we also propose language restating our previous recommendation that daily staffing numbers and levels for all types of staff should be posted in the facility and on the facility website for residents and caregivers (and the public) to see.
- We agree with the addition that administrators should be responsible for ensuring satisfactory housekeeping and maintenance.
- We believe the pandemic made apparent that administrators should be responsible for clear and open communication with residents and their representatives. We propose adding this requirement to (e) and (e)(8) and offer language, which we had previously recommended.
- We believe the administrator should be required to report to the governing body at least monthly on critical information the governing body should know.
- We also believe the facility assessment must look at facility operations.

We object to the proposed deletion in (f) related to residents' funds and to expenditures and disbursements on behalf of the resident. The state regulation provides better protection than the federal regulation, which requires quarterly statements. We do not understand why this would be deleted and do not agree with this deletion. It is

important that the facility maintain a complete record of everything it has done with residents' funds and that this be available to residents at all times.

We object to the revision to (h) that would allow facilities 3 days to issue a resident a check so that they can access their own money. Residents should have access to their funds and we do not support an unnecessary delay of more than 1 day. Additionally, there is no recognition in this section of the possibility of electronic transfers of funds. This should also be an option the resident can choose and should be processed within 1 day of request even if it takes more than 1 day for the electronic transfer to be effectuated. There is no reason the writing a check or requesting the electronic payment cannot be done in 1 day.

Comments on Section 201.19 – Personnel Records

The regulations should be revised to require all facilities to develop and follow specific policies and procedures on designated topics.

- **Rename this section to reflect the broader requirements around policies and procedures.** This section was previously called "personnel policies and procedures". In November 2020, we had recommended that this section be broadened and renamed to cover all of the facility's "policies and procedures". The Department is herein proposing to narrow the original title and focus of this section to just "personnel records". We do not support this narrowing and continue to recommend that language be added to the regulations outlining requirements for the facility to have specific written policies and procedures and for what must be included in those. We offer tracked changes suggestions to this section that reflect our recommendations. And, in light of the Department's addition of language enhancing the personnel records requirements, we again propose renaming this section.
- **Require facilities to have and submit to the Department written policies and procedures related to all aspects of operations and to make these available to all personnel.** These should be available to the Department at all times, they should be reviewed and updated (if necessary) annually, and they should cover at least several specific important topics that we suggest. We also recommend requiring the facilities to send the Department updates as policies and procedures are revised. We propose language to make these recommendations part of the regulations.
- **Add to the requirements for what must be included in personnel records.** We like many of these additions to what should be in a personnel record and support their inclusion. We recommend that this should be a list of what must be in the record at a minimum but that the record does not need to be limited to this list. Additionally, we proposed some additional recommendations of items we had previously recommended be added like including in the personnel record a record of all training, all background checks, and all credentials; a copy of the employment application; documentation of any monitoring, performance, or disciplinary action related to the employee; and a record of the employee's receipt of required vaccinations.

Comments on Section 201.20 – Staff Development

Staff development section requires considerable improvements that were not made.

We had made many previous and very important recommendations for improving this section. We are very disappointed to see that most of them were not incorporated into the proposed regulations.

- **Scope of this section and title need to be broadened.** We had recommended renaming this section "Staff development, orientation and annual training". The scope of the section title was not expanded.
- **Training Topics Need to be Added.**
    - While the federal regulations at 42 CFR 483.95 include training on what is abuse, what are the procedures to report it, and abuse prevention, the federal regulations do not require training on detection (which is critically important) nor on mandatory reporting laws. We urge the Department to add these as required training topics.
    - The federal regulations do not require training on the topics of 1) Disability competency, 2) LGBTQ Cultural Competency, 3) Implicit Bias, 4) Non-discrimination, or 5) Understanding dementia and effective communication skills with people living with dementia and how to apply that to residents of the facility. Additionally, each facility shall train all direct care staff in dementia care and treatment including: understanding Alzheimer's disease and dementia; person-centered care; assessment and care planning; activities of daily living; and dementia-related behaviors and communication. We had previously recommended that these needed to be added to the regulations as essential topics for training and we restate that recommendation here.
- **Demonstration of Competency Needs to be Required.** The regulations do not articulate that direct care staff must demonstrate competency. We recommended language about this previously. We recommend this language again. We also recommend language (as proposed (i)) around random competency checks that we believe the Department should conduct.
- **Facility-specific orientation needs to be required.** Training on how to be a direct care staff person is not the same as training on any given facility's policies and procedures. For example, training on infection control generally is not the same as being oriented to the specific facility's infection control procedures. For this reason, we had previously recommended a number of topic areas for which there must be facility-specific orientation required for staff before they start work in any specific facility. We recommend these again and offer suggested language for adding this recommendation.
- **Resident-specific training is essential and should be added.** Similar to our comment just above, we had previously flagged that direct care staff need resident-specific training before they can begin independent work in a facility. Residents are all unique human beings and the approach to care needs to be tailored to each resident. Knowing how one resident is most safely transferred or knowing how another resident's skin is most successfully protected from decubiti is knowledge that should be conveyed to new staff so that they can promote the best health and well-being, and positive

outcomes, for residents. We had previously recommended, and we continue to recommend, inclusion of proposed language we have suggested to address this.

- **Role-specific orientation and training for administrative staff should be added.**
- **Portability of training.** We believe that individuals who complete training, orientation, and annual/ongoing trainings should receive documentation that is portable and enables them to transfer the training, orientation, and annual/ongoing training to a new job. One day, it would be great if this portability concept could be expanded to enable work across settings within the LTC workforce sector but, that is a comment for another conversation. We had previously recommended and continue to recommend language that would require providing those trained with just such a certificate.
- **Annual Training needs to be strengthened not removed.** We do not support deleting language requiring annual training. We do support strengthening the existing language of the regulations to require the annual training to be at least 16 hours per year and to expand on the topics that should be covered in the annual training. We recommended language on this previously and restate that recommendation here.
- **Training must be provided by appropriately knowledgeable trainers.** We had previously recommended adding language to make this fundamental concept a requirement of the regulations and we again propose that here.

Comments on Section 201.21 – Use of Outside Resources

Eliminating most of this section on "Use of Outside Resources" is unjustified.
We are confused by the proposed deletion of much of this section. We believe the facility should be held accountable for ensuring that the outside resources or related parties with whom they contract are appropriately qualified to provide high-quality services. We also believe that facilities must be required to use contracted services if they cannot directly provide the required services through their own employees. We strongly object to the deletion of (a) through (c). Additionally, we suggest adding language that requires that facility contracts with outside resources obligate them to cooperate with state-funded programs, demonstrations, or partnerships with local hospitals or health systems or other entities (like were created in response to COVID-19) that are designed to provide quality of care for residents.

Comments on Section 201.24 – Admission Policy

Resident protections within the admissions process need to be improved not diminished or deleted.

- In section 201.24 of the proposed regulations, language that prohibits a facility from requiring a resident from designating a representative has been removed. Designating a representative is a resident choice and should not be mandated by a facility.
- Additionally, we had previously recommended language that would prevent a facility employee from being named as the representative of a resident and the Department did not include this resident protection. The proposed regulations would also remove language that protects a resident from being forced to sign a waiver of rights.

- We strongly urged the Department to not allow a facility to require a resident representative or other third party to sign an admissions agreement or to otherwise try to financially bind that resident's representative or third party personally for a resident's care. The prohibition needs to be stated outright and enforced. We recommend adding the language we propose.
- This section of the proposed regulations would also remove language that prohibits facilities from making residents release a facility from liability for failure to fulfill its duties. We object to this being eliminated.

Facilities should not have so much discretion to deny admissions as is afforded in 201.24(c).

This section presently gives too much leeway to a nursing home to deny admission. The language says only that: "A facility shall admit only residents whose individual needs can be provided by the staff and facility." This, again, is an opportunity to improve upon an inadequate regulation to provide greater protection against discriminatory admissions practices. We recommend revising this section to state:

(c) A facility shall provide nursing facility level of care as residents require, in accordance with Section 211.10a Resident Services. A facility shall admit only residents whose individual needs can be provided by the staff and facility. A facility must have and follow a written admission policy that outlines admission procedures, criteria for admission, and what nursing care and physical needs they can and cannot provide. This policy must

1) *be pre-approved by the Department and any revisions must be approved by the Department before being implemented*
2) *be compliant with the Americans with Disabilities Act and all other non-discrimination laws and regulations, including provisions in 201.29 (Residents Rights)*
3) *not permit discrimination on the basis of payor source*
4) *be publicly posted on the facility website and within the facility*
5) *be applied uniformly by the facility*

A facility can only deny admissions if a potential resident's acuity exceeds what is defined in the facility's admissions policy, that which a nursing home is required to provide or if a facility is at capacity of available beds.

We add language at 201.24(c.1) to require facilities to keep track and report annually on whom they are turning away.

Consistent with the recommendations we made in our report on racial and ethnic disparities in nursing homes, we identified the admissions process as a prime time for discriminatory practices that go undetected and that require transparency and compliance with civil rights requirements. This language would operationalize our prior recommendations: "A facility shall retain a log of all referrals, all verbal or written requests or application for admission, and all outcomes of any referrals, requests, or applications for admission. The log shall contain for each referral a patient identifier, and indicate the race, sex, color, national origin of the referral, the date of referral, referring hospital or agency, and date and type of disposition of

referral by the facility. This log shall be submitted to the Department annually with the civil rights compliance questionnaire."

We add language at 201.24(c.2) to require a written denial notice with follow-up action steps an applicant for admission can take.
Applicants for admission should receive a written statement that articulates that they were denied admission and why, and it should indicate what they can do to challenge an admission decision they believe is inappropriate or discriminatory. We add: "Any individual denied admission must be provided with a written notice of denial including the basis for the denial and a statement of their right to appeal and the process for appealing."

While the addition of 201.24(e) is a good start, more standards and protections for the admissions process are necessary and should be added, particularly to prevent the perpetuation of racial and ethnic segregation in nursing facilities.

- Requiring the governing body of each facility to establish written admissions policies is a good start but, the Department fell short in what it requires, and we recommend multiple important additions to this section. Information and orientation for new residents is a great idea and we support this addition.
- The admissions process has been ripe with discriminatory practices that have been documented for decades and we had previously strongly urged the Department to add language related to preventing discrimination in the admissions process. It is unfortunate that the long-standing structural racism and segregation demonstrated within our nation's nursing homes has not been redressed by the industry itself. Given that, it is incumbent upon the state to take all necessary steps to mitigate this gross yet ongoing problem. We vigorously urge the Department to revise the regulations to include the language we had proposed in November 2020 and that we propose here to be added to 201.24(e).
- Residents would considerably benefit from the Department requiring facilities to use a Department-approved standard admissions agreement and detailing exactly what must be included in the agreement. We have previously recommended language that would add this requirement to the regulations and detail what must be in the standard agreement that would be uniformly presented to all of a facility's residents.

Comments on Section 201.25 – Discharge Policy

Discharge protections should not be deleted from the regulations when they really need to be strengthened. The Department proposes to delete language requiring discharge and transfer planning for residents. For years, residents have lacked adequate protections against unjust and unsafe discharge or transfers to other settings. Robust protections must be articulated to prevent residents from being arbitrarily and carelessly evicted from the place they call home. We previously recommended, and continue to recommend, language that would far better protect residents from mistreatment through discharge. We urge the Department to adopt our recommended language which we revised to reflect the addition of 201.24(c) that a facility must have and follow a Department-approved policy that details what needs it cannot meet so that there is a yard stick by which to measure

whether a facility is rightfully or wrongfully discharging a resident for reasons inconsistent with its written policy, including for discriminatory reasons.

Just as applicants for admission should receive a written statement that articulates that they were denied and why, and it should indicate what they can do to challenge an admission decision they believe is inappropriate or discriminatory, residents facing discharge or transfer should also be given the same notice and appeal right.

Comments on Section 201.26 – Power of Attorney/Resident Representative

This section used to contain prohibitions on facility staff serving as power of attorney and needed to be expanded to prohibit staff from service as guardian, healthcare proxy, or other surrogate too but, instead the Department weakened it and made it only about who could be a resident representative. We recommend language that would expand the prohibition on the facility or facility staff serving as surrogate or representative and renaming the section to reflect this. We also recommend one caveat in that the facility could be representative payee for Social Security payment, with permission of the resident or their representative. We provide language for this as well.

Comments on Section 201.29 – Resident Rights

We understand the Department's asserted justification for wanting to delete state regulatory provisions on topics that are addressed in federal law but, as we have repeatedly stated: we are very concerned about the deletions for this reason and the need for a single consolidated statement of residents' rights is the perfect example of why we are concerned.

- **Residents and their representatives or other loved ones need a single, comprehensive statement of all of their rights.** While their rights may derive from multiple statutory or regulatory sources, these rights are meaningless if residents cannot refer to one single statement of what their rights are, and we are concerned articulated statements of rights will contribute to residents not knowing those rights exist or that they are able to exercise them. Additionally, simply deleting previously articulated rights from the state regulations without noting the source of a federal right that exists to replace the previously articulated rights is unreasonable drafting. For example, instead of completely deleting 201.29(f) because 42 CFR 483.15(c)(1) provides a more comprehensive statement related to grounds for discharge, the state regulations should state: "Residents have the right to remain in the facility and not be discharged or transferred except as articulated in 42 CFR 483.15(c)(1)."
- **State regulations such as section 201.29(e) often provide more specificity than the federal regulations and that is helpful to residents.** Whereas 42 CFR 483.10(g)(18) requires facilities to inform a resident before changes in charges, the state regulations at 201.29(e) require the facility to inform the resident **verbally and in writing** of changes in charges. This added resident protection, perfectly permissible under federal preemption rules, should not be eliminated. On this similar theme, we do support deletion of any portions of the regulations that have become contradictory of the federal regulations as it is not permissible for state regulations to provide less

protection than the federal regulations. Accordingly, we do support the revisions to 201.29(e) of the language requiring 30 day advance notice because federal regulations at 42 CFR 483.10(g)(18)(i) and (ii) require at least 60 days advance notice of charges not covered under Medicare or Medical Assistance. But, the federal regulations only address changes due to charges not being covered by Medicare or Medical Assistance and the Department's wholesale deletion of a requirement of at least 30 days advance notice is inappropriate. The Department could extend the 60 days' notice requirement to all potential changes in charges or could clarify that changes in coverage for items and services covered under Medicare and Medical Assistance must be made at least 60 days in advance in accordance with 42 CFR 483.10(g)(18)(i) and (ii) while 30 days' notice must be provided for all other changes in charges. We oppose the complete deletion of (e).

- **Cross references to federal regulations must include embedded links to that provision of the regulation for the state regulations when posted online and must include a requirement that a resident receive a hard copy of both the federal and state residents' rights upon admission and at least annually thereafter.**

We urge the person-centered revision of many subsections such that they begin, where possible with: "Residents have the right" or "A resident has the right".

We support the language added to 201.29(a) that would involve residents in the development, implementation, and review of policies related to residents' rights. We propose language to this section to explicitly state that a facility's policies must be consistent with state and federal law and regulations.

We oppose the deletion of 201.29(d) that required staff to be trained annually on and involved in the implementation of policies related to residents' rights. While the federal regulations do require staff to be trained on residents' rights, they do not require staff to be involved in the implementation of policies related to residents' rights. Additionally, we believe staff should be trained at least annually on residents' rights by the LTC Ombudsman Program. We also believe staff should be trained at least annually on abuse, neglect and exploitation by Older Adults Protective Services staff. We propose language that would add this here. Similarly, we believe that residents should be provided annual presentations on residents' rights from the LTC Ombudsman Program and on abuse, neglect, and exploitation from Older Adults Protective Services staff and we add language with that recommendation to our mark-up of the regulations.

We suggest a new 201.29(d.1) that explicitly cross-references the rights afforded by 42 CFR 483.10. The rights section should explicitly cross-reference the rights afforded by 42 CFR 483.10 and should require that any summary of rights provided must articulate those that are found in the federal and in the state regulations. We provide language to this effect. It reads "All residents have the rights outlined in 42 CFR 483.10, regardless of payer source. A single, consolidated, written summary of all resident rights retained in 42 CFR 483.10 and contained herein shall be provided to residents upon admission and at least annually thereafter and shall be posted throughout the facility."

We understand the Department's reason for deleting (e) but, as we have repeatedly stated: we are very concerned about the deletions because the content is covered in federal regulations and the need for a single consolidated statement of residents' rights is the perfect example of why we are concerned. Residents and their representatives or other loved ones need a single, comprehensive statement of all of their rights. While their rights may derive from multiple statutory or regulatory sources, these rights are meaningless if residents cannot refer to one single statement of what their rights are and we are concerned articulated statements of rights will contribute to residents not knowing those rights exist or that they are able to exercise them.

While there is much that was in 201.29(f) that is stated in the federal regulations, we oppose the entire removal of this section. As we have said previously, residents and their representatives or other loved ones need a single, comprehensive statement of all of their rights. While their rights may derive from multiple statutory or regulatory sources, these rights are meaningless if residents cannot refer to one single statement of what their rights are, and we are concerned articulated statements of rights will not include the federal rights and contribute to residents not knowing those rights exist or that they are able to exercise them. Additionally, simply deleting previously articulated rights from the state regulations without noting the source of a federal right that exists to replace the previously articulated rights is unreasonable drafting. For example, instead of completely deleting 201.29(f) because 42 CFR 483.15(c)(1) provides a more comprehensive statement related to grounds for discharge, the state regulations should state: "Residents have the right to remain in the facility and not be discharged or transferred except as articulated in 42 CFR 483.15(c)(1)." The rest of the section should read: "Residents have the right to advance written notice of transfer or discharge as stated and in accordance with the requirements and limitations contained in 42 CFR 483.15(c)(3) and (4). Residents' rights related to bed-holds at the facility are outlined in 42 CFR 483.15(d). All transfer and discharge actions and actions leading up to the need for transfer and discharge shall be well-documented on the resident record. In addition to the requirements under 42 CFR 483(c), relating to transfer of medical records, non-medical care notes and service and service plan records describing the resident's LTSS needs and preferences shall accompany the resident if the resident is sent to a medical facility or to another long-term care facility."

While the existing 201.29(g) is not as robust as it could have been, it should be revised and improved instead of removed because of the language in the federal regulations at 42 CFR 483.15(c)(7), which we find lacking in itself. The federal regulations at 42 CFR 483.15(c)(7) calls for "A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand." In our experience, this is not sufficient language to prompt nursing homes to engage in comprehensive, person-centered discharge planning. Discussion of alternatives settings, including possibly even transition back to a home and community-based setting, is frequently skipped. For example, facilities have been known to discharge residents to

homeless shelters. And, thus far, the state and federal regulations have failed to provide residents sufficient time, information, or assistance to ensure a safe and orderly transfer or discharge. We urge the Department to use its authority to expand upon the minimum requirements set by the federal regulations instead of deleting this section. We provide suggested language that would improve this section.

Do not delete 201.29(i) or (j). While we understand the federal regulations outline these residents' rights, it is important for this to be clearly stated in the state regulations. Additionally, the Department hot line and local legal services called for in (i) are not expressly listed in the federal regulations, nor is the requirement that the information be physically posted in a prominent location and in large print. We oppose this deletion. Likewise, we oppose the deletion of (j). We appreciate that the federal regulations require a facility to "treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident." We feel this statement is important to keep in the regulations. It calls for consideration and for recognition of a resident's individuality, as well as for privacy in caring for residents' social needs.

Revise instead of deleting 201.29(l). We oppose the wholesale deletion of this section when it should be improved upon by language that reflects the importance of residents still having rights and the ability to participate in person-centered service planning processes despite the representative. We recommend language that would ensure this. We also recommend language that codifies a resident's right to visitors and an essential caregiver.

Retain language in 201.29(n) that requires rights to be provided on admission and requires the facility to accommodate LEP or low-literacy individuals in how they inform residents of rights. We oppose the deletion of this language. Residents must be provided a copy of their rights and facilities must make accommodations for LEP or low-literacy individuals.

We have concerns about 201.29(o) and believe residents need more protection than just a requirement for informed consent before initiation of experimental research or treatment. We recommend language that makes it clear that residents have the right to not be required to participate in any experimental research or treatment, that they also have the right to choose to participate in these activities. If the facility is involved in the experimental research or treatment, the facility must have Department approval, IRB approval or other similar, written, safety protocols like the ones the IRB requires and these must be provided to residents, and written approval based on informed consent. We also expand the definition of experimental research or treatment to make it broader, more like it was, and not as narrow as the Department's proposed revision.

We strongly support the explicit statement of non-discrimination, that residents have the right to be free of any discrimination. This is a good and important addition. Residents and facilities alike need to read this and be regularly reminded of it. We are hopeful

that this right will come with robust enforcement activities to ensure that facilities and staff are in compliance.

Add additional rights that we had previously recommended the Department expressly articulate in the regulations. We previously strongly recommended and continue to vigorously recommend the addition of these important rights for residents:

(p) Residents have the right to receive care in accordance with their person-centered service plan and in compliance with a person-centered approach.
(q) Residents have the right to have recognition of their families of choice and domestic partnerships the same as traditional family units and marriages.
(r) Residents have the right to go to their hospital of choice even if the facility has a transfer agreement with other hospitals and/or that facilities must inform residents or their resident representative of the facility's transfer agreements upon admission.
(s) Residents must be provided with annual resident rights training by the LTC ombudsman.
(t) Residents shall have the right to bring a private right of action, which the facility shall not ask them to waive.
(u) Residents must be provided with written notice of residents' rights and responsibilities and payment policies, including filial responsibility and estate recovery rules that may apply as well as information about the right to choose whether to have the facility serve as the resident's representative payee for Social Security.
(v) Residents must be informed about bed hold policies prior to a transfer to a hospital and must be provided information on how the facility tracks each full 24 hour period in which the resident is absent from the facility.
(x) Residents have the right to privacy. LGBT residents have the right to decide who knows about their sexual orientation and gender identity, and if, when or how they choose to come out. Outing a resident or disclosing their gender history, sexual orientation or HIV status without their consent is prohibited.
(y) Residents have the right to be free from restraints except where medically ordered and are the least restrictive alternative, and as outlined in the resident's person-centered service plan.

Comments on Section 201.30 – Access Requirements

While the federal regulations specify the resident's right to visitors, 201.30 provided more detail to prohibit the facility from interfering with access by others and should be kept (with some suggested improvements) not deleted. The existing section provided more detail than the federal regulations and we suggest more specificity to ensure access by all government entities that would need access. We also suggest language that explicitly states that access can be telephonic, videographic, or in person. We urge the Department to revise and not delete.

Comments on Section 201.31 – Transfer Agreement

We object to the deletion of this section. We believe these are important requirements to hold facilities to and do not want to see them removed. We do believe this section should be

revised to reflect that residents have choice in which hospital they are admitted to and that facilities must work in concert with the resident's insurance so that admissions are consistent with Community HealthChoices or other insurance plan provider network limitations. We propose language to this effect.

Comments on Section 207.2 – Administrator's Responsibility

We object to the Department deleting this entirely. While we understand that (a) has been moved up to 201.18, the deletion of (b) and the Department's unacceptable justification of the deletion of (b) – prohibiting nursing personnel from being assigned housekeeping duties - prompts us to vigorously oppose this deletion. In the proposed regulation package, the Department explains: "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." This right here is a considerable way for facilities to avoid the staffing level increases/requirements.

We also recommend the addition of (c) as housekeeping and maintenance personnel must be trained on infection control.

Comments on Section 209.3 Smoking

We object to the proposal to delete this section on Smoking entirely. This is an important section. The federal regulations do not cover all that is presently included in the state regulations. The federal regulations do not require smoking policies to be posted. They do not require supervision to be provided for those residents who require it. Also, we had recommended and still recommend the addition of: "(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."

Comments on Section 211.2 Medical Director

This section should be improved upon instead of deleted. We had previously made and continue to make recommendations to improve this section, specifically to be clearer as to what role the medical director must play within the nursing home. We do not agree that this section should be deleted. We are also concerned that the preamble would allow consultant medical directors to be used and to apply their own interpretation of the nursing home regulations in their role as medical director. We provide mark-up of how to improve upon instead of deleting this section.

Comments on Section 211.5 Medical Records

This section should be retitled as "Resident Records" to include Medical and Person-Centered Service Records and the content related to person-centered services should be retained not deleted. This section should be about the whole resident not just about medical services. This section should be renamed "Resident records". We object to the deletions in this section. The list of items that must be in a medical record that already existed in the regulations was revised to be entirely medical and the Department proposes to delete anything related to the needs assessment and person-centered service plan, etc. The Department states its reason is to eliminate duplication with the federal regulations but, we continue to have concerns about facilities' ability to comply with requirements that are split across multiple different source documents and would rather see the non-medical care documents listed in this section. This section should be improved upon instead of deleted. We recommend language to improve this section by adding the documentation related to person-centered assessments and service delivery, needs and preferences, social, psychosocial, emotional, and well-being items.

Comments on Section 211.6 - Dietary Services

We cannot support the Department's proposal to remove a requirement that at all times a facility have enough food on site to cover at least three days. The Department removes this stating: "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." There are no imaginable circumstances in which having enough food to last through at least 3 days would be wasteful and it is short-sighted to remove a minimally protective requirement for this reason. Additionally, (f) should be revised to say, "Dietary personnel shall practice hygienic food handling techniques *and follow all facility infection control protocols*."

Comments on Section 211.8 – Restraints

We strongly object to the revisions to 211.8 Restraints and this section on restraints should have been considerably strengthened instead of wholly deleted. We had previously recommended several additions to clarify and strengthen this section. We are extremely disappointed to see that the Department did not incorporate those recommendations.

Under the Department's proposed revisions, this section would read:

211.8 Restraints

(a) (Reserved).

(b) (Reserved).

(c) (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) 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.
(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.

If our recommended strengthening revisions are accepted, the section would read:

211.8 Restraints

(a) Residents have the right to be free of physical, mechanical, and chemical restraints.
(b) Restraints are prohibited unless
(i) authorized in accordance with state and federal law,
(ii) ordered by a physician as appropriate to treat the individual's medical condition,
(iii) consented to by the resident or resident's representative, and
(iv) approved by the resident's person-centered service planning interdisciplinary team as part of the resident's written person-centered service plan and must include a written demonstration that less restrictive alternative means of controlling movement or behavior do not work. The person-centered service plan must outline how and when restraints are approved.
(c) Restraints may not be used for discipline, convenience, or in lieu of staff effort or adequate staffing levels to meet residents' needs.
(d) Locked restraints or any mechanical apparatus or device, such as shackles, straightjackets, cage-like enclosures or other similar devices, employed to restrict voluntary movement of a person that is not removable by that person may not be used.
(e) Restraints may not be used or applied in a manner which causes injury to the resident.
(f) Physical and mechanical 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.
(g) If restraints are used, a facility shall ensure that appropriate interventions are in place to safely and adequately respond to resident needs.
(h) A signed, dated, written physician 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. It shall include the period for which the restraint is being authorized and the circumstances under which the restraints may be used. All other circumstances are prohibited and a violation of the resident's right to be free of restraints.
(i) 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.
(j) Every 30 days, or sooner if necessary, the interdisciplinary team shall review and reevaluate the use of all restraints ordered by physicians. Residents' person-centered services plan shall be updated to reflect the outcomes of these reviews.
(k) Any chemical restraints must be closely monitored to ensure no adverse reactions.
(l) The facility shall document daily all uses of restraints, including dates and times and staff persons involved. These documents shall be stored and made available for inspection by the Department and others authorized to view these records.

Comments on Section 211.9 – Pharmacy Services

Facilities must be affirmatively required to timely refill prescriptions and to ensure that expired medications are not administered to residents. This is an important addition as we know of instances in which facilities have not timely refilled prescriptions as well as times in which facilities have not taken care to ensure that medications are not expired. We also believe that the facility's policies for disposition of medications should be submitted to and approved by the Department.

Comments on Section 211.11 - Resident care plan.

This section also required improvements that expand upon the federal requirements but instead the Department would delete it. We previously recommended and continue to recommend that this section should provide more detail around the person-centered service planning process, frequency of meetings, involvement of managed long-term care Medicaid plans through the Community HealthChoices program as they have a role in service planning, training staff to understand person-centered service delivery and reading/following person-centered service plans, and more. None of these recommendations were implemented in the proposed regulations, much to our great disappointment, and the Department proposes to delete this section instead. Resident-centered care is supposed to be the hallmark of what a nursing home delivers. The Department owes it to residents to provide details that would help ensure they actually receive resident-centered care. We again recommend language that would improve upon this section and help ensure that residents receive person-centered services.

Comments on Section 211.12 - Nursing Services

While the revisions proposed for nursing services staffing the package 1 of the regulations and here in package 4 reflect a vast improvement in the staffing levels and ratios over the current standards, these changes need to be further strengthened and accompanied by a holistic consideration of the residents' needs and the facility makeup. We previously recommended and continue to vigorously urge the inclusion as (f) of language that states: "The following minimum nursing and nurse aide staffing ratios and minimum staffing levels are minimums. Actual staffing levels, which shall meet or exceed the minimum levels, must be determined specifically for each facility based on the actual needs of each resident as outlined in their comprehensive assessments and person-

centered service plans, as well as in accordance with the facility assessment required in 42 CFR 438.70(e), which facilities shall be required to complete quarterly." This language facilities a more holistic, facility-specific, and resident-specific consideration as part of adjusting the minimum staffing hours upward to reflect unique or increased needs for staff hours.

We previously recommended and continue to strenuously recommend the resident-related care ratio of 1:7, 1:7, and 1:15 recommendation for direct care. The language should be revised to reflect this stronger recommendation that better supports residents and direct care workers, alike. The difference between our language proposed here and the proposed regulation is that the proposed regulation includes only a ratio of nursing services professionals to residents whereas our language includes both a proposed ratio and a resident-related breakdown of the minimum amount of time of direct care they can expect and hold each facility to provide for each type of nursing/direct care professional and non-professional. Ratios alone do not address this and do not provide residents with a number they can understand and advocate around.

We continue to strongly support the proposal from package 1 to improve the minimum number of hours of direct care per resident per day to 4.1 in 211.12(f). We stress how long overdue this change is and want to convey that this is an essential element for us. Anything less than 4.1 per resident per day minimum is unacceptable.

We also recommend the addition of language that requires staffing levels with a specific minimum required breakout of RN, LPN, and CNA time. Ratios alone are not enough. They do not provide the resident, their loved ones, and the public a clear understanding of exactly the minimum amount of care they can expect a resident to be provided and this information is imperative to being able to advocate for a resident getting the services they should.

We also recommend the addition of language that requires staffing levels and ratios to only count RNs, LPNs, and CNAs who are providing direct care to residents. Ancillary staff cannot and should not be included in the calculation for purposes of compliance with staffing level and ratio requirements.

Transparency is fundamentally important. Residents and the public must be able to know what a facility's actual staffing is from day to day. This should be both posted physically and online. We recommend language that would require this.

Comments on 211.15 – Dental Services

This section should be improved not deleted. We object to the deletion of this section. Facilities must help residents access dental services. The Department should strengthen this section to ensure facilities assist residents in accessing outside providers when needed or preferred.

Comments on Section 211.16 Social Services

While the deletions in (a) and (b) are acceptable, and while we support the requirement that all facilities have a social worker, we also want some improvements added to this section. These recommendations include requiring the person-centered service plan to identify the resident's social service needs and how those will be addressed for and with the resident. We also recommend language that requires nursing homes to facilitate the use of technology to support residents' ability to remain connected with their outside social connections. We provide language that would implement these additions.

Sections the Department did not propose to revise but should have.

201.27 Advertisement of Special Services should have been enhanced but was not revised at all. The Department did not propose any revisions to 201.27 but, we believe some important additions to that section are needed. They are: 1) an express requirement that facilities comply with the requirements of the Unfair Trade Protection and Consumer Protection Law, 2) an express prohibition on facilities advertising their services in a manner that misrepresents their scope of services as being greater or lesser than their licensure and certification covers, and 3) an express prohibition on facilities advertising or promoting the facility has providing services or having specialties unless they are defined by the state as specific services or specialties. We believe the PA Supreme Court case COMMONWEALTH OF PENNSYLVANIA ACTING BY ATTORNEY GENERAL, JOSH SHAPIRO, Appellant v. GOLDEN GATE NATIONAL SENIOR CARE LLC; GGNSC HOLDINGS LLC et al strongly supports the need for this addition.

New sections the Department did not add but should have.

The regulations are missing an affirmative statement of what services each nursing facility must be able to provide and what needs each nursing facility must be able to meet. We believe this provision needs to be included. This coupled with language we propose adding to 201.25 increases protections against individual's being denied admission arbitrarily or discriminatorily. We propose, as section § 211.10a. Resident Services, the following language:

Resident Services

A facility must provide all medical, social, nursing, pharmacy, dementia care, activities, and other services to meet the physical health, behavioral health, psychosocial, emotional, social, personal care, technological, equipment, and other needs and preferences of each individual resident and as may be required of a person who meets the nursing facility level of care. Facilities must also assist residents with activities of daily living and instrumental activities of daily living.

The nursing home regulations are long overdue for specific requirements for Dementia Care or Memory Units. It is disheartening that none of the proposed regulations packages cover this critical topic. Nursing homes are allowed to promote themselves as having these units but, there are not criteria for them. Our state personal care home and assisted living regulations have criteria for memory care units but, still our nursing homes do

not. We recommend language for the addition of this. We provided this language to the Department in November 2020 and were disappointed to see that the regulations still do not address this. This should have been its own section or at least some of it could have been added to section 201.27 related to advertisement of specialty services. This is the language that we proposed:

Dementia Care or Memory Units

(a) A Dementia Care or Memory Unit is a unit or portion of a facility that has submitted an application to and been approved by the Department as a Dementia Care or Memory Unit that provides one or both of the following:

(1) Specialized care and services for residents with Alzheimer's disease or dementia in the least restrictive manner consistent with the resident's person-centered services plan to ensure the safety of the resident and others in the residence while maintaining the resident's ability to receive the care and services they need.

(2) Intense neurobehavioral rehabilitation for residents with severely disruptive and potentially dangerous behaviors as a result of brain injury in the least restrictive manner consistent with the resident's rehabilitation and person-centered services plan to ensure the safety of the resident and others in the facility.

(b) Only a facility authorized by the Department as a Dementia Care or Memory Unit may so advertise, regardless of what terminology the facility uses to describe their unit. The Department will consider the licensee's demonstration that:

(1) Staff collaboratively assess, plan, and provide care that is consistent with current advances in dementia care practices.

(2) Staff have the qualifications, skills, training, and education to assess and provide care for a resident population with memory impairment.

(3) The facility provides activities that match the resident's cognitive ability, memory, attention span, language, reasoning ability, and physical function.

(4) Non-pharmacological interventions are used as an alternative to antipsychotic medication use.

The organization has a designated physical environment to promote safety and minimize confusion and overstimulation.

The nursing home industry and regulations are long-overdue for requirements around ethics and compliance, and this should have been included in the regulations but was not.

Compliance and Ethics

Each facility shall have a compliance and ethics program. The compliance and ethics program required pursuant to these regulations may be a component of more comprehensive compliance activities by the nursing home so long as the requirements of this section are met. A compliance and ethics program shall include the following elements:

(a) written policies and procedures that describe compliance expectations as embodied in a code of conduct or code of ethics, implement the operation of the compliance program, provide guidance to employees and others on dealing with potential compliance issues, identify how to communicate compliance issues to appropriate compliance personnel and describe how potential compliance problems are investigated and resolved;

(b) designate an employee vested with responsibility for the day-to-day operation of the compliance program; such employee's duties may solely relate to compliance or may be combined with other duties so long as compliance responsibilities are satisfactorily carried out; such employee shall report directly to the entity's chief executive or other senior administrator and shall periodically report directly to the facility's Board of Directors and governing body on the activities of the compliance program;
(c) establish a compliance committee consisting of executives, governing board members and facility personnel to assist the employee described in paragraph (b) in the performance of compliance functions;
(d) training and education of all affected employees and persons associated with the nursing home, including owners, executives and governing body members, on compliance issues, expectations and the compliance program operation; such training shall occur periodically but not less than annually and shall be made a part of the orientation for a new employee, appointee or associate, executive and governing body member;
(e) communication lines to the responsible compliance position, as described in paragraph (b), that are accessible to all employees, persons associated with the nursing home, owners, executives and governing body members, to allow compliance issues to be reported; such communication lines shall include a method for anonymous and confidential good faith reporting of potential compliance issues as they are identified;
(f) disciplinary policies to encourage good faith participation in the compliance and ethics program by all affected individuals, including policies that articulate expectations for reporting compliance issues and assist in their resolution and outline sanctions for: (1) failing to report suspected problems; (2) participating in non-compliant behavior; or (3) encouraging, directing, facilitating or permitting non-compliant behavior; such disciplinary policies shall be fairly and firmly enforced;
(g) a system for routine identification of compliance risk areas specific to the nursing home industry, for self-evaluation of such risk areas, including internal audits and as appropriate external audits and reviews, and for evaluation of potential or actual non-compliance as a result of such self-evaluations and audits;
(h) a system for responding to compliance issues as they are raised; for investigating potential compliance problems; responding to compliance problems as identified in the course of self-evaluations and audits; correcting such problems promptly and thoroughly and implementing procedures, policies and systems as necessary to reduce the potential for recurrence; identifying and reporting compliance issues to the appropriate federal and state entities; and refunding overpayments;
(i) a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, self-evaluations, audits and remedial actions, and reporting to appropriate federal and state entities.

We have attached a marked-up version of Annex A, reflecting all the changes we believe are necessary and identifying where we have specific concerns.

We are dedicated to helping improve the lives of nursing facility residents. We would appreciate the opportunity to meet with your staff in the weeks ahead to further discuss our

recommended revisions to the regulations. You can reach us through Diane Menio at menio@carie.org or Kathy Cubit at cubit@carie.org.

Sincerely,

Diane A. Menio, Executive Director
Kathy Cubit, Advocacy Manager
Center for Advocacy for the Rights and Interests of Elders

Michael Grier, Executive Director
Pennsylvania Council on Independent Living

Laval Miller-Wilson, Executive Director
Amy E. Lowenstein, Director of Policy
Pennsylvania Health Law Project

Karen C. Buck, Executive Director
SeniorLAW Center

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

KEY for this document–

- Language in black text is language that exists in the current regulations.
- Language in black [ ] brackets is language that exists in the current regulations but that the proposed regulations propose to delete. In a normal tracked-changes world, this would be struckthrough to reflect a deletion.
- Language in black underline is language the proposed regulations propose to add.
- Language in red ~~strikethrough~~ is language we advocates recommended that the state delete (in our November 2020 recommendations).
- Language in red underline is language we advocates recommended that the state add (in our November 2020 recommendations).

CHAPTER 201. APPLICABILITY, DEFINITIONS, OWNERSHIP AND GENERAL OPERATION OF LONG-TERM CARE NURSING FACILITIES

GENERAL PROVISIONS

§ 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).~~**

(1) The Facility shall maintain written documentation to evidence how the governing body was created and by whom and maintain a listing of all current and past members.

(2) The governing body is legally responsible for establishing and implementing policies regarding the management and operation of the facility.

(3) The governing body shall report monthly to the licensee on operational activities including, at a minimum, the items identified in 201.18(b).

(4) The governing body appoints the administrator of the facility.

(5) The governing body shall be actively engaged in the establishment of all policies and procedures governing the facility and oversee the Quality Assurance Performance Improvement process. The administrator shall present, at least quarterly, a detailed description of the QAPI projects being performed by facility staff and the results of QAPI projects completed. The governing body shall review the projects, provide oversight and analyze outcomes to ensure that the QAPI program is performing effectively.

(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.

Commented [AH1]: We object to the deletion of this. We believe it should be strengthened, not deleted. We had previously recommended adding language clarifying and expanding on the responsibilities of the governing body and we continue to recommend that again here in the tracked changes additions we offer to this section.

(2) Protection of personal and property rights of the residents, while in the facility, and upon discharge or after death, and return of any resident property remaining at the facility within 10 business days after discharge or death.

(3) The general operation of the facility.

(c) [The governing body shall [provide the information required in § 201.12 (relating to application for license) and prompt reports of changes which would affect the current accuracy of the information required] report to the Department within 30 days changes to the information that was submitted with the facility's application for licensure under section 201.12 (relating to application for license of a new facility of 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), 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 work schedule, including what days and times the administrator will be physically present in the facility, shall be public posted in the facility and posted on the facility's publicly website along with the daily posting of staffing numbers and levels for all types of staff.

Commented [AH2]: Because there have been instances of facilities not returning property of discharged or deceased residents at all or delaying returning property for extended periods of time, we had previously recommended adding language requiring that property be returned within 10 days and we continue to recommend that again here in the tracked changes additions we offer to this section.

Commented [AH3]: We support the affirmative requirement for facilities to report changes in their governing body to the Department within 30 days. Transparency is critically needed.

Commented [AH4]: We think it is important to keep this affirmative statement of the responsibility and mission of the governing body.

Commented [AH5]: We thank the Department of changing references from "responsible persons' to resident representatives. We support this change and hope to see that it has been universally revised throughout all four packages, wherever the term "responsible person" previously was stated.

Commented [AH6]: We like these additions to what had previously been in (e). In addition to the requirement that the administrator's schedule should be posted in the facility, we recommend that it should also be available on the facility's website for residents and families to be able to have transparency into when the administrator will be on-site. We propose language recommending this. In furtherance of the goal of transparency, we also propose language restating our previously recommendation that daily staffing numbers and levels for all types of staff should be posted in the facility and on the facility website for residents and caregivers (and the public) to see.

(d.3) The Administrator shall report to the governing body on an at least monthly basis, in writing, regarding the operation of the facility to include survey results, allegations of abuse or neglect, complaints, or any other information relevant to risks, safety and security of the facility's residents. The governing body shall respond in writing to the administrator's report within thirty (30) days acknowledging receipt and development of a plan to address any non-compliant conduct.

(d.4) The administrator shall also be responsible to report, on a monthly basis, information regarding the facility's management and operation through the use of audits, review of budgets, projected and actual staffing tools, supplies available, in order to ensure compliance with regulatory requirements and meet the needs of the residents.

(d.5) The facility assessment process shall include a detailed review of the assessment of the operations by the governing body and documentation of said review as part of the facility assessment.

(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 groups.

Commented [AH7]: We support this addition to the administrator's responsibilities.

(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.

(8) Communicating to residents and resident representatives any updates about the composition of or decisions made by the governing body.

(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 1 ~~3 bank business~~ days~~s~~ of the request and in the form—cash or check—as requested by the resident]. The facility shall process a request for electronic transfer of funds~~provide cash~~, if requested, within one day of the request ~~or a check, if requested, within three days of the request~~.

§ 201.19. Operating policies and procedures, including p~~P~~ersonnel [policies and procedures] records.

(a) The facility shall have and maintain written policies and procedures for all facets of operations. These policies and procedures must be provided to employes during Initial Training and Orientation. The policies and procedures must be maintained in writing and made available to the state for review at annual survey inspection and any time, on demand.

(b) Policies and procedures shall be reviewed annually and updated at least annually in accordance with best practices in resident care and service delivery.

(c) The facility must have policies covering at least the following topics:

- Hygiene, infection control, tracking resident interactions (for contact tracing),
- Hiring, staffing, staff sick time and sick pay and other family leave policies,
- Cultural non-discrimination,

Commented [AH8]: We believe the pandemic made apparent that administrators should be responsible for clear and open communication with residents and their representatives. We propose adding this language, which we had previously recommended.

Commented [AH9]: We don't understand why this would be deleted and don't agree with this deletion. It is important that the facility maintain a complete record of everything it has done with residents' funds.

Commented [AH10]: We object to the revision that would allow facilities 3 days to issue a resident a check so that they can access their own money. Residents should have access to their funds and we do not support an unnecessary day of more than 1 day. Additionally, there is no recognition in this section of the possibility of electronic transfers of funds. This should also be an option the resident can choose and should be processed within 1 day of request even if it takes more than 1 day for the electronic transfer to be effectuated. There is no reason the writing a check or requesting the electronic payment cannot be done in 1 day.

Commented [AH11]: This section was previously called "personnel policies and procedures". In November 2020, we had recommended that this section be broadened and renamed to cover all of the facility's "policies and procedures". The Department is herein proposing to narrow the original title and focus of this section to just "personnel records" We do not support this narrowing and continue to recommend that language be added to the regulations outlining requirements for the facility to have specific written policies and procedures and for what must be included in those. We offer tracked changes suggestions to this section that reflect our recommendations. And, in light of the Department's addition of language enhancing the personnel records requirements, we again propose renaming this section.

- Guaranteed access to the facility (for LTC Ombudsman, Protective Services, surveyors, etc.),
- Conducting person-centered service planning and providing person-centered care
- Mandatory reporting of Abuse, Neglect, and Exploitation and reporting of critical/adverse incidents or sentinel events

(d)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] including but not limited to:

(1) The employee's job description, educational background and employment history.

(2) Employee performance evaluations.

(3) Documentation of all credentials including but not limited to 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, if 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 initial, annual, and ongoing trainings.

(8) A criminal history and other background check records.

(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.

10) The employee's completed employment application

11) Documentation of monitoring, performance, or disciplinary action related to the employee

12) Records of the employee's receipt of required vaccinations

Commented [AH12]: We like many of these additions to what should be in a personnel record and support their inclusion. We recommend that this should be a list of what must be in the record at a minimum but that the record does not need to be limited to this list. Additionally, we proposed some additional recommendations of items we had previously recommended be added.

(e) At least 30 days advance written notice of changes to any policies must be provided to the Department, the residents, the residents' representatives, and the LTCOP.

§ 201.20. Staff development, orientation, and annual training.

(a) There shall be an ongoing coordinated educational program which is planned and conducted for the development and improvement of skills of the facility's personnel, including [training related to problems, needs and rights of the residents], at a minimum, annual in-service training on the topics outlined in 42 CFR 483.95 (relating to training requirements) in addition to the following topics:

(1) Accident prevention.

(2) Restorative nursing techniques.

(3) Emergency preparedness in accordance with 42 CFR 483/73(d) (relating to emergency preparedness).

(4) Fire prevention and safety in accordance with 42 CFR 483.90 (relating to physical environment).

(5) Training on the detection and prevention of resident abuse, neglect, and exploitation and the mandatory reporting of the abuse, neglect, and exploitation.

(6) Disability Competency

(7) LGBTQ Cultural Competency

(8) Implicit Bias

(9) Non-Discrimination

~~(4)~~(10) Understanding dementia and effective communication skills with people living with dementia and how to apply that to residents of the facility. Additionally, each facility shall train all direct care staff in dementia care and treatment including: understanding Alzheimer's disease and dementia; person-centered care; assessment and care planning; activities of daily living; and dementia-related behaviors and communication.

(b) All direct care staff trained by the facility or elsewhere shall demonstrate competency through a combination of observation and other competency testing prior to independent work in any facility.

Commented [AH13]: We had previously recommended that the facility have to have written policies and procedures completed and submitted to the Department prior to opening or assuming ownership of a license. As follow-up on that theme, it is critical that the facility be required to submit updates to the Department. Additionally, updates should also be shared with residents, their representatives, and made available to the LTC Ombudsman program.

Commented [AH14]: We had previously recommended and continue to recommend that the scope of this section and the title of this section be expanded. We recommend that this section be renamed "Staff development, orientation, and annual training".

Commented [AH15]: We support the articulation of these topics but recommended previously that additional topics be included and we restate our recommendation that these be added.

Commented [AH16]: While the federal regulations at 42 CFR 483.95 include training on what is abuse, what are the procedures to report it, and abuse prevention, the federal regulations do not require training on detection (which is critically important) nor on mandatory reporting laws. We urge the Department to add these as required training topics.

Commented [AH17]: The federal regulations do not require training on the topics of 1) disability competency, 2) LGBTQ Cultural Competency, 3) Implicit Bias, 4) Non-discrimination, or 5) Understanding dementia and effective communication skills with people living with dementia and how to apply that to residents of the facility. Additionally, each facility shall train all direct care staff in dementia care and treatment including: understanding Alzheimer's disease and dementia; person-centered care; assessment and care planning; activities of daily living; and dementia-related behaviors and communication. We had previously recommended that these needed to be added to the regulations as essential topics for training and we restate that recommendation here.

Commented [AH18]: The regulations do not articulate that direct care staff must demonstrated competency. However, this is am important requirement to state explicitly. Training is not enough. Knowledge acquisition must be measured. We recommended language about this previously and restate it here.

(c) Every~~An~~ [employe] employee shall receive appropriate facility-specific orientation that covers ~~to the facility,~~ its policies and procedures. Each employe ~~and to the position and duties~~shall demonstrate competency through a combination of observation and other means prior to independent work with residents. ~~[~~The orientation shall include:

~~training on the prevention of resident abuse and the reporting of the abuse.]~~

i. Infection prevention, detection, and control procedures in the facility

ii. Emergency, Pandemic, and Disaster Preparedness Plan and preparedness for the facility

iii. Fire Prevention and Resident Safety procedures for the facility

iv. Incident reporting and accident prevention procedures for the facility

v. Person-centered service planning and care provision for the residents of the facility

vi. Understanding dementia and effective communication skills with people living with dementia and how to apply that to residents of the facility

(d) Every direct care employee shall additionally receive resident-specific, appropriate orientation specific to the actual residents of the facility, the facility's policies, and to their specific position and duties, and shall demonstrate competency through a combination of observation and other means prior to independent work with residents. The orientation shall include:

i. Personal care functions such as correct resident transfer techniques, Hoyer lift usage, and assistance with feeding;

ii. Management of aggressive behaviors;

iii. Documentation of care delivery; and

iv. Dementia care and treatment needs specific to the residents in the facility.

(e) Upon completion of the initial orientation and training as required under Subsections (b), the facility shall issue a certificate of completion to each employee, which shall be portable between settings within Pennsylvania, provided that the employe does not have a lapse of direct service or administration employment for 24 consecutive months or more, the staff member shall not be required to repeat the initial training.

(f) ~~[~~There shall be at least annual in-service training of at least 16 hours per year which includes at least the following topics:

Commented [AH19]: Training on how to be a direct care staff person is not the same as training on any given facility's policies and procedures. For example, training on infection control generally is not the same as being oriented to the specific facility's infection control procedures. For this reason, we had previously recommended a number of topic areas for which there must be facility-specific orientation required for staff before they start work in any specific facility. We recommend these again and offer suggested language for adding this recommendation.

Commented [AH20]: Similar to our comment just above, we had previously flagged that direct care staff need resident-specific training before they can begin independent work in a facility. Residents are all unique human beings and the approach to care needs to be tailored to each resident. Knowing how one resident is most safely transferred or knowing how another resident's skin is most successfully protected from decubiti is knowledge that should be conveyed to new staff so that they can promote the best health and well-being, and positive outcomes, for residents. We had previously recommended and we continue to recommend inclusion of this language we have suggested.

Commented [AH21]: We believe that individuals who complete training, orientation, and annual/ongoing trainings should receive documentation that is portable and enables them to transfer the training, orientation, and annual/ongoing training to a next job. One day, it would be great if this portability concept could be expanded to enable work across settings within the LTC workforce sector but, that is a comment for another conversation. We had previously recommended and continue to recommend language that would require providing those trained with just such a certificate.

Commented [AH22]: We do not support deleting language requiring annual training. We do support strengthening the existing language of the regulations to require the annual training to be at least 16 hours per year and to expand on the topics that should be covered in the annual training. We recommended language on this previous and restate that recommendation here.

i. Best practices and updated procedures for infection prevention, detection, and control

ii. Effective cleaning and disinfecting processes and procedures

iii. ~~,~~ F~~f~~ire prevention and resident safety,

iv. A~~a~~ccident prevention,

v. Emergency, Pandemic, and Disaster Preparedness Plan~~disaster~~ preparedness,

vi. R~~r~~esident confidential information,

vii. R~~r~~esident psychosocial needs,

viii. R~~r~~estorative nursing techniques ~~and~~

ix. R~~r~~esident rights, including personal property rights, privacy, preservation of dignity

x. Cultural competency including linguistic competency, disability competency, ethnic and racial equity competency, and LGBTQ competency

xi. Person-Centered care planning and service delivery~~and~~

xii. Understanding brain injury providing traumatic brain injury capable care

xiii. Dementia treatment and care, including new information and best practices

xiv. T~~t~~he prevention and reporting of resident abuse, neglect, exploitation

xv. Incident reporting

~~i.~~xvi. Proper use, donning, and doffing of PPE.~~]~~ **~~(Reserved).~~**

(g~~d~~) Written records shall be maintained which indicate the content of and attendance at [the] staff development programs.

(h) Initial and Ongoing/Annual Training must be provided by individuals with knowledge and expertise in the designated topic of each training.

(i) The Department shall conduct random competency audits of staff during annual surveys.

§ 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).~~**

Commented [AH23]: Training must be provided by appropriately knowledgeable trainers. We had previously recommended adding language to make this fundamental concept a requirement of the regulations and we again propose that here.

Commented [AH24]: We are confused by the proposed deletion of much of this section. We believe the facility should be held accountable for ensuring that the outside resources or related-parties with whom they contract are appropriately qualified to provide high-quality services. We also believe that facilities must be required to use contracted services if they cannot directly provide the required services through their own employees. We strongly object to the deletion of (a) through (c).

(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.

(f) The facility must cooperate with state-funded programs, demonstrations, or partnerships with local hospitals/health systems that the state makes available to improve quality of care or respond to a pandemic/infectious disease outbreak.

§ 201.24. Admission policy and process.

(a) [The resident may be permitted to name a [resident's responsible person] resident representative. The resident is not required to name a [resident's responsible person] resident representative if the resident is capable of managing the resident's own affairs. A resident representative may not be an employee of the facility. A facility shall not request or require a resident representative or any other third party to sign an admissions contract unless the resident lacks decisional capacity and the resident representative or other third party has legal authority to act on the resident's behalf.

(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 provide nursing facility level of care as residents require, in accordance with Section 211.10a Resident Services. A facility shall admit only residents whose individual~~nursing care and physical~~ needs can be provided by the staff and facility. A facility must have and follow a written policy that outlines what nursing care and physical needs they can and cannot provide. This policy must

Commented [AH25]: We again suggest adding language that requires that facility contracts with outside resources obligate them to cooperate with state-funded programs, demonstrations, or partnerships with local hospitals or health systems or other entities (like were created in response to COVID-19) that are designed to provide quality of care for residents.

Commented [AH26]: We oppose the deletion of (a) and (b). Designating a representative is a resident choice and should not be mandated by a facility. Additionally, we had previously recommended language that would prevent an facility employee from being named as the representative of a resident and the Department did not include this resident protection. The proposed regulations would also remove language that protects a resident from being forced to sign a waiver of rights.

Commented [AH27]: We strongly urged the Department to not allow a facility to require a resident representative or other third party to sign an admissions agreement or to otherwise try to financially bind that resident's representative or third party personally for a resident's care. The prohibition needs to be stated outright, and enforced. We recommend adding the language we propose.

Commented [AH28]: This section presently gives too much leeway to a nursing home to deny admission. The language say only that: "A facility shall admit only residents whose individual needs can be provided by the staff and facility." This, again, is an opportunity to improve upon an inadequate regulation to provide greater protection against discriminatory admissions practices. We recommend revising this section to limit the nursing home's ability to arbitrarily or discriminatorily deny admission.

1) be pre-approved by the Department and any revisions must be approved by the Department before being implemented
2) compliant with the Americans with Disabilities Act and all other non-discrimination laws and regulations, including provisions in 201.29 (Residents Rights)
3) not discriminate on the basis of payor source
4) be publicly posted on the facility website and within the facility
5) be applied uniformly by the facility

Outside of the facility's written policy, a facility can only deny admissions if a potential resident's acuity exceeds that which a nursing home is required to provide or if a facility is at capacity of available beds.

(c.1) A facility shall retain a log of all referrals, all verbal or written requests or application for admission, and all outcomes of any referrals, requests, or applications for admission. The log shall contain for each referral a patient identifier, and indicate the race, sex, color, national origin of the referral, the date of referral, referring hospital or agency, and date and type of disposition of referral by the facility. This log shall be submitted to the Department annually with the civil rights compliance questionnaire.

(c.2) Any individual denied admission must be provided with a written notice of denial including the basis for the denial, a statement of their right to appeal and the process for appealing, contact information for local legal services to assist with the appeal, and contact information for the appropriate agency that can help them find alternative services.

(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 grievance or complaint officer.

(3) A description of facility routines, including nursing shifts, mealtimes and posting of menus.

Commented [AH29]: Consistent with the recommendations we made in our report on racial and ethnic disparities in nursing homes, we identified the admissions process as a prime time for discriminatory practices that can fly under the radar and that require some bright light to be shone for transparency and compliance with civil rights requirements. This language would operationalize our prior recommendations.

Commented [AH30]: Applicants for admission should receive a written statement that articulates that they were denied and why and it should indicate what they can do to challenge an admission decision they believe is inappropriate or discriminatory.

Commented [AH31]: Requiring the governing body of each facility to establish written admissions policies is a good start but, the Department fell short in what it requires and we recommend multiple important additions to this section. Information and orientation for new residents is a great idea and we support this addition.

(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 (relation 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.

(6) Each facility governing body shall develop and submit to the Department an admissions non-discrimination policy that reflects the facility's plan to implement the following requirements:

(i) A facility shall not discriminate against any potential resident on the basis of payment source.

(ii) A facility shall not discriminate against any potential resident on the basis of race, gender, creed, color, sexual orientation, gender identity or expression, or in violation of the *Pennsylvania Human Relations Act* (PHRA) and applicable federal laws.

(7) The facility governing body shall establish policy and require the facility administrator and admissions personnel to use a Department-approved standard admissions agreement that shall serve as a legally binding agreement that defines the rights and obligations of each person (or party) signing the contract. Residents and/or resident's representatives should be advised that this contract can be reviewed by a legal representative, or by any other advisor, before signing. The admissions agreement must include the following required sections:

(i) Consent to Treatment

(ii) Resident Rights

(iii) Non-Discrimination Statement and Recourse

(iv) Financial Arrangements

1) Charges for Private Pay Residents

2) Security Deposits

3) Charges for Medicaid, Medicare, or Insured Residents

4) Billing and Payment

(v) Transfers and Discharge

1) Bed Holds and Readmission

(vi) Personal Property and Funds

Commented [AH32]: The admissions process has been ripe with discriminatory practices that have been documented for decades and we had previously strongly urged the Department to add language related to preventing discrimination in the admissions process.

It is unfortunate that the long-standing structural racism and segregation demonstrated within our nations nursing homes has not been redressed by the industry itself. Given that, it is incumbent upon the state to take all necessary steps to mitigate this gross yet ongoing problem. We vigorously urge the Department to revise the regulations to include the language we had proposed in November 2020 and that we propose here to be added to 201.24(e)(6).

(vii) Photographs

(viii) Confidentiality of Medical Information

(viii) Facility Rules and Grievance Procedure(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. ~~F~~Discharge or transfer policy.

A facility shall provide nursing facility level of care as residents require. A resident shall not be discharged or transferred for any reason other than those outlined in 42 CFR 483.15(c). A facility must have and follow a written policy that outlines what nursing care and physical needs they can and cannot provide. This policy must

1) be pre-approved by the Department and any revisions must be approved by the Department before being implemented
2) compliant with the Americans with Disabilities Act and all other non-discrimination laws and regulations, including provisions in 201.29 (Residents Rights)
3) not discriminate on the basis of payor source
4) be publicly posted on the facility website and within the facility
5) be applied uniformly by the facility

A facility can only discharge or transfer a resident on the grounds that it cannot meet the resident's needs if it can demonstrate that the decision is consistent with the facility's written policy. Outside of the facility's written policy, a facility can only discharge or transfer a resident if a resident's acuity exceeds that which a nursing home is required to provide or if a facility is at capacity of available beds.

Any individual discharged or transferred must be provided with a written notice of denial including the basis for the denial, a statement of their right to appeal and the process for appealing, contact information for local legal services to assist with the appeal, and contact information for the appropriate agency that can help them find alternative services.

Commented [AH33]: Just as applicants for admission should receive a written statement that articulates that they were denied and why and it should indicate what they can do to challenge an admission decision they believe is inappropriate or discriminatory, residents facing discharge or transfer should also be given the same notice and appeal right.

Prior to any discharge or transfer, t~~T~~here shall be developed and implemented a centralized, coordinated, individualized discharge plan for the~~each~~ resident who would be discharged or transferred to ensure that the resident has a program of continuing, person-centered care after discharge from the facility and that the setting to which the individual is being discharged or transferred has the capability to meet the resident's needs and preferences. The discharge plan shall be in accordance with each resident's needs and preferences and shall include transfer by

the facility of current person-centered service plans and any advance planning documents or orders related to the resident.] ~~**(Reserved).**~~

§ 201.26. Prohibition on Facility or Facility Staff Serving as Surrogate or Representative [~~Power of attorney~~] Resident representative.

~~[~~Power of attorney, guardianship, healthcare proxy, other surrogacy, or resident representative 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. A facility may serve as representative payee only with the express written permission of the resident or the resident's representative, after providing notice and information about the representative payee role, process, and a Resident's right to their Personal Needs Allowance.

§ 201.29. Resident rights.

(a) The governing body of the facility shall establish written policies consistent with federal and state regulations 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 related to residents rights.] ~~**(Reserved).**~~ At least annually, facility staff shall receive training on residents' rights as required by 42 CFR 483.95(b) and Section 201.20 provided by the LTC Ombudsman and training on prevention, detection, and reporting of abuse, neglect, and exploitation provided by state or local Older Adult Protective Services personnel. At least annually, residents shall receive a presentation on residents' rights by the LTC

Commented [AH34]: Discharge protections should not be deleted from the regulations when they really need to be strengthened. The Department proposes to delete language requiring discharge and transfer planning for residents. For years, residents have lacked adequate protections against unjust and unsafe discharge or transfers to other settings. Robust protections must be articulated to prevent residents from being arbitrarily and carelessly evicted from the place they call home. We previously recommended and continue to recommend language that would far better protect residents from mistreatment through discharge. We urge the Department to adopt our recommended language which we revised to reflect the addition of 201.24(c) that a facility must have and follow a Department-approved policy that details what needs it cannot meet so that there is a yard stick by which to measure whether a facility is rightfully or wrongfully discharging a resident for reasons inconsistent with its written policy, including for discriminatory reasons.

Commented [AH35]: This section used to contain prohibitions on facility staff serving as power of attorney needed to be expanded to prohibit staff from service as guardian, healthcare proxy, or other surrogate too but, instead the department gutted it and made it only about who could be resident representative. We recommend language that would expand the prohibition on the facility of facility staff serving as surrogate or representative and renaming the section to reflect this. We also recommend one caveat in that the facility could be representative payee for Social Security payment, with permission of the resident or their representative. We provide language for this as well.

Commented [AH36]: We support the language added to 201.29(a) that would involve residents in the development, implementation, and review of policies related to residents rights. We propose language to this section to explicitly state that a facility's policies must be consistent with state and federal law and regulations.

Ombudsman and on prevention, detection, and reporting of abuse, neglect, and exploitation by state or local Older Adult Protective Services personnel.

(d.1) All residents have the rights outlined in 42 CFR 483.10, regardless of payer source. A single, consolidated, written summary of all resident rights retained in 42 CFR 483.10 and contained herein shall be provided to residents upon admission and at least annually thereafter and shall be posted throughout the facility.

(e) Residents have the right to notice of changes in charges. ~~[~~The resident or if the resident lacks decisional capacity~~is not competent~~, the ~~resident's responsible person~~ resident representative, 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 by Medicare or Medical Assistance and not covered by the per diem rate of the facility, as required by 42 CFR 483.10(g)(18). 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~~ resident representative 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 the nature of which does not allow for advanced notice, a resident may not be transferred or discharged from the facility without prior notification. The resident and the [resident's responsible person] resident representative 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.~~] Residents have the right to remain in the facility and not be discharged or transferred except as articulated in 42 CFR 483.15(c)(1). Residents have the right to advance written notice of transfer or discharge as stated and in accordance with the requirements and limitations contained in 42 CFR 483.15(c)(3) and (4). Residents' rights related to bed-holds at the facility are outlined in 42 CFR 483.15(d). ~~The~~ All transfer and discharge actions and actions leading up to the need for transfer and discharge shall be well-documented on the resident record. In addition to the requirements of under 42 CFR 483(c) relating to transfer of medical records, ~~Suitable~~ non-medical care notes and ~~clinical~~ service and service plan records describing the resident's LTSS needs and preferences~~, including list of orders and medications as directed by the attending physician~~ shall accompany the resident

Commented [AH37]: While the federal regulations do require staff to be trained on residents rights, they do not require staff to be involved in the implementation of policies related to residents rights. Additionally, we believe staff should be trained at least annually on residents rights by the LTC Ombudsman Program. We also believe staff should be trained at least annually on abuse, neglect and exploitation by Older Adults Protective Services staff. We propose language that would add this here. Similarly, we believe that residents should be provided annual presentations on residents rights from the LTC Ombudsman Program and on abuse, neglect, and exploitation from Older Adult Protective Services staff and we add language with that recommendation to our mark-up of the regulations.

Commented [AH38]: The rights section should explicitly cross-reference the rights afforded by 42 CFR 483.10 and should require that any summary of rights provided must articulate those that are found in the federal and in the state regulations. We provide language to this effect.

Commented [AH39]: Whereas 42 CFR 483.10(g)(18) requires facilities to inform a resident before changes in charges, the state regulations at 201.29(e) require the facility to inform the resident **verbally and in writing** of changes in charges. This added resident protection, perfectly permissible under federal preemption rules, should not be eliminated. On this similar theme, we do support deletion of any portions of the regulations that have become contradictory of the federal regulations as it is not permissible for state regulations to provide less protection than the federal regulations. Accordingly, we do support the revisions to 201.29(e) of the language requiring 30 day advance notice because federal regulations at 42 CFR 483.10(g)(18)(i) and (ii) require at least 60 days advance notice of charges not covered under Medicare or Medical Assistance. But, this federal regulations only covered changes due to charges not being covered by Medicare or Medical Assistance and the Department's wholesale deletion of a requirement of at least 30 days advance notice is inappropriate. The Department could extend the 60 days' notice requirement to all potential changes in charges or could clarify that changes in coverage for items and services covered under Medicare and Medical Assistance must be made at least 60 days in advance in accordance with 42 CFR 483.10(g)(18)(i) and (ii) while 30 days' notice must be provided for all other changes in charges. We oppose the complete deletion of (e).

Commented [AH40]: As we have said previously, residents and their representatives or other loved ones need a single, comprehensive statement of all of their rights. While their rights may derive from multiple statutory or regulatory sources, these rights are meaningless if residents cannot refer to one single statement of what they rights are and we are concerned articulated statements of rights will not include the federal rights and contribute to residents not knowing those rights they exist or that they are able to exercise them. Additionally, simply deleting previously articulated rights from the state regulations without noting the source of a federal right that exists to replace the previously articulated rights is unfair drafting. For example, instead of completely deleting 201.29(f) because 42 CFR 483.15(c)(1) provides

if the resident is sent to a~~nother~~ medical facility or to another long-term care facility.~~]~~ **~~(Reserved).~~**

(g) ~~[~~Residents have the right to safe and orderly, well-planned discharge or transfer. ~~Unless the discharge is initiated by the resident or resident's responsible person, t~~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.~~]~~ If a discharge is initiated by the resident or the resident representative, the facility will assist with appropriate arrangements to assure a safe and orderly discharge or transfer. 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) ~~[~~Residents have the right to exercise their rights as a resident and as a citizen and to be encouraged and supports in exercising these rights. 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~~resident representative shall be made aware of the Department's Hot Line (800) 254-5164, the telephone number of the local 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) Residents have the right to ~~[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) Residents have the right to ~~[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).~~**

Commented [AH41]: While the existing 201.29(g) is not as robust as it could have been, it should be revised and improved instead of removed because of the language in the federal regulations at 42 CFR 483.15(c)(7), which we find lacking in itself. The Department that 42 CFR 483.15(c)(7) calls for "A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand." In our experience, this is not sufficient language to prompt nursing homes to engage in comprehensive, person-centered discharge planning. Discussion of alternatives settings, including possibly even transition back to a home and community-based setting is frequently skipped. Facilities have been known to discharge a resident to a homeless shelter. And, thus far, the state and federal regulations have failed to prevent residents from being given insufficient time, information, or assistance in having a safe and orderly transfer or discharge. We urge the Department to use its authority to expand upon the minimum requirements set by the federal regulations instead of deleting this section. We provide suggested language that would improve this section.

Commented [AH42]: While we understand the federal regulations that outline these residents rights, it is important for this to be clearly stated in the state regulations. Additionally, the Department hot line and local legal services are not expressly listed in the federal regulations, nor is the requirement that the information be physically posted in a prominent location and in large print. We oppose this deletion.

Commented [AH43]: We appreciate that the federal regulations require a facility to "treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident." We feel this statement is important to keep in the regulations. It calls for consideration and for recognition of a resident's individuality, as well as for privacy in caring for residents social needs.

(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).~~** In the case of a resident adjudged legally incapacitated by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law.

(i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decision outside the representative's authority.

(ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative.

(iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process.

(iv) The resident shall retain the right to visitors and to their choice of visitors, except where a court order restricts this right. At any time that visitation is restricted, the resident retains the right to identify at least one essential caregiver to visit in-person following all necessary safety protocols to provide needed care, support, and oversight. The facility may not prohibit admission of any essential caregiver that is following the facility's required safety protocols.

(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, including the rights articulated in 42 CFR 483.10 and those contained in this section. [The facility shall on admission provide a resident or ~~resident's responsible person~~ resident representative 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) A resident has the right not to be required to participate in any experimental research or treatment while in a facility, whether by the facility or as guided by their doctor. The resident has the right to participate in experimental research or treatment with their doctors only after informed consent is obtained by the resident and/or their legal representative. Experimental research or treatment involving a resident in a [nursing home] facility whether conducted by the

Commented [AH44]: We oppose the wholesale deletion of this section when it should be improved upon by language that reflects the important of residents still having rights and the ability to participate in person-centered service planning processes despite the representative. We recommend language that would ensure this. We also recommend language that codifies a resident's right to visitors and an essential caregiver.

Commented [AH45]: We oppose the deletion of this language. Rights must be provided a copy of their rights and facilities must make accommodations for LEP or low-literacy individuals.

Commented [AH46]: We have concerns about 201.29(o) and believe residents need more protection than just a requirement for informed consent before initiation of experimental research or treatment. We recommend language that makes it clear that residents have the right to not be required to participate in any experimental research or treatment, that they also have the right to choose to participate in these activities. If they facility is involved in the experimental research or treatment, the facility must have Department approval, IRB approval or other similar, written, safety protocols like the ones the IRB requires and these must be provided to residents, and written approval based on informed consent. We also expand the definition of experimental research or treatment to make it more broad, more like it was, and not as narrow as the Department's proposed revision.

facility or by any doctor under contract with or employed by the facility may not be carried out 1) without the approval of the Department, 2) without IRB approval or other written, safety protocols that are provided to the resident and resident representative, if applicable, and, 3) 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, the safety protocols, 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 or treatment'' ~~[~~means an ~~experimental~~ treatment or procedure that is ~~one of the following~~:

(1) Not a generally accepted treatment, procedure, or practice in the medical community, and~~.~~

(2) Exposes or has the potential to expose the resident to pain, injury, unknown risks, or invasion of privacy or asks the resident to surrender autonomy, such as a drug study.~~]~~

An experimental research or treatment often involves ~~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. It can also involve such things as nursing or social science exploration of new approaches to providing assistance with activities or daily living or addressing social isolation.

(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 of guide animals. (p) Residents have the right to receive care in accordance with their person-centered service plan and in compliance with a person-centered approach.

(q) Residents have the right to have recognition of their families of choice and domestic partnerships the same as traditional family units and marriages.

(r) Residents have the right to go to their hospital of choice even if the facility has a transfer agreement with other hospitals and/or that facilities must inform residents or their resident representative of the facility's transfer agreements upon admission.

(s) Residents must be provided with annual resident rights training by the LTC ombudsman

(t) Residents shall have the right to bring a private right of action, which the facility shall not ask them to waive.

Commented [AH47]: This is a good and important add. Residents and facilities alike need to read this and be regularly reminded of it. We are hopeful that this right will come with robust enforcement activities to ensure that facilities and staff are in compliance.

(u) Residents must be provided with written notice of residents' rights and responsibilities and payment policies, including filial responsibility and estate recovery rules that may apply as well as information about the right to choose whether to have the facility serve as the resident's representative payee for Social Security

(v) Residents must be informed about bed hold policies prior to a transfer to a hospital and must be provided information on how the facility tracks each full 24 hour period in which the resident is absent from the facility

(x) Residents have the right to privacy. LGBT residents have the right to decide who knows about their sexual orientation and gender identity, and if, when or how they choose to come out. Outing a resident or disclosing their gender history, sexual orientation or HIV status without their consent is prohibited.

(y) Residents have the right to be free from restraints except where medically ordered and are the least restrictive alternative, and as outlined in the resident's person-centered service plan.

§ 201.30. [Access requirements.

(a) The facility may not limit physical or other forms of access (including telephonic, videographic, and electronic) 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.~~ except in accordance with state and federal public health mandates or court orders. 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 or local Long-Term Care 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 person] resident representative 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).**

(c) The facility may not limit access to the facility for the Department, the Department of Human Services, the Long-Term Care Ombudsman Program, Protective Services, Protection and Advocacy, Law Enforcement, and others with legal authority to enter.

Commented [AH48]: We previously strongly recommended and continue to vigorously recommend the addition of these important rights for residents.

Commented [AH49]: While the federal regulations specify the residents' right to visitors, 201.30 provided more detail to prohibit the facility from interfering with access by others and should be kept (with some suggested improvements) not deleted. The existing section provided more detail than the federal regulations and we suggest more specificity to ensure access by all government entities that would need access. We also suggest language that explicitly states that access can be telephonic, videographic, or in person. We urge the Department to revise and not delete.

§ 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).~~

(c) Residents shall have a choice of hospital to which they are transferred.

(d) Facility transfer plans must take resident Medicare and Medicaid health plan network limitations into account prior to proposing a transfer to a hospital.

HOUSEKEEPING AND MAINTENANCE

§ 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).**

(c) The administrator must ensure that housekeeping and maintenance staff are properly trained in infection control and that they operate at all times in accordance with the infection control instructions of the facility's infection preventionist.

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

FIRE PROTECTION AND RESIDENT SAFETY

§ 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.

Commented [AH50]: We object to the deletion of this section. We believe these are important requirements to hold facilities to and do not want to see them removed. We do believe this section should be revised to reflect that residents have choice in which hospital they are admitted to and that facilities must work in concert with the resident's insurance so that admissions are consistent with Community HealthChoices or other insurance plan provider network limitations. We propose language to this effect.

Commented [AH51]: We object to the Department deleting this entirely. While we understand that (a) has been moved up to 201.18, the deletion of (b) and the Department's unacceptable justification of the deletion of (b) – prohibiting nursing personnel from being assigned housekeeping duties - prompts us to vigorously oppose this deletion. In the proposed regulation package, the Department explains: "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." This right here is a considerable way for facilities to skirt around the staffing level increases/requirements.

We also recommend the addition of (c) as housekeeping and maintenance personnel must be trained on infection control.

Commented [AH52]: We object to the proposal to delete this section entirely. This is an important section. The federal regulations do not cover all that is presently here in the state regulations. The federal regulations don't require smoking policies to be posted. They don't require supervision to be provide for those residents who require it. Also, we had recommended and still recommend the addition of:

(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.

(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).~~

(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. All smoking policies must be posted and shared with residents.

CHAPTER 211. PROGRAM STANDARDS FOR LONG-TERM CARE NURSING FACILITIES

§ 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 or 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

Commented [AH53]: This section should be improved upon instead of deleted. We had previously made and continue to make recommendations to improve this section, specifically to be clearer as to what role the medical director must play within the nursing home. Additionally, we disagree with the Department's endorsement of a consultant as Medical Director. We believe the medical director needs to be on staff and have a close tie to the facility and firm understanding of the facility policies and procedures.

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) Documented ~~R~~review of incidents and accidents that occur on the premises and addressing the health and safety hazards of the facility. The medical director shall evaluate the incidents and accidents for need in a change in residents' care plans and possible systems modifications to avoid future incidents and accidents. 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 relate to resident medical care and delineate the responsibilities of attending physicians.~~]~~ **~~(Reserved).~~** The medical director shall, on at least an annual basis, evaluate the care being delivered by attending physicians to ensure consistency with the facility's clinical practices and standards of care. This evaluation shall identify performance expectations for attending physicians as well as facilitating feedback based on performance and practices. If a health care practitioner is providing care inconsistent with current standards of care, the medical director must intervene as appropriate.

(3) Participate in quality assurance and performance improvement meetings.

(4) Utilize evidence-based best practices related to the care of nursing home residents and how to oversee and communicate with other health care practitioners.

(5) Assist with developing and implementing staff education.

(6) Identify potential conflicts of interest and implement steps to mitigate any such conflicts. Conflicts of interest should be reviewed and addressed through the facility's Compliance and Ethics Program.

(e) Medical director communication and interactions with residents and resident representatives shall be person-centered and conducted in a manner easily understood by the specific resident, providing in the form, format, and language of the resident's need or preference.

§ 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 readily available [at each nursing station] and kept onsite in a location accessible and familiar to all personnel at all times.

(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~~ Resident records.

Commented [AH54]: This section should be about the whole resident not just about medical services. This section should be renamed "Resident records". We object to the deletions in this section. It should be improved upon instead of deleted. We recommend language to improve this section by adding the documentation related to person-centered assessments and service delivery, needs and preferences, social, psychosocial, emotional, and well-being items.

(a) ~~[Clinical~~ A facility shall maintain a single resident record for each resident that is comprehensive and reflects all of the assessments, treatments, items, and services provided to a resident as well as case notes on their care and wellbeing. Resident records shall be available to, but not be limited to, representatives of the Department of Aging Ombudsman Program, Older Adult and Adult Protective Services, and the state Protection and Advocacy entity.~~]~~ **~~(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 I~~information pertaining to a resident's stay shall be centralized in the resident's record.

(e) When a facility closes, resident [clinical] ~~medical~~ records or copies thereof must~~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 [clinical] ~~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 resident ~~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) Identification and demographic information.

(vi) Admission data.

(vii) Comprehensive person-centered assessment of a resident's physical, behavioral health, LTSS, social, emotional, psychosocial, transportation, equipment, technology, and other needs and preferences

(i) Person-centered service planning documents reflecting service planning activities including who participated and a service plan that defines how the facility will meet the individual resident's needs and preferences that were identified in the person-centered assessment process

~~(i)~~(ii) Service notes

(vi) Hospital diagnoses authentication.

(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 staff person, contracted provider, or other professional that provides services to a resident~~ discipline~~ shall enter the appropriate historical, service, 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.

Commented [AH55]: We cannot support the Department's proposal to remove a requirement that at all times a facility have enough food on site to cover at least three days. The Department removes this stating: "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." There are no imaginable circumstances in which having enough food to last through at least 3 days would be wasteful and it is short-sighted to remove a minimally protective requirement for this reason. Additionally, (f) should be revised to say "Dietary personnel shall practice hygienic food handling techniques *and follow all facility infection control protocols*."

(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 and follow all facility infection control protocols. [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.]

§ 211.8. Use of restraints.

Commented [AH56]: This is a section of the regulations that requires considerable strengthening. Instead of strengthening, consistent with recommendations we had previously made, the department proposes to delete this majority of this section of the regulations.

(a) Residents have the right to be free of physical, mechanical, and chemical restraints.

(b) Restraints are prohibited unless

(i) authorized in accordance with state and federal law,

(ii) ordered by a physician as appropriate to treat the individual's medical condition,

(iii) consented to by the resident or resident's representative, and

(iv) approved by the resident's person-centered service planning interdisciplinary team as part of the resident's written person-centered service plan and must include a written demonstration that less restrictive alternative means of controlling movement or behavior do not work. The person-centered service plan must outline how and when restraints are approved.

(c) [Restraints may not be used ~~in~~ for discipline, convenience, or in lieu of staff effort or adequate staffing levels to meet residents' needs.

(d)Locked restraints or any mechanical apparatus or device, such as shackles, straightjackets, cage-like enclosures or other similar devices, employed to restrict voluntary movement of a person that is not removable by that person may not be used.] ~~**(Reserved).**~~

(cb) [Restraints may not be used or applied in a manner which causes injury to the resident.] **(Reserved).**

(fc) [Physical and mechanical 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.

(gd) [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.] It shall include the period for which the restraint is being authorized and the circumstances under which the restraints may be used. All other circumstances are prohibited and a violation of the resident's right to be free of restraints.

(he) 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.

(if) Every 30 days, or sooner if necessary, the interdisciplinary team shall review and reevaluate the use of all restraints ordered by physicians. Residents' person-centered services plan shall be updated to reflect the outcomes of these reviews.

(j) Any chemical restraints must be closely monitored to ensure no adverse reactions.

(k) The facility shall document daily all uses of restraints, including dates and times and staff persons involved. These documents shall be stored and made available for inspection by the Department and others authorized to view these records.

§ 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). A facility shall timely refill prescriptions for residents and shall ensure that residents are not administered expired prescription or non-prescription medications.

(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.

(2) Shall have procedures for receipt of medications from outside pharmacies including requirements for ensuring accuracy and accountability. Procedures shall include the review of medications for labeling requirements, dosage and instructions for use by licensed individuals who are authorized to administer medications.

(3) Shall ensure that the pharmacist or pharmacy consultant will receive a monthly resident medication profile from the selected pharmacy provider.

(4) Shall have a policy regarding the procurement of medications in urgent situations. Facilities may order a 7-day supply from a contract pharmacy if the resident's selected pharmacy is not able to comply with these provisions.

(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

Commented [AH57]: This is an important addition as we know of instances in which facilities have not timely refilled prescriptions as well as times in which facilities have not taken care to ensure that medications are not expired.

Commented [AH58]: We object to this deletion. There needs to be a paper trail to resolve any concerns or discrepancies about prescribed medications.

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 medication that are submitted and approved by the Department and that address:

(1) Timely and safe identification and removal of medications for disposition.

(2) Identification of storage methods for medications awaiting final disposition.

(3) Control and accountability of medications awaiting final disposition consistent with standards of practice.

(4) Documentation of actual disposition of medications to include the name of the individual disposing of the medication, the name of the resident, the name of the medication, the strength of the medication, the prescription number if applicable, the quantity of medication and the date of disposition.

(5) A method of disposition to prevent diversion or accidental exposure consistent with applicable 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.

§ 211.10a. Resident Services

A facility must provide all medical, social, nursing, pharmacy, dementia care, activities, protective supervision, cueing, and other services to meet the physical health, behavioral health, skilled nursing, nursing, psychosocial, emotional, cognitive, social, personal care, nutritional, rehabilitative, technological, equipment, transportation, Medicaid eligibility, and other needs and preferences of each individual resident and as may be required of a person who meets the nursing facility level of care. Facilities must also assist residents with activities of daily living and instrumental activities of daily living and in preparing for transition out of the nursing facility.

Commented [AH59]: The regulations are missing an affirmative statement of what services each nursing facility must be able to provide and what needs each nursing facility must be able to meet. We believe this needs to be included. This coupled with language we propose adding to 201.25 increases protections against individuals being denied admission arbitrarily or discriminatorily. We propose, as section § 211.10a, language that would remedy this.

§ 211.11. [Resident ~~care~~ person-centered service plan.

(a) The facility shall designate an individual to be responsible for the coordination and implementation of a written resident ~~care~~ service plan through a person-centered service planning process. 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~~ service plan shall be part of the interdisciplinary team. The interdisciplinary team shall include individuals selected by the resident and/or resident's representative and shall meet at least every three months, at the request of the resident and/or resident's representative, or upon a change in condition to revisit and revise, if necessary, the resident service plan. For residents that have insurance coverage of their nursing facility care, the resident should be encouraged to include in their interdisciplinary team, the insurance company's service coordinator, if applicable.

(c) The facility shall ensure an educational strategy to ensure staff have the knowledge and skills to understand and implement person-centered planning and care.

(d) A registered nurse shall be responsible for developing the nursing assessment portion of the resident ~~care~~ service plan.

(e~~d~~) The resident ~~care~~ service plan shall be available at all times for use by personnel caring for the resident. Staff are required to acquaint themselves with and refer back to the person-centered service plans for all residents to ensure that needs and preferences are being met. Facility policy must require that person-centered care be provided and person-centered service plans be honored at all times, even during a pandemic or other disaster.

(f~~e~~) The resident, when able, and where desired by the resident, family and resident representative, shall participate in the development and review of the person-centered service~~care~~ plan. 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

Commented [AH60]: We previously recommended and continue to recommend that this section should provide more detail around the person-centered service planning process, frequency of meetings, involvement of managed long-term care Medicaid plans through the Community HealthChoices program as they have a role in service planning, training staff to understand person-centered service delivery and reading/following person-centered service plans, and more. None of these recommendations were implemented in the proposed regulations, much to our great disappointment, and the Department proposes to delete this section instead. Resident-centered care is supposed to be the hallmark of what a nursing home delivers. The Department owes it to residents to flesh out details that would help ensure they actually receive resident-centered care. We again recommend language that would improve upon this section and help ensure that residents receive person-centered services.

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.] **~~(Reserved).~~**

§ 211.12. Nursing services and staffing minimums and baseline ratios.

(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) The following minimum nursing and nurse aide staffing ratios and minimum staffing levels are minimums. Actual staffing levels, which shall meet or exceed the minimum levels, must be determined specifically for each facility based on the actual needs of each resident as outlined in their comprehensive assessments and person-centered service plans, as well as in accordance with the facility assessment required in 42 CFR 438.70(e), which facilities shall be required to complete quarterly.

Commented [AH61]: We previously recommended and continue to vigorously urge the inclusion as (f) of language. This language facilities a more holistic, facility-specific, and resident-specific consideration as part of adjusting the minimum staffing hours upward to reflect unique or increased needs for staff hours.

(g) [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:

Day shifts.--With respect to a day shift, the nursing facility must have—

- at least 1 registered professional nurse for every 28 residents, with a minimum of 0.29 hours of care provided per resident during each such shift;
- at least 1 licensed practical nurse for every 40 residents, with a minimum of 0.20 hours of care provided per resident during each such shift; and
- at least 1 nurse aide for every 7 residents, with a minimum of 1.14 hours of care provided per resident during each such shift.

Evening shifts.--With respect to an evening shift, the nursing facility must have—

- at least 1 registered professional nurse for every 30 residents, with a minimum of 0.26 hours of care provided per resident during each such shift;
- at least 1 licensed practical nurse for every 40 residents, with a minimum of 0.20 hours of care provided per resident during each such shift; and
- at least 1 nurse aide for every 7 residents, with a minimum of 1.14 hours of care provided per resident during each such shift.

Night shifts.--With respect to a night shift, the nursing facility must have—

- at least 1 registered professional nurse for every 40 residents, with a minimum of 0.20 hours of care provided per resident during such shift;
- at least 1 licensed practical nurse for every 56 residents, with a minimum of 0.14 hours of care provided per resident during such shift; and
- at least 1 nurse aide for every 15 residents, with a minimum of 0.53 hours of care provided per resident during such shift.

~~*Census*~~	~~*Day*~~	~~*Evening*~~	~~*Night*~~
~~59 and under~~	~~1 RN~~	~~1 RN~~	~~1 RN or 1 LPN~~
~~60/150~~	~~1 RN~~	~~1 RN~~	~~1 RN~~

Commented [AH62]: We previously recommended and continue to strenuously recommend the resident-related care ratio of 1:7, 1:7, and 1:15 recommendation for direct care. The language should be revised to reflect this stronger recommendation that better supports residents and direct care workers, alike. The difference between our language proposed here and the proposed regulation is that the proposed regulation includes only a ratio of nursing services professionals to residents whereas our language includes both a proposed ratio and a resident-related breakdown of the minimum amount of time of direct care they can expect and hold each facility to provide for each type of nursing/direct care professional and non-professional. Ratios alone don't address this and don't provide residents with a number they can understand and advocate around.

~~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~~ seven residents during the day, one nurse aide per ~~ten~~ seven residents during the evening and one nurse aide per fifteen residents overnight.

Commented [AH63]: Again, we had previously recommended and continue to recommend no less than 1:7 of CNA to resident as a daytime and evening minimum staffing ratio.

(5) A minimum of 2 RNs and 1LPN during the day, 1 RN and 1 LPN during the evening, and 1 RN overnight per 60 residents as follows:

Census	Day	Evening	Night
1-60	2 RNs and 1 LPN	1 RN and 1 LPN	1 RN
61-120	4 RNs and 2 LPNs	2 RNs and 2 LPNs	2 RNs
121-180	6 RNs and 3 LPNs	3 RNs and 3 LPNs	3 RNs
181-240	8 RNs and 4 LPNs	4 RNs and 4 LPNs	4 RNs
241-300	10 RNs and 5 LPNs	5 RNs and 5 LPNs	5 RNs
301-360	12 RNs and 6 LPNs	6 RNs and 6 LPNs	6 RNs
361-420	14 RNs and 7 LPNs	7 RNs and 7 LPNs	7 RNs

421-480	16 RNs and 8 LPNs	8 RNs and 8 LPNs	8 RNs
481-540	18 RNs and 9 LPNs	9 RNs and 9 LPNs	9 RNs

Facilities with more than 540 residents shall calculate and provide additional nursing services personal 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)

(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 and other 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, well-being, health and safety of the residents.~~]~~ **(Reserved).**

(m) The required nursing services and staffing minimums and baseline ratios shall not be interpreted to minimize the facility's requirement to have sufficient ancillary staff to provide services for the residents other than nursing services. Ancillary staff may include staff who meet the licensure requirements of being RNs, LPNs, dieticians, or skilled professionals but do not provide direct care. Ancillary staff may include activities planners, housekeepers, cooking staff or facilities staff but also staff who conduct assessment, care planning or care management activities or serve as the full-time Infection Preventionist.

(n) Daily, the facility shall conspicuously and publicly post the actual staffing levels for all types of staff as scheduled for the day. This information shall be posted inside and outside the front door of the facility for residents and visitors to see and shall be posted on the facility's website.

Commented [AH64]: We continue to strongly support the proposal from package 1 to improve the minimum number of hours of direct care per resident per day to 4.1 in 211.12(f). We stress how long overdue this change is and want to convey that this is an essential element for us. Anything less than 4.1 per resident per day is unacceptable.

Commented [AH65]: We also recommend the addition of language that requires staffing levels and ratios to only count RNs, LPNs, and CNAs who are providing direct care to residents. Ancillary staff cannot and should not be included in the calculation for purposes of compliance with staffing level and ratio requirements.

Commented [AH66]: Transparency is fundamentally important. Residents and the public must be able to know what a facility's actual staffing is from day to day. This should be both posted physically and online.

§ 211.15. ~~[~~Dental services.

(a) The facility shall assist residents in obtaining routine and 24-hour emergency dental care. If a resident has a dental provider of their choice, the facility shall provide the necessary assistance to ensure the resident can access their provider of choice.

(b) The facility shall make provisions to assure that resident dentures are retained by the resident. Dentures shall be marked for each resident.~~]~~ **~~(Reserved).~~**

(c)

§ 211.16. Social services, supports, and minimizing isolation.

(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).**

(c) Each resident's person-centered service plan shall identify what social services the resident wants and how the facility will provide or assist the resident. Additionally, the plan shall address how to resident might be supported during any prolonged periods of isolation caused by pandemic, infection, or other contagious disease.

(d) The facility must have a meaningful plan to support residents and their social interaction using current technology and must have internet services to support this. Residents who are able should be taught how to self-manage technology.

(e) The facility shall consider current best practices in minimizing isolation as it plans its social services and resident supports.

§ 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.

Commented [AH67]: We object to the deletion of this section. Facilities must help residents access dental services. The department should strengthen this section to ensure facilities assist residents in accessing outside providers.

Commented [AH68]: While we are ok with the deletions in (a) and (b) and while we support the requirement that all facilities have a social worker, we also want some improvements added to this section. These include requiring the person-centered service plan to identify the residents' social service needs and how those will be addressed for and with the resident. We also recommend language that requires nursing homes to facilitate the use of technology to support residents' ability to remain connected with their outside social connections.

(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 or 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.