3343

From: Jennifer A. Ebersole
To: Gutierrez, Lori; DH, LTCRegs
Subject: [External] Regulation #10-224: Long Term Nursing Care Facilities - Alzheimer"s Association Comment Submission
Date: Monday, June 27, 2022 12:30:08 PM
Attachments: SNF Proposed Regs #4 AA Comments.pdf

Good afternoon Ms. Gutierrez,

Please find attached the Delaware Valley and and Greater Pennsylvania Chapters of the Alzheimer's Association public comments to Proposed Regulation #10-224: Long Term Nursing Care Facilities.

Thank you,
Jen

Jen Ebersole (she, her, hers)| Director of State Government Affairs | Alzheimer's Association | 2595 Interstate Drive, Suite 100, Harrisburg, PA 17110 | office: 717.678.6464 ext 1792 | cell: 717.364.9102 | jaebersole@alz.org | www.alz.org/pa | 24/7 helpline 1.800.272.3900

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June 27, 2022

Lori Gutierrez, Deputy Director for the Office of Policy
PA Department of Health
625 Forster Street, Room 814 Health and Welfare Building Harrisburg, PA 17120
Submitted via email to: RA-DHLTCRegs@pa.gov

Re: Rulemaking #10-224 (IRRC#3343): Long Term Nursing Care Facilities, Proposed Rulemaking #4

Dear Ms. Gutierrez,

On behalf of the Delaware Valley and Greater Pennsylvania Chapters of the Alzheimer's Association, we appreciate the opportunity to submit comments in response to Rulemaking #10-224 (Long Term Nursing Care Facilities, Proposed Rulemaking #4). The mission of the Alzheimer's Association is to eliminate Alzheimer's and other dementia through the advancement of research; to provide and enhance care and support for all affected; and to reduce the risk of dementia through the promotion of brain health. Together, our Pennsylvania Chapters focus on carrying out our mission for the nearly 400,000 Pennsylvanians living with Alzheimer's or another dementia, the 401,000 Pennsylvanians providing unpaid care for them and countless others impacted by this devastating disease.

The Association profoundly appreciates the Department's commitment to update Pennsylvania's skilled nursing facility regulations, and we have been relatively encouraged with the proposed changes in the first three regulatory packages. **However, the fourth and final package of proposed regulations is very concerning, most notably around staff development (Section 201.20), resident care plans (Section 211.11) and nursing services (Section 211.12).** We appreciate the opportunity to provide comments and recommended suggestions for Proposed Rulemaking #10-224 that we strongly encourage the Department to consider and adopt in the final rulemaking. For ease of reviewing, we will start with comments most concerning to the Alzheimer's Association, then will provide additional comments in the order they appear in the proposed regulations.

COMMENTS ON SECTION 201.20 – STAFF DEVELOPMENT

The Alzheimer's Association strongly opposes the Department's proposal to remove a significant portion of this section and instead defer to federal training requirements found at 42 CFR 483.95. The Association believes a serious curriculum topic is lacking in the federal

regulations, and strongly recommends the Department adds language to provide for dementia-capable training of all direct care and administrative staff.

Nearly half (48%) of all residents living in skilled nursing facilities have Alzheimer's or other dementia[1]. The care needs of individuals living with dementia are complex and often require a higher level of care than residents without dementia. Dementia is characterized by a group of symptoms that include a decline in cognitive abilities, loss of memory, poor judgment, changes in personality, disorientation and problems with abstract thinking, all of which worsen over time and require individualized and person-centered care plans. Federal regulations do not require training on the topic of understanding dementia and effective communication skills with residents living with dementia. As such, an emphasis must be placed for professional caregiving staff to fully develop their competency in dementia care.

The Alzheimer's Association has noted that the single most important determinant of quality dementia care across all care settings is direct care staff,[2] who help shape the daily lives of people with dementia and assist with all aspects of physical care. Through their close interactions with people with dementia, direct care workers gain an in-depth knowledge of the individual with dementia, including their preferences, behaviors and functioning. The Alzheimer's Association Dementia Care Practice Recommendations (DCPR) outline recommendations for quality care practices based on a comprehensive review of current evidence, best practice, and expert opinion. The DCPRs were developed to better define quality care across all care settings and throughout the disease course, and are fundamentally based on a person-centered focus and acknowledge that this focus is the core of quality care. Enhanced training is a win-win-win, benefitting staff (decreases stress, burn-out, turnover and increases job satisfaction), residents (improved quality of care and quality of life outcomes) and providers (improved resident outcomes, less adverse events and health-related deficiencies and better staff retention) in a number of meaningful ways. **Therefore, the Alzheimer's Association urges the Department to add a dementia training and competency requirement - in addition to other important training program requirements - under Section 201.20.** We offer the following language to accomplish this:

> **(a)(5) For direct care staff, understanding dementia and effective communication skills with people living with dementia and how to apply that to residents of the facility. Each facility shall provide at least eight hours of initial training for all direct care staff in dementia care and treatment including: understanding Alzheimer's disease and**

[1] Alzheimer's Association 2020 Alzheimer's Disease Facts and Figures, https://alz-journals.onlinelibrary.wiley.com/doi/epdf/10.1002/alz.12068
[2] https://academic.oup.com/gerontologist/article/58/suppl_1/S103/4816757

dementia; person-centered care; assessment and care planning; activities of daily living; and dementia-related behaviors and communication.

(a)(6) For administrative staff, each facility shall provide initial training for all administrative 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, medical management information education and support; staffing; supportive and therapeutic environments; and transitions and coordination of services.

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(c) **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.**

(d) Upon completion of the initial training as required under Subsections (a)(5) and (a)(6), the facility shall issue a certificate of completion to each employee, which shall be portable between settings within Pennsylvania, provided that the employee 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.

(e) Initial and annual training must be provided by individuals with at least two years of work experience related to Alzheimer's disease or other dementias or in health care, gerontology, or other related field; and have completed training equivalent to the requirements provided herein, including successful passage of any skills competency or knowledge test required by the Department.

(f) In addition to the initial training required under Section (a)(5) and (a)(6), each direct care and administrative staff shall receive four hours of annual in-service training on dementia treatment and care, including new information and best practices.

The Alzheimer's Association also has concerns with deleting language in Section 201.20(d) related to prevention of resident abuse and reporting. While 42 CFR 483.95 includes 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. **The Alzheimer's Association urges the Department to add the following language:**

> **(a)(7)Training on the detection and prevention of resident abuse, neglect, and exploitation and the mandatory reporting of the abuse, neglect, and exploitation.**

COMMENTS ON SECTION 211.11 - RESIDENT CARE PLANS

The Alzheimer's Association strongly opposes the Department's proposal to remove a significant portion of this section and instead defer to federal requirements found at 42 CFR 483.21(b) for the development and implementation of comprehensive care plans. Comprehensive person-centered care plans are the hallmark of how nursing homes are delivering quality care to each resident and the Department has the responsibility to ensure all licensed facilities are meeting this standard. **The Alzheimer's Association recommends adding the following language to Section 211.11:**

(a) The comprehensive person-centered care plan shall be completed using a template approved by the Department within 30 days after admission.

(b) The comprehensive person-centered care plan shall include the following:

1. **Description of identified needs and date identified based upon the admission, physical examination, resident interview, fall risk, assessment of psychological, behavioral, and emotional functioning, and other sources.**
2. **A written description of what services will be provided to address identified needs, and if applicable, other services, and who will provide them.**
3. **Preferences around social interaction, with specific planning focused on supporting the resident during periods of prolonged isolation.**
4. **Considerations that reflect the individuality, values and cultural preferences of the resident.**
5. **Opportunities for meaningful engagement, support interests and preferences, and allow for choice.**

(c) The comprehensive person-centered care plan shall be signed and dated by the licensee, administrator, or designee and by the resident or his resident representative. The plan shall also indicate any other individuals who contributed to the development of the plan, with a notation of the date of contribution. The title or relationship to the resident of each person who was involved in the development of the plan shall be included. These requirements shall also apply to reviews and updates of the plan.

(d) Comprehensive person-centered care plan shall be reviewed and updated at least once every six months and as needed for a significant change of a resident's condition. The review and update shall be performed by a qualified staff person and in

conjunction with the resident and, as appropriate, with the resident's family, legal representative, direct care staff, case manager, health care providers, qualified mental health professionals, or other persons. For residents that have insurance coverage of their nursing facility care, the resident should be encouraged to include the insurance company's service coordinator.

(e) Each facility shall ensure that the care and services specified in the individualized service plan are provided to each resident, except as provided for in Section 211.22(e).

(f) There may be a deviation from the plan when mutually agreed upon between the facility and the resident or the resident's representative at the time the care or services are scheduled or when there is an emergency that prevents the care or services from being provided. Any deviation from the plan shall:

1. **Be documented in writing or electronically.**
2. **Include a description of the circumstances warranting deviation and the date such deviation will occur.**
3. **Certify that notice of such deviation was provided to the resident or the resident's legal representative.**
4. **Be included in the resident's file.**
5. **Be signed by an authorized representative of the facility and the resident or the resident representative if the deviation is made due to a significant change in the resident's condition.**

COMMENTS ON SECTION 211.12 - NURSING SERVICES

In residential long-term care settings, staffing is a key driver of quality care. A review of scholarly literature on this subject verifies that there is a clear association between higher levels of licensed staff and higher quality of care.[3] A resident's individual outcomes (including the presence of weight loss, bed sores and general functional ability), is regularly linked to staffing and there is an association between higher turnover rates and lower quality of care.[4] Beyond meeting any mandatory staffing numbers required in organizations serving persons with dementia, there is a growing awareness of the need to deploy staff in a manner that aligns with resident routines and needs.[5] A simple staffing ratio, while clear, may not be sufficient to consistently deliver high quality care. The makeup of the resident population including, for example, the number of people with dementia, should not only be accounted for in the resident care plan as outlined in Section 211.10, but also impact the numbers of nursing staff present at

[3] Bostick JE, Rantz MJ, Flesner MK, Riggs CJ. Systematic review of studies of staffing and quality in nursing homes. J Am Med Dir Assoc. 2006 Jul;7(6):366-76. doi: 10.1016/j.jamda.2006.01.024. Epub 2006 Apr 25. PMID: 16843237.
[4] ibid
[5] Cohen-Mansfield & Bester, 2006.

any given time. That is why it's important to consider dementia care best practices, as outlined in the Dementia Care Practice Recommendations, and why an acuity-based staffing model should be in place to ensure a resident's quality of care/life, based on their medical complexity, activities of daily living dependency, and behavior challenges, as defined by a formal assessment process."[6] **The Alzheimer's Association recommends the following language for Section 211.12:**

(a) Facilities must have qualified awake direct care staff, sufficient in number to meet the 24-hour scheduled and unscheduled needs of each resident. Direct care staff provide services for residents that include assistance with activities of daily living, medication administration, resident-focused activities, supervision, and support.

(b) If a facility employs universal workers whose duties include other tasks (e.g., housekeeping, laundry, food service), in addition to direct resident care, only hours devoted to resident care should be included.

(c) The following facility employees are ancillary to the caregiver requirements in this section:

- **(i) Individuals whose duties are exclusively housekeeping, building maintenance, clerical, administrative, or food preparation.**
- **(ii) Licensed nurses who provide services (Resident Health Services).**
- **(iii) Administrators who do not provide direct care.**

(d) The Department retains the right to require minimum staffing standards based on acuity, complaint investigation or survey inspection.

(e) Based on resident acuity and facility structural design, there must be adequate direct care staff present at all times, to meet the fire safety evacuation needs of non-ambulatory residents as required by the fire authority or the Department.

(f) The licensee is responsible for assuring that staffing is increased to compensate for the evaluated care and service needs of residents at move-in and for the changing physical or mental needs of the residents.

(g) A minimum of two direct care staff must be scheduled and available at all times whenever a resident requires the assistance of two direct care staff for scheduled and unscheduled needs in accordance with the resident's comprehensive person-centered care plan.

(h) In facilities where residents are housed in two or more detached buildings, or if a building has distinct and segregated areas, at least two direct care staff must be awake and available in each building and each segregated area at all times.

[6] Youles, L. (2019). *Acuity-based staffing: What does it mean?* https://www.mcknights.com/marketplace/marketplace-experts/acuity-based-staffing-what-does-it-mean/

(i) Facilities shall employ a system approved by the Department to determine appropriate numbers of direct care staff and general staffing based on resident acuity and service needs in accordance with the resident's comprehensive person-centered care plan. Such systems may be either manual or electronic.

- **(i) Facilities must consider the resident's needs as expressed in the Person-centered Care Plan.**
- **(ii) Guidelines for systems must also consider physical elements of a building, use of technology if applicable and staff experience.**
- **(iii) Facilities must be able to demonstrate how their staffing system works.**
- **(iv) Staffing shall not be less than the following:**
  - **(1) DAY SHIFT: 1 nursing assistant per 7 residents.**
  - **(2) EVENING SHIFT: 1 nursing assistant per 9.5 residents.**
  - **(3) NIGHT SHIFT: 1 nursing assistant per 17 residents.**

COMMENTS ON SECTION 201.18 - MANAGEMENT

Generally, we support the new additions to this section, with a few recommendations to enhance transparency related to communications with residents and residents' representatives. In addition to the requirement that the administrator's schedule be posted in the facility, we recommend also being available on the facility's website for residents and families to see when the administrator will be on-site. We also propose that daily staffing numbers and levels for all types of staff be posted in the facility and on the facility website for residents, caregivers and the public to see. **The Alzheimer's Association suggests the following language to enhance Section (d.2):**

> **(d.2) The administrators work schedule, including what days and times the administrator will be physically present in the facility, shall be publicly posted in the facility and posted on the facility's public website, along with the daily posting of staffing numbers and levels for all types of staff.**

The pandemic made it clear that administrators should be responsible for clear and open communication with residents and their representatives. Therefore, to further ensure transparency and communication, **the Alzheimer's Association suggest the following language:**

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

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COMMENTS ON 201.21 - USE OF OUTSIDE RESOURCES

The Alzheimer's Association does not support the deletion of Section 201.21(a) through (c). We believe the facility should be held accountable for ensuring that the outside resources or related-parties with whom they contract are appropriately qualified and trained 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. Lastly, we suggest language requiring 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. **The Alzheimer's Association recommends the Department to add the following language:**

> **(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 or other infectious disease outbreak.**

COMMENTS ON 201.25 - DISCHARGE POLICY

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. As Alzheimer's and other dementias progress through the disease stages, behaviors often change and can become challenging for direct care staff to navigate. Unfortunately, we know this has been a basis for facilities to abruptly discharge or transfer dementia residents, which can add to the resident's behavioral symptoms. Robust protections must be in place to prevent residents from being arbitrarily and carelessly evicted from the place they call home. **The Alzheimer's Association urges the Department to add the following language:**

(a) A resident shall not be discharged or transferred for any reason other than those outlined in 42 CFR 483.15. Prior to any discharge or transfer, there shall be developed and implemented a centralized, coordinated, individualized discharge plan for 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.

(b) **The department shall establish an appeals process for any individual discharged or transferred from a residential facility.**

(c) **Each facility shall collect data and report to the Department any involuntary discharges, including reasons for discharge or transfer and other conditions surrounding it.**

COMMENTS ON SECTION 211.8 - RESTRAINTS

The Alzheimer's Association believes that use of chemical and physical restraints are an option of last resort for individuals living with dementia. If restraints are necessary, the least restrictive means necessary should be applied and the facility must have exhausted, and documented, all possible behavior interventions attempted before restraints are prescribed by the physician.

The Association recommends adding the following language:

(c) The facility shall first exhaust all appropriate behavior interventions with residents, and provide documentation of attempted behavior interventions, prior to requesting a physician order for restraints.

COMMENTS ON SECTION 211.10 - RESIDENT CARE POLICIES

The Alzheimer's Association recommends one addition to Section 211.10(a). We agree that resident care policies should reflect the awareness of, and provision for, meeting the total medical and psychological needs of residents. Given that nearly half of all residents are living with some form of dementia, we believe cognitive needs should also be expressly stated in the resident care policies. **The Alzheimer's Association recommends the following language in Section 211.10 (a):**

…meeting the total medical, cognitive and psychological needs of residents.

COMMENTS ON SECTION 211.16 - SOCIAL SERVICES

The Alzheimer's Association supports the requirement for each facility to employ a full-time social worker. We do recommend enhancing this section to require a 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. **The Alzheimer's Association recommends the following language in Section 211.16:**

(b) 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 residents will be supported during any prolonged periods of isolation caused by pandemic, infection, or other contagious disease.

(c) 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.

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

The Alzheimer's Association is committed to advocating on the resident's behalf to ensure they receive high quality care while preserving their overall health, safety and well-being. We appreciate the Department for initiating this long overdue process of updating Pennsylvania's nursing home regulations. That said, the Alzheimer's Association **does not support the fourth package of proposed regulations and strongly urges the Department to adopt the recommendations outlined in this letter.** We look forward to working with the Department, the PA General Assembly and other stakeholders to address these concerns prior to publication of the final rulemaking.

Respectfully Submitted,

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