Comments from AARP Connecticut regarding proposed regulations concerning Nursing Home Staffing Ratios (PR2022-032)
Department of Public Health Public Hearing
August 1, 2023

Commissioner Juthani and members of the Department of Public Health:

Thank you for the opportunity to submit comments regarding the Department of Public Health's proposed regulations concerning Nursing Home Staffing Ratios (PR2022-23). We support these regulations with one exception, which we will outline below.

These proposed regulations are the culmination of work that began with the Nursing Home and Assisted Living Oversight Work Group (NHALOWG), which met during the early months of the COVID-19 pandemic in 2020. As part of their final recommendations, the NHALOWG's Staffing Levels Subcommittee recommended that the State:

Update and modernize minimum direct care staffing requirements for nursing homes by:

- *Eliminating distinctions between Chronic and Convalescent Nursing Homes (CCNH) and Rest Homes with Nursing Supervision (RHNS) in favor of a single CCNH standard;*
- *Establishing a daily minimum staffing ratio of at least 4.1 hours of direct care per resident, composed of:*
  - *.75 hours Registered Nurse*
  - *.54 hours Licensed Practical Nurse*
  - *2.81 hours Certified Nurse Assistant; and*
- *Informed by best practice, modifying ratios for social work and recreational staff to residents, with the result that they are lower than present standards.*

In response to the NHALOWG's recommendations, the Connecticut General Assembly's Public Health Committee introduced SB 1030 in 2021. As introduced, SB 1030 recommended the following, beginning on Line 161:

> *(b) On or before January 1, 2022, the Department of Public Health shall (1) establish minimum staffing level requirements for nursing homes of at least four and one-tenth hours of direct care per resident, including three and three-quarter hours of care by a registered nurse, fifty-four hundredth hours of care by a licensed practical nurse and two and eighty-one hundredth hours of care by a certified nurse's assistant, (2) modify staffing level requirements for social work and recreational staff of nursing homes such that the requirements are lower than the current requirements, as deemed appropriate by the Commissioner of Public Health, and (3) eliminate the distinction between a chronic and convalescent nursing home and a rest home, as defined in section 19a-490 of the general statutes, as such distinction relates to nursing supervision, for purposes of establishing a single, minimum direct staffing level requirement for all nursing homes.*

AARP CT believes that staffing levels are critical to quality care in nursing homes. Low staffing levels mean that residents cannot get out of bed, use the bathroom, or eat in a timely manner; staff risk physical injury and cannot give residents the time and attention they deserve; visits with loved ones may be limited or cancelled; and it is more difficult for facilities to contain the

spread of infectious diseases. In its report on the spread of COVID-19 in Connecticut nursing homes, Mathematica determined that "staffing rating [referring to the Centers for Medicare and Medicaid Services 5-star quality rating system] was highly predictive of the ability to limit the spread of COVID-19 in nursing homes."[i]

Even prior to COVID-19, researchers saw the connection between staffing levels and other factors than impact care. "For example, low staffing levels are associated with high turnover rates and vice versa. It is likely that adequate staffing levels must be addressed before improvements can be made in other factors such as turnover, management, and competency."[ii] The Centers for Medicare and Medicaid Services (CMS) have long recommended 4.1 hours of care per resident per day as the minimum necessary to ensure adequate care.[iii] Legislation to improve staffing levels has been raised on a regular basis in Connecticut going back at least to 2014.[iv]

SB 1030 from 2021 was ultimately amended to "establish minimum staffing level requirements for nursing homes of three hours of direct care per resident per day," and the legislation was passed as Public Act 21-185. Although staffing levels were not raised to 4.1 hours of care per resident per day, AARP CT applauded the new requirement for 3.0 hours of direct care per resident per day as a step in the right direction, and we support the proposed regulations under discussion today that will implement this change. We are sympathetic to the current challenges that nursing homes, and the healthcare industry in general, are facing when it comes to recruiting and retaining staff. These challenges are real, and we know that there are no easy solutions to the problem. Despite these challenges, it is important to require staffing levels that more appropriately support the health and safety of residents, as well as the workers who care for them.

There is one exception to our support for the proposed regulations concerning staffing ratios (PR2022-032). We believe that there was a drafting error in PA 21-185 that has led DPH to propose *decreased* staffing levels for therapeutic recreation staff. From the proposed regulations (beginning on the bottom of page 3):

> *(3) Therapeutic recreation [director(s)] director or directors shall be employed in each facility sufficient to meet the following ratio of hours per week to the number of licensed beds in the facility:*
>
> *(A) 1 to 15 beds, [10] nine hours during any three days;*
>
> *(B) 16 to 30 beds, [20] nineteen hours during any five days; and*
>
> *(C) Each additional 30 beds or fraction thereof, [20] nineteen additional hours.*

AARP believes that these regulations, while faithful to the letter of the law, are counter to the legislative intent of PA 21-185. As previously mentioned, in its final recommendations, the Nursing Home and Assisted Living Oversight Work Group recommended the following:

Update and modernize minimum direct care staffing requirements for nursing homes by…modifying ***ratios*** *for social work and recreational staff to residents, with the result that they are* ***lower than present standards****.*

The Work Group recommended a ***lower ratio*** of rec staff to residents, but PA 21-185, reads as follows:

> *Sec. 10. (NEW) (Effective October 1, 2021) (a) On or before January 1, 2022, the Department of Public Health shall (1) establish minimum staffing level requirements for*

> *nursing homes of three hours of direct care per resident per day, and (2)* ***modify staffing level requirements for social work and recreational staff of nursing homes such that the requirements*** *(A) for social work are one full-time social worker per sixty residents, and (B)* ***for recreational staff are lower than the current requirements, as deemed appropriate by the Commissioner of Public Health.***

Somewhere in the bill drafting process, "lower staffing **ratio**" turned into "lower staffing **level**," which is the opposite of what the NHALOWG wanted, and, based on transcripts from the floor debate, is not what the legislature intended when it passed PA 21-185. In summarizing SB 1030 on the Senate floor, Senator Daugherty Abrams, then co-chair of the Public Health Committee, noted of the bill:

> *"It would also increase the ratio of social workers from one to 120, to one to 60, and increase -- and* ***increase recreational staff*** *as determined by the public health department."*

While AARP appreciates that the Department of Public Health has proposed regulations that align with what was passed in PA 21-185, we believe that the bill, as drafted, was not what advocates and legislators intended. For this reason, we do not support the changes to therapeutic recreation staffing levels that are included in these regulations, and we would ask that you consider amending the regulations to align with legislative intent – which was to ***increase*** recreational staffing levels.

Thank you for the opportunity to submit our comments both in support and opposition to these proposed regulations regarding nursing home staffing levels (PR2022-032). If you have any questions regarding our comments, please contact AARP CT's Associate State Director for Advocacy and Outreach, Anna Doroghazi, at: adoroghazi@aarp.org.

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[i] Rowan et al. A Study of the COVID-19 Outbreak and Response in Connecticut Long-Term Care Facilities: Final Report. Princeton, NJ: Mathematica; September 30, 2020. p 20

[ii] Harrington et al. The Need for Higher Minimum Staffing Standards in U.S. Nursing Homes. *Health Services Insights* 2016:9 13-19 doi:10.4137/HIS.S38994.

[iii] Centers for Medicare & Medicaid Services (CMS). Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes Phase II Final Report. Baltimore, MD: CMS; 2001.

[iv] For example, Connecticut General Assembly House Bill 5322 from 2014. https://cga.ct.gov/asp/cgabillstatus/cgabillstatus.asp?selBillType=Bill&which_year=2014&bill_num=5322

WACHUSETT
HEALTHCARE

August 14, 2023

Comments on DPH Proposed Regulation (PR2022-32)

To the Department of Public Health:

My name is Sharon Ellis, and I am the Director of Human Resources for Wachusett Healthcare, a company that owns, operates and manages four facilities in Connecticut - Parkway Pavilion Health and Rehab Center in Enfield (130 beds), Beechwood in New London (60 beds), Harbor Village Rehabilitation & Nursing Center in New London (128 beds) and Villa Maria Rehabilitation & Nursing Center in Plainfield (62 beds). All Wachusett facilities are longstanding providers of nursing care in the communities we serve with 380 skilled beds and over 400 employees. Our facilities are proud members of the Connecticut Association of Health Care Facilities (CAHCF) and Parkway Pavilion recently received the Bronze Quality Award from the American Health Care Association.

I am writing to ask you to make some significant changes to this proposed regulation. We do not oppose an increase in the direct care staffing minimum as outlined in the public health code, but we strongly oppose how DPH is proposing the implementation of the requirement. There are major problems with how DPH has proposed increasing the direct care minimum staff from the outdated 1.9 hours to 3.0 hours per resident per day.

Our primary areas of concern with this regulation are as follows:

1. The proposed regulation wrongly increases the CNA minimums from 1.26 to 2.16 hours of care per resident per day and reverses the Public Health Code rule that appropriately allowed for licensed staff hours to be counted toward meeting the minimum staffing standard. This approach eliminates our flexibility to staff the facility to meet the needs and acuity of our residents. If implemented, this will not create better outcomes but will likely worsen the situation.
2. In theory the proposed regulation looks good on paper but it is impossible to meet. There is an insufficient supply of workers to meet the needs of our healthcare facilities. We have seen a mass exodus of workers since the start of the pandemic, and we have not seen this correct itself to date. Our facilities have been facing the most significant staffing challenges we have ever experienced. Over the past two years, we have exhausted all efforts to recruit staff to work at our facilities. We have increased wages on an annual basis, offered sign-on bonuses, Refer-A-Friend bonuses, offered flexible scheduling through online platforms such as Indeed and Apploi and offered to sponsor candidates to become certified nursing assistants (CNAs). Unfortunately, these efforts have not been effective enough to fill our open CNA positions, resulting in us needing to use agency staff at an exorbitant cost. In addition to the cost, the use of agency staff doesn't allow for consistent assignments for our residents which is a best practice we strive for. It is a constant struggle to find balance for our staff so that they do not face burnout.
3. The proposed regulation doesn't take into consideration the modern nursing home staffing model. To best meet the needs of our residents, we utilize a collaborative approach including our entire interdisciplinary team. This regulation doesn't count all the staff that are providing direct care daily. In addition to the CNAs, direct care is provided by licensed nurses, occupational therapists, and physical therapists. Additionally, we believe Therapeutic Recreation staff also play a key role in the daily needs

of our residents and should also be considered in the staffing rule. This rule should account for all these staff members providing direct care to meet our residents' needs.

4. The amount of Medicaid resources the state made available for compliance with the DPH increased minimum staffing rule is significantly inadequate. We thought that the state legislature was making sufficient resources available to the Department of Social Services to assure nursing homes had the necessary resources to comply with this anticipated staffing rule, but this proposed regulation requires significantly more resources. Our nursing home's labor-related costs began a dramatic rise last fall and are showing no sign of relenting. This is a direct result of our team having no choice but to turn to staffing agencies to help staff our building to ensure our residents get the care they deserve. Using these nurse staffing agencies has been a measure of last resort at our nursing home. However, like so many other nursing homes we have had no other option. The financial consequences have been enormous. We are seeing unbelievable spikes in the costs of staffing agencies. For example, many staffing agencies charge additional fees for the difficult to fill shifts, weekend and off shifts, or the agency staff will not pick up shifts unless an additional incentive is added to their already exorbitant pay rates.
5. The public health code does not reflect the reality of the three shifts most nursing homes use as their staffing template. It is currently written for two 12-hour shifts and this should be updated to be a more accurate reflection of staffing ratios per shift.

In closing, the above reasons are why we are requesting that the proposed DPH regulation (PR2202-32) be substantially revised. Implementation of the regulation as it is now proposed will only make matters worse for our nursing facilities, staff, and residents. We are not opposed to a meaningful increase to our minimum staffing levels to update the outdated public health code ratios but not the one being currently proposed.

Thank you for your time and consideration.

Sincerely,

Sharon Ellis

Sharon Ellis
Director of Human Resources
Wachusett Healthcare

WACHUSETT
HEALTHCARE

August 14, 2023

Comments on DPH Proposed Regulation (PR2022-32)

To the Department of Public Health:

My name is Maureen L'Abbe and I am the Regional, Clinical Reimbursement Coordinator for Wachusett Healthcare, a company that owns, operates and manages four facilities in Connecticut - Parkway Pavilion Health and Rehab Center in Enfield (130 beds), Beechwood in New London (60 beds), Harbor Village Rehabilitation & Nursing Center in New London (128 beds) and Villa Maria Rehabilitation & Nursing Center in Plainfield (62 beds). All Wachusett facilities are longstanding providers of nursing care in the communities we serve with 380 skilled beds and over 400 employees.

I am writing to ask you to make some significant changes to this proposed regulation. We do not oppose an increase in the direct care staffing minimum as outlined in the public health code, but we strongly oppose how DPH is proposing the implementation of the requirement. There are major problems with how DPH has proposed increasing the direct care minimum staff from the outdated 1.9 hours to 3.0 hours per resident per day.

Our primary areas of concern with this regulation are as follows:

1. The proposed regulation wrongly increases the CNA minimums from 1.26 to 2.16 hours of care per resident per day and reverses the Public Health Code rule that appropriately allowed for licensed staff hours to be counted toward meeting the minimum staffing standard. This approach eliminates our flexibility to staff the facility to meet the needs and acuity of our residents. If implemented, this will not create better outcomes but will likely worsen the situation.
2. There is an insufficient supply of workers to meet the needs of our healthcare facilities. We have seen a mass exodus of workers since the start of the pandemic, which has not turned around as of yet. Our facilities have been facing the most significant staffing challenges we have ever experienced. We have exhausted all efforts to recruit staff to work at our facilities. We have increased wages on an annual basis, offered sign-on bonuses, offered flexible scheduling through online platforms such as Indeed and Apploi and offered to sponsor candidates to become certified nursing assistants (CNAs). Unfortunately, these efforts have not been effective, resulting in the use of agency staff at outrageous fees. In addition to the cost, the use of agency staff doesn't allow for consistent assignments for our residents which is a best practice we strive for.
3. The proposed regulation doesn't take into consideration the modern nursing home staffing model. To best meet the needs of our residents, we utilize a collaborative approach including our entire interdisciplinary team. This regulation doesn't count all the staff that are providing direct care daily. In addition to the CNAs, direct care is provided by licensed nurses, occupational therapists, and physical therapists. Additionally, we believe Therapeutic Recreation staff also play a key role in the daily needs of our residents and should also be considered in the staffing rule. This rule should account for all these staff members providing direct care to meet our residents' needs.
4. The amount of Medicaid resources the state made available for compliance with the DPH increased minimum staffing rule is significantly inadequate. We thought that the state legislature was making sufficient resources available to the Department of Social Services to assure nursing homes had the necessary resources to comply with this anticipated staffing rule, but this proposed regulation requires

significantly more resources. Our nursing home's labor-related costs began a dramatic rise last fall and is not showing an end in the rise of costs. This is a direct result of our team having no choice but to turn to staffing agencies to help staff our building to ensure our residents get the care they deserve. Using these nurse staffing agencies has been a measure of last resort at our nursing home. However, like so many other nursing homes we have had no other option. The financial consequences have been enormous. We are seeing unbelievable spikes in the costs of staffing agencies. For example, many staffing agencies charge additional fees for the difficult shifts to fill,

5. The public health code does not reflect the reality of the three shifts most nursing homes use as their staffing template. It is currently written for two 12-hour shifts and this should be updated to be a more accurate reflection of staffing ratios per shift.

In closing, the above reasons are why we are requesting that the proposed DPH regulation (PR2202-32) be substantially revised. Implementation of the regulation as it is now proposed will only make matters worse for our nursing facilities, staff, and residents. We are not opposed to a meaningful increase to our minimum staffing levels to update the outdated public health code ratios but not the one being currently proposed.

Thank you for your time and consideration.

Respectfully,

Maureen L'Abbe, RAC

Maureen L'Abbe

Regional, Reimbursement Coordinator

Wachusett Healthcare

Autumn Lake HealthCare at Norwalk

34 Midrocks Drive

Norwalk, CT 06851

July 31st, 2023

Comments on DPH Proposed Regulation (PR2022-32)

To the Department of Public Health:

My name is Adrian Thomas. I am the Administrator, at Autumn Lake Health Care at Norwalk in Norwalk, Connecticut. Autumn Lake Healthcare at Norwalk] has been providing nursing home care in our community for over 20 years. We are a 150-bed nursing home, and we have [number of employees] employees working at our facility.

Please consider these comments and request that you substantially revise the proposed regulations.

There are major problems with how DPH has proposed increasing the direct care minimum staff from the outdated 1.9 hours to 3.0 hours of direct care staff per resident per day.

There are four main areas of concern:

THE PROPOSED REGULATION WRONGLY INCREASES THE CNA MINIMUMS FROM 1.26 TO 2.16 HOURS OF PER DAY.

This one-size fits all approach removes Autumn Lake Healthcare at Norwalk flexibility in assigning staff to address the care needs of our residents....

THE PROPOSED REGULATION REVERSES THE PUBLIC HEALTH CODE RULE THAT APPROPRIATELY COUNTED DIRECT CARE LICENSED STAFF AND CNA STAFF TOWARD MEETING THE MINIMUM STAFFING STANDARD.

It won't lead to better care and will likely worsen the situation by writing the rule this way.

THE PROPOSED RULE DOESN'T REFLECT MODERN NURSING HOME STAFFING BECAUSE IT DOESN'T COUNT ALL THE STAFF THAT ARE PROVIDING DIRECT CARE

The rule should also include additional licensed staff that provide direct care.

Our facility is facing the most significant staffing challenges we have ever experienced....

CONCLUSION

In conclusion, this is why we are requesting the proposed DPH regulation be substantially revised to address these concerns.

Respectfully submitted,

Adrian Thomas,LNHA

BEECHWOOD
Family-owned and operated since 1955

July 31st, 2023

Comments on DPH Proposed Regulation (PR2022-32)

To the Department of Public Health:

My name is William White. I am the President and Administrator at Beechwood, in New London, Connecticut. We have been providing nursing home care in our community for 68 years. We are a 60-bed nursing home, and we have 87 employees working at our facility.

We are not opposed to increased Connecticut's direct care staffing minimum from 1.9 to 3.0, but we are strongly opposed to how specifically DPH has interpreted this state legislative requirement in the proposed regulations and how DPH is currently implementing the requirement.

There are major problems with how DPH has proposed increasing the direct care minimum staff from the outdated 1.9 hours to 3.0 hours of direct care staff per resident per day.

There are several areas of concern:

THE PROPOSED REGULATION WRONGLY INCREASES THE CNA MINIMUMS FROM 1.26 TO 2.16 HOURS OF PER DAY.

This one-size fits all approach removes Beechwood's flexibility in assigning staff to address the personalized care needs of our residents,

THE PROPOSED REGULATION REVERSES THE PUBLIC HEALTH CODE RULE THAT APPROPRIATELY COUNTED DIRECT CARE LICENSED STAFF AND CNA STAFF TOWARD MEETING THE MINIMUM STAFFING STANDARD.

It won't lead to better care and will likely worsen the situation by writing the rule this way. It is in direct contradiction to our mission to provide resident centered care.

THERE IS AN INSUFFICENT SUPPLY OF WORKERS

31 VAUXHALL STREET | NEW LONDON, CT 06320-5723
860.442.4363 | FAX 860.447.3749 | WWW.BEECHWOODREHAB.NET

Our facility is facing the most significant staffing challenges we have ever experienced. We are have open, full-time positions, in every nursing classification on every shift.

THE AMOUNT OF MEDICAID RESOURCES THE STATE MADE AVAILABLE FOR COMPLIANCE WITH THE DPH INCREASED MINIMUM STAFFING RULE IS SIGNFICANTLY INADEQUATE

We thought that the state legislature was making sufficient Medicaid resources available to the Department of Social Services to assure nursing homes had the resources to comply with the anticipated DPH minimum staffing rule. Instead DPH put out a policy that requires significantly more resources than what has been provided.

That DSS had to **prorate the true costs down** based on the insufficient amount of money in the budget shows clearly that DPH imposed a rule that required a much more substantial funding amount. Beechwood does not have the resources to cover this unfunded state mandate.

Please make substantial changes to this proposed regulation. It will make matters worse for our Beechwood's residents and staff members.

ADVANCED

CENTER FOR NURSING & REHABILITATION

August 2, 2023

Comments on DPH Proposed Regulation (PR2022-32)

To the Department of Public Health:

My name is Robert Fritz and I am the Administrator at Advanced Nursing and Rehabilitation Center in New Haven, Connecticut. We are one of the largest nursing homes in the state with 126 beds and over 225 employees working at our facility.

I am writing to ask you to make some changes to this proposed regulation as after working in this industry for over 30 years, there are many concerns that need to be addresses and considered. The proposed regulation reverses the Public Health Code rule that appropriately counted Direct Care Licensed staff and CNA staff toward meeting the minimum staffing standard. The proposed rule doesn't reflect modern nursing home staffing because it doesn't count all the staff that are providing direct care.

One of the biggest concerns is the insufficient supply of workers that are in the workplace. Never in 30 plus years has there been a greater staffing challenge and lack of available workers to provide care to our residents. Things are not going to change overnite.

Finally, there are the unfunded costs associated with this proposed regulation. The legislature has not provided our facilities with sufficient Medicaid resources be able to comply with the DPH minimum staffing rule.

These are just some of the reasons why we are requesting the proposed DPH regulation be substantially revised to address these concerns, otherwise it will make matters worse for our nursing facility, our staff, and our residents.

Sincerely,

Robert Fritz, Administrator

169 Davenport Avenue, New Haven, CT 06519 | Tel: 203-789-1650 | Fax: 203-562-4498 | www.Advancednh.com

MURTHA CULLINA
ATTORNEYS AT LAW

JENNIFER M. DELMONICO
203.772.7735 DIRECT TELEPHONE
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JDELMONICO@MURTHALAW.COM

February 28, 2023

VIA U.S. MAIL

Commissioner Manisha Juthani, MD
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, Connecticut 06134

Re: Connecticut Association of Health Care Facilities, Inc.'s Petition for Declaratory Rulings Regarding the Applicability of Conn. Gen. Stat. § 19a-563h

Dear Commissioner Juthani:

Enclosed is Connecticut Association of Health Care Facilities, Inc.'s ("CAHCF") Petition for Declaratory Rulings and supporting affidavit under General Statutes § 4-176 and RCSA § 19a-9-12 regarding the meaning and applicability of minimum staffing level requirements under Conn. Gen. Stat. § 19a-563h.

Sincerely,

Jennifer M. DelMonico

Enclosures

cc: Matthew V. Barrett, Esq. (w/o encl.)

Murtha Cullina LLP
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New Haven, CT 06510
T 203.772.7700
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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

PETITION OF CONNECTICUT ASSOCIATION OF HEALTH CARE FACILITIES, INC. FOR DECLARATORY RULINGS AS TO THE APPLICABILITY OF MINIMUM STAFFING REQUIREMENTS UNDER CONN. GEN. STAT. § 19a-563h	:	February 28, 2023

PETITION FOR DECLARATORY RULINGS

Pursuant to Conn. Gen. Stat. § 4-176, and the rules and regulations promulgated thereunder, including Conn. Agencies Regs. §§ 19a-9-1 *et seq.*, Connecticut Association of Health Care Facilities, Inc. ("CAHCF" or "Petitioner"),[1] a Connecticut trade association and advocacy organization which includes 151 skilled nursing facility members, hereby petitions the Commissioner of the Connecticut Department of Public Health ("DPH"), for declaratory rulings as to the meaning and applicability of minimum staffing level requirements under Conn. Gen. Stat. § 19a-563h. Specifically, CAHCF requests the following declaratory rulings:

(1) Under Conn. Gen. Stat. § 19a-563h(a), Connecticut nursing homes meet the statutory minimum staffing level requirement by providing the minimum of three (3.0) hours of direct care per resident per day with three (3.0) hours of total nursing and nurse's aide personnel time, as intended by the Connecticut General Assembly; and

[1] Petitioner CAHCF is located at 213 Court Street, Middletown, Connecticut 06457. CAHCF is an association permitted under Conn. Agencies Regs. § 19a-9-9 to file this Petition for a declaratory ruling.

(2) Regulations, policies and procedures promulgated by DPH with respect to minimum staffing level requirements that set specific minimum staffing levels for each category of nursing services (registered nurses ("RNs"), licensed practical nurses ("LPNs") and/or nurse's aide personnel ("CNAs")) for those three (3.0) hours of direct care per resident per day violate Conn. Gen. Stat. § 19a-563h(a).

I. BACKGROUND

Section 19a-563h of the General Statutes establishes minimum staffing levels for Connecticut's nursing homes. The new statute, effective May 23, 2022, requires DPH to "establish minimum staffing level requirements for nursing homes of *three hours of direct care per resident per day*." Conn. Gen. Stat. § 19a-563h(a)(1) (emphasis added). Section 19a-563h commands the Commissioner to adopt regulations to implement the new statute, and further provides the Commissioner with permissive authority to implement interim policies and procedures pending adoption of final regulations. Conn. Gen. Stat. § 19a-563h(b).

Before Section 19a-563h was enacted, the Connecticut General Assembly had refrained from adopting minimum staffing level requirements for nursing homes even though such requirements had been proposed many times over the last decade, instead maintaining the more aggressive and flexible approach under state regulations which mirror strict federal staffing requirements. These requirements are focused on ensuring sufficient staffing to meet the individual needs of nursing home residents, while state regulations also provide for minimum staffing levels.

Specifically, existing DPH regulations require that each nursing home "employ sufficient nurses and nurse's aides to provide appropriate care" to residents and that the

"number, qualifications and experience of such personnel shall be sufficient" to assure each resident receives care and treatment as prescribed in the patient care plan; be kept clean, comfortable, and well-groomed; and be protected from accident, infections, or other unusual occurrence. Conn. Agencies Regs. § 19-13-d8t(m). The regulations further require that the nursing home administrator and director of nurses meet at least once every 30 days to determine the number, experience, and qualifications of staff necessary to comply with these staffing requirements. Finally, the regulations require nursing homes to provide patients with a minimum staffing of 1.9 hours per patient per day from a combination of "total nursing and nurse's aide personnel."[2] Conn. Agencies Regs. § 19-13-D8t(m) (requiring staffing of 1.4 hours per patient from 7 a.m. to 9 p.m., and .5 hours per patient from 9 p.m. to 7 a.m.) Although a subset of the 1.9 hours of staffing per patient per day is required to be from "[l]icensed nursing personnel," *i.e.*, RNs and LPNs, *see id.* (requiring staffing of licensed nursing personnel for .47 hours per patient from 7 a.m. to 9 p.m., and .17 hours per patient from 9 p.m. to 7 a.m.), the Public Health Code has permitted nursing homes full discretion and flexibility to staff the balance of the minimum hours between licensed nursing and nurse aide personnel based on the needs of individual patients.

The existing DPH regulations are consistent with federal regulations, which similarly place focus on ensuring sufficient staffing to meet the particular needs of the facility's residents, requiring that each nursing home "have sufficient nursing staff with the

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[2] Conn. Agencies Regs. § 19-13-D8t(a)(11) defines "licensed nursing personnel" as "registered nurses or licensed practical nurses licensed in Connecticut." "CNA" is separately defined in Section 19-13-D8t(a)(3) as "a nurse's aide issued a certificate – from January 1, 1982 through January 31, 1990 – of satisfactory completion of a training program which has been approved by the department."

appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, *as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at 483.70(e)."* 42 C.F.R. 483.35 (emphasis added).

When the General Assembly in the 2021 session sought to codify minimum staffing levels in nursing homes, it initially considered a bill that would not only increase the minimum hours to 4.1 hours of direct care per resident per day, but also would impose statutory minimum staffing levels based on licensure status, *i.e.*, minimum hours for RNs, LPNs, and CNAs. The full legislative body rejected that proposal in the final version of S.B. No. 1030, however, in favor of increasing the minimum hours (from 1.9 to 3.0) while specifically eliminating mandated staffing ratios without specifying *any* minimum hours based on *any* licensure status, leaving intact the flexibility required for nursing homes to staff at different levels based on patient needs.

It is important to note that CAHCF agrees with the policy goal of increasing staffing levels to 3.0 hours per resident per day as directed by the General Assembly consistent with the state appropriations adopted for this purpose – as informed by the estimated fiscal impact – and does not seek any declaratory ruling as to the overall statutory increase of minimum staffing levels from a total of 1.9 hours to 3.0 hours of direct care per resident per day – an increase of 1.1 hours or nearly 60%. CAHCF further commends DPH for the open and transparent explanation of the limited input and factors DPH considered in its proposed agency regulations and corresponding policies and

procedures. This Petition is submitted solely to seek declaratory rulings that confirm that the statute does not reverse the policy of flexibility in determining the appropriate combination of nursing and nurse's aide staffing that has existed in Connecticut for over 30 years, and rather continues that policy of flexibility – while meeting the increased minimum total hours – as the General Assembly plainly intended.

For these reasons, as explained in more detail below: (1) under Conn. Gen. Stat. § 19a-563h(a), nursing homes should satisfy the minimum staffing level requirement of three (3.0) hours of direct care per resident per day with three (3.0) hours of total nursing and nurse's aide personnel time; and (2) regulations, policies and procedures promulgated by DPH with respect to minimum staffing level requirements that set specific minimum staffing levels for each category of nursing services (RNs, LPNs, and/or CNAs) for those three (3.0) hours of direct care per resident per day violate Conn. Gen. Stat. § 19a-563h(a).

II. DISCUSSION

A. Under The Plain Meaning Of Section 19a-563h(a), Nursing Homes Satisfy The Minimum Staffing Level Requirement Of 3.0 Hours Of Direct Care Per Resident Per Day With 3.0 Hours Of Total Nursing And Nurse's Aide Personnel Time.

As with any statutory interpretation issue, as DPH considers the meaning of Conn. Gen. Stat. § 19a-563h(a) and its applicability to staffing the minimum 3.0 hours with a combination of RNs, LPNs, and CNAs, it must first look to the plain meaning of the statute. *See* Conn. Gen. Stat. § 1-2z ("[t]he meaning of a statute shall, in the first instance, be ascertained from the text of the statute itself and its relationship to other statutes.").

In this case, the plain language in Section 19a-563h(a) mandates minimum staffing levels for nursing homes at 3.0 hours of direct care per patient per day, without mandating

minimum hours for any subset thereof and without mandating any staffing ratios among RNs, LPNs and CNAs. Accordingly, based on the plain meaning of the statute, nursing homes meet the minimum staffing level requirement 3.0 hours of direct care per resident per day, as required under Section 19a-563h, by staffing the requisite hours through a combination of total nursing and nurse's aide personnel.

B. The Legislative History And Fiscal Impact Analysis Supports The Plain Meaning Interpretation.

Although Section 19a-563h is clear, to the extent the statute could be subject to more than one interpretation, consideration of the legislative history, underlying policy issues, and existing DPH regulations further support its plain meaning interpretation.

1. The General Assembly Specifically Rejected Minimum Staffing Levels By Licensure Status, Opting Instead To Preserve Staffing Flexibility Based On Resident Needs.

Section 19a-563h began as Senate Bill 1030, introduced during the January 2021 legislative session, in which the following language regarding minimum staffing level requirements was initially proposed in the Senate:

> Sec. 13 (NEW) (Effective October 1, 2021) … (b) On or before January 1, 2022, the Department of Public Health shall (1) establish minimum staffing level requirements for nursing homes of at least four and one-tenth hours of direct care per resident, including *three and three-quarter hours of care by a registered nurse, fifty-four hundredth hours of care by a licensed practical nurse and two and eighty-one hundredth hours of care by a certified nurse's assistant*, …

(emphasis added).[3] *See* ***Exhibit 1*** (S.B. 1030, Original Draft). The initial draft not only increased the number of direct care hours per patient from the DPH-regulated 1.9 hours per day to 4.1 hours a day, it also included particular ratios based on licensure status.

[3] The initial version of S.B. 1030 includes a typographical error, mandating "three and three-quarter hours of care by a registered nurse," which requirement during discussions on the Senate floor and in drafts specifically included only the three-

At hearings on S.B. 1030 in March 2021, numerous interested parties, including the DPH Acting Commissioner and Commissioner of the Department of Social Services, Dr. Deidre S. Gifford, submitted testimony regarding the proposed minimum staffing level requirements. While agreeing with the desirability of creating statutory minimums at levels higher than the existing DPH regulations of 1.9 hours per patient per day, many of those presenting testimony criticized mandated staffing ratios based on licensure status and supported continuing the same degree of flexibility in staffing based on patient needs, as federal and state regulations had allowed for decades.

Notably, DPH Acting Commissioner Dr. Gifford gave testimony *supporting* the continued flexibility in determining appropriate staffing within minimum staffing level requirements rather than imposing staffing ratios on nursing homes:

> The Department recommends all facilities have adequate staffing with the appropriate competencies and skill sets to provide nursing and related services, *based on a facility assessment*, to assure resident safety and attain or maintain the highest practicable level of physical, mental, and psychosocial well-being of each resident. The facility assessment uses individual resident assessments and plans of care to ascertain the number, type of diagnoses, and acuity of the facility's resident population. In the nursing home setting, regulations require that the administrator and director of nursing meet monthly *to determine adequate staffing levels using a tool based on the acuity of their current resident census*.

Exhibit 2 (emphasis added) (Gifford Testimony). Dr. Gifford, as Acting Commissioner of DPH and Commissioner of the Department of Social Services, expressly recognized and supported the need to allow each facility to determine independently how to fill the minimum staffing levels to meet patient needs, consistent with the flexibility that had been

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quarter hours of direct care by registered nurses. Indeed, adding up all of the specific required hours in this initial version equals seven and one-tenth (7.1) hours rather than the four and one-tenth (4.1) hours in the bill.

fostered and permitted under DPH's existing regulation. *See* Conn. Agencies Regs. § 19-13-D8t(m).

CAHCF's President and CEO, Matthew V. Barrett, also testified, raising two significant concerns with the proposed ratios in S.B. 1030: (i) reduced flexibility in the proposed legislation in allowing nursing homes to direct the percentages of staffing resources, between RNs, LPNs and CNAs, based on specific care needs of individual nursing homes, and (ii) increased labor costs to achieve the proposed minimum staffing that would result from the mandated percentages, especially for hiring additional CNAs to meet the specific mandated ratios. ***Exhibit 3*** (Barrett Testimony).

Mag Morelli, President of LeadingAge Connecticut, also questioned the wisdom of the proposed specific ratios per licensure category. While supporting an increase in overall hours per patient per day, Morelli did not support the mandated ratios of RNs, LPNs and CNAs which would completely remove the critical flexibility nursing homes needed (and DPH regulations previously allowed) to determine how best to staff those hours based on changing patient needs. ***Exhibit 4*** (Morelli Testimony).

In addition to eliminating flexibility in staffing decisions, S.B. 1030, as originally drafted, caused concerns over the significant fiscal impact of the staffing ratios. At a Senate hearing on March 17, 2021, Dr. Gifford, as Acting Commissioner of DPH and Commissioner of the Department of Social Services, was specifically asked whether DPH and the Department of Social Services was in favor of the proposed staffing level ratios in the existing version of S.B. 1030, to which she responded:

> I think the Department would like to continue to have the conversation of minimum staffing ratios. We certainly understand the impetus behind it and ensuring that there is always adequate staff to meet the needs of the residents based on their acuity. While I think we would also want to talk

> about the implications of the minimum staffing ratios *or financial support of the facility*, so I think we probably are aligned on the intent and want to just engage you a little bit more on the specifics and how it would be implemented and *supported*.

Exhibit 5, at 20 (Connecticut Committee Transcript Excerpt, PH 3/17/2021) (emphasis added). In sum, Dr. Gifford declined to offer support for the existing version of S.B. 1030 until, among other things, the financial support for the proposed staffing ratios could be properly vetted.

The Office of Fiscal Analysis then prepared and submitted an analysis of the financial impact of the original proposed staffing ratios in the File Copy of S.B. 1030. "*Staffing ratio requirements will result in a significant cost to DSS* to the extent nursing home staffing costs are reflected in future Medicaid payments ... The cost for nursing homes to staff at the proposed levels will depend on the actual number and level of staff required and their associated wages but is anticipated to *be at least $200 million*." ***Exhibit 6*** (April 13, 2021 Fiscal Note, Office of Fiscal Analysis).

When S.B. 1030 was taken up on the floor of the State Senate prior to the end of the 2021 session, the Public Health Committee Chair offered an amended version of S.B. 1030, referred to as Senate Amendment Schedule "A" to S.B. 1030, which eliminated the staffing ratios by category of personnel, and reduced the minimum staffing level requirement from 4.1 hours to 3.0 hours of direct patient care per day. *See* ***Exhibit 7*** (Amended S.B. 1030).

The Office of Fiscal Analysis Fiscal Note on the amended version of S.B. 1030 confirmed that the amended bill (based on an evaluation of 2019 cost report data) – without mandated staffing ratios – would have a nominal financial impact:

> The amendment requires the Department of Public Health (DPH) to establish a minimum staffing level of three hours of direct care per resident per day, by January 1, 2022. Based on 2019 cost report data, there are several homes providing less than three hours of direct care per resident per day. The total cost for these homes to meet the bill's provisions is approximately $600,000 to $1 million. ***If the state supported those costs through increased rates, it would result in a state Medicaid cost of $300,000 to $500,000***. The actual cost depends on the number and type of staff required.

Exhibit 8 (May 27, 2021 Fiscal Note, Office of Fiscal Analysis) (emphasis added).

In advocating for the passage of this modified version of S.B. 1030, the Chair of the Public Health Committee, Senator Mary Daugherty Abrams summarized the new language in the provision on minimum staffing, noting that "changes have been made to address the fiscal note and feedback from various stakeholders." Senator Daugherty Abrams continued that "[s]taffing would be increased. Currently it's 1.9 hours per resident per day. This would increase that to 3.0. It would also increase the ratio of social workers from one to 120, to one to 60, and increase recreational staff as determined by the public health department." Senator Abrams emphasized the mandated staffing ratio for social workers, but specifically addressed only the overall increase in nursing and nurse's aide hours from 1.9 to 3.0 per day, making clear her committee had rejected including ratios for nursing personnel. ***Exhibit 9*** (Connecticut Senate Transcript Excerpt, 5/27/2021).

Senator Heather Somers further stated clearly that the new version of the bill "starts the beginning of the process, I believe, a process to improve the long-term care that we can provide to our citizens in the State of Connecticut. It looks at infection prevention, infection control, it looks at staffing levels *that are reasonable and are affordable*. It looks at emergency plan. It deals with visitation of loved ones. It deals with patients' rights." *Id.* (emphasis added).

Based on the data, testimony and important policy considerations, the mandated staffing ratios were eliminated. Section 19a-563h was enacted, providing:

> (a) On or before January 1, 2022, the Department of Public Health shall (1) establish minimum staffing level requirements for nursing homes of three hours of direct care per resident per day …

The statute eliminated any specific minimum hours or ratios based on licensure status, consistent with the testimony of the DPH Acting Commissioner and others. By eliminating specific staffing ratios, the statute preserved nursing homes' flexibility to determine – based on patient needs – the staffing arrangements most appropriate to meet the increased minimum staffing levels.

2. The Allocation of $500,000 To Support The Minimum Staffing Levels In Section 19a-563h Confirms The Legislative Intent To Reject Minimum Staffing Levels By Licensure Status.

The General Assembly allocated $500,000 in state funding to DSS for two fiscal years to support the minimum staffing levels imposed by Section 19a-563. This level of funding was entirely consistent with the Office of Fiscal Analysis Fiscal Note that the cost of increasing the minimum staffing level to three hours of direct care per resident per day – without mandated staffing ratios – would be nominal, an estimated $300,000 to $500,000. *See* ***Exhibit 8***. As such, the General Assembly's allocation of $500,000 to support the increased costs of Section 19a-563h further supports the legislature's intent to increase the total hours of direct care *without* imposing the mandated staffing ratios that were estimated to have a fare greater significant financial impact. ***See Exhibit 6*** (estimating the financial impact of the original S.B. 1030 – which included mandated staffing ratios – to be $200 million).

DSS interpreted the statute the same way. Indeed, in anticipation of the effective date of Public Act 21-185, now codified as Section 19a-563h, DSS included guidance for nursing homes on its website that specified the General Assembly had allocated up to $500,000 in state funding to DSS for the next two fiscal years to support the minimum nursing home staffing requirement, reflecting the figures in the May 27, 2021 Fiscal Note. This guidance reflected DSS' belief that the final statute did not require any mandatory staffing ratios – consistent with its plain language – since including mandatory staffing ratios would have substantially increased the associated costs.

It is clear that the statute was intended to *not* require mandatory staffing ratios. An interpretation that mandatory staffing ratios are permitted under Section 19a-563h would impose significant financial burdens that are not supported by the statute, that are not funded by the General Assembly, and that – as a practical matter – Connecticut's nursing homes cannot afford.

C. The DPH Policies and Procedures Violate the Statute, Do Not Comport With The Fiscal Impact Analysis and Available Appropriations, And Are Inconsistent With DSS' Interpretation And The Medicaid Increased Rate Application Process.

Section 19a-563h(b) also authorizes the Commissioner to implement interim policies and procedures "necessary to administer the provisions of this section . . . while in the process of adopting such policies and procedures as regulations, provided notice of intent to adopt regulations is published on the eRegulations System not later than twenty days after the date of implementation." Based on this, DPH has issued an Operational Policy entitled "Policies and Procedures regarding Nursing Home Staffing Levels to implement the requirements of Section 19a-563h," which amends the existing regulations in Conn. Agencies Regs. § 19-13-D8t(m) (the "Policies and Procedures").

Despite the plain language of Section 19a-563h and the opposition during the legislative process for mandatory staffing ratios – including by DPH's Acting Commissioner – DPH nevertheless has mandated in the Policies and Procedures not just an increase in the minimum staffing to 3.0 hours of direct care per resident per day, but also a specific minimum for nurse aide staffing of 2.16 hours per resident per day, requiring: (i) for licensed nursing personnel (RNs and LPNs), 0.57 hours per patient during day shifts (7 a.m. to 9 p.m.) and 0.27 hours per patient during night shifts (9 p.m. to 7 a.m.); and (ii) for CNAs, 1.6 hours per patient during day shifts (7 a.m. to 9 p.m.) and 0.56 hours per patient during night shifts (9 p.m. to 7 a.m.). In addition, the Policies and Procedures add an ambiguous definition of direct care. These interpretations are clearly contrary to the legislative intent evidenced in the final fiscal analysis dated May 27, 2021, which is uses 2019 cost report data to conclude a nominal fiscal impact resulting from the passage of Section 19a-563h.[4]

Given that the General Assembly rejected any allocation of minimum hours among different nursing staff categories, it is clear that the state legislature intended to leave specific staffing choices to the individual nursing homes, which are in the best positions to assess the specific needs of individual patients and determine specific staffing to meet those patients' needs.

The General Assembly's decision to leave specific staffing choices to individual nursing homes is evident given the significant fiscal impact that mandatory staffing ratios

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[4] Notably, in filing the Notice of Intent to Adopt Regulations concerning these minimum staffing requirements, DPH failed to include the Fiscal Note, including estimated costs or revenue impact on the State required under the regulation-making process in Connecticut. *See* Conn. Gen. Stat. § 4-168(a).

would pose for nursing homes and the State. As discussed *supra*, the initial Fiscal Note on the original draft of S.B. 1030 made clear that imposing the minimum of 4.1 hours of direct care per resident per day, plus imposing mandated staffing ratios, would cost DSS as much as an additional $200 million per year. The second Fiscal Note, addressing the amended version of S.B. 1030 that both reduced the minimum hours from 4.1 to 3.0 of direct care per resident per day and eliminated all mandatory staffing ratios, anticipated increased costs of between $300,000 and $500,000 per year. DSS then had an additional $500,000 allocated for Medicaid costs for subsequent fiscal years, reflecting the clear intent to allocate to DSS additional funding to cover only the increase in minimum staffing levels to 3.0 hours *without* accounting for additional costs of mandatory staffing ratios. The DPH Policies and Procedures do not take these financial impacts into account, and would impose an unfunded mandate that the legislature expressly chose not to impose, thus violating the statute.

Not only do the Policies and Procedures violate the plain language and legislative intent of Section 19a-563h, they represent a significant, overreaching departure from DPH's *existing* regulations regarding staffing ratios for nursing homes. *See* Conn. Agencies Regs. § 19-13-D8t(m). These regulations – which were the sole source of minimum staffing levels for nursing homes before the enactment of Section 19a-563h – permitted nursing homes to staff 1.5 hours of the total minimum 1.9 hours of direct care with any combination of "total nursing and nurse's aide personnel" based on patient needs; only 0.4 hours of the minimum time was expressly allocated for licensed nursing professionals. DPH cannot regulate beyond this without specific legislative authority, approval, and funding.

Yet, the Policies and Procedures as written have significant fiscal impact, in stark contrast with the nominal impact included in the fiscal analysis. The legislature clearly intended for the minimum staffing ratio to be established as a combined total of licensed nursing staff and nurse's aide personnel, consistent with the existing Public Health Code methods. Instead, DPH has created two separate minimum staffing levels, one for licensed nursing staff and one for nurse's aide personnel, which is a major change that will significantly increase the fiscal impact and require staffing modifications for over 100 nursing homes. In addition, in at least two presentations on the new Policies and Procedures, DPH has incorrectly claimed that the new Policies and Procedures only increase the total minimum staffing levels by 0.46 hours per day. This is clearly incorrect, as the minimum staffing levels are increased by 1.1 hours per day overall (from 1.9 to 3.0) and the Policies and Procedures establish for the first time minimum staffing levels for nurse's aide personnel, at a level of 2.16 hours per patient per day.

The Policies and Procedures undermine and contradict the plain language of Section 19a-563h and its clear legislative intent, and implement mandates that the legislature specifically sought to avoid when it modified the proposed legislation to delete staffing ratios. In addition, substantively the Policies and Procedures are not supported by proper procedure and/or substantial evidence. While the General Assembly authorized DPH to implement interim policies and procedures, DPH was not given authority to ignore the plain language of the statute or its legislative history. Accordingly, the Policies and Procedures that mandate particular minimum staffing ratios to meet the minimum staffing levels for nursing homes violate Section 19a-563h, and its purpose and intent. In addition, to the extent that DPH intends to craft regulations that incorporate any

staffing ratios, for the same reasons set forth above, those regulations also would violate Section 19a-563h.

The General Assembly intended to preserve flexibility for nursing homes to determine how best to meet the new minimum staffing level requirements based on individual patient needs, not arbitrary, fixed staffing ratios. Section 19a-563h must be read to allow nursing homes to make those staffing decisions, so long as the minimum mandate of 3.0 hours of direct patient care is achieved and staffing is sufficient to meet patient needs.

III. CONCLUSION

For the foregoing reasons, Connecticut Association of Health Care Facilities, Inc. respectfully requests that the Commissioner of the Department of Public Health issue a declaratory ruling that (i) nursing homes in Connecticut meet the minimum staffing level requirement of three (3.0) hours of direct care per resident per day under Conn. Gen. Stat. § 19a-563h with three (3.0) hours of total nursing and nurse's aide personnel time, and (ii) any regulations, policies and procedures promulgated by DPH with respect to minimum staffing level requirements which set specific minimum staffing levels for each category of nursing services (RNs, LPNs and/or CNAs) for those three (3.0) hours of

direct care per resident per day would be in violation of the purpose and intent of Conn. Gen. Stat. § 19a-563h(a).

Respectfully submitted,

CONNECTICUT ASSOCIATION OF HEALTH CARE FACILITIES, INC.

By: _____

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Exhibit 1

General Assembly

Raised Bill No. 1030

January Session, 2021

LCO No. **4720**

Referred to Committee on PUBLIC HEALTH

Introduced by:
(PH)

AN ACT CONCERNING LONG-TERM CARE FACILITIES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective October 1, 2021*) (a) As used in this section and sections 2 to 12, inclusive, of this act, "long-term care facility" means a nursing home, as defined in section 19a-521 of the general statutes, a residential care home, as defined in section 19a-521 of the general statutes, a home health agency, as defined in section 19a-490 of the general statutes, an assisted living services agency, as defined in section 19a-490 of the general statutes, an intermediate care facility for individuals with intellectual disability, as described in 42 USC 1396d(d), except any such facility operated by a Department of Developmental Services' program subject to background checks pursuant to section 17a-227a of the general statutes, a chronic disease hospital, as defined in section 19a-550 of the general statutes, or an agency providing hospice care which is licensed to provide such care by the Department of Public Health or certified to provide such care pursuant to 42 USC 1395x.

(b) Each long-term care facility shall employ a full-time infection prevention and control specialist who shall be responsible for the

following:

(1) Ongoing training of all employees of the long-term care facility on infection prevention and control using multiple training methods, including, but not limited to, in-person training and the provision of written materials in English and Spanish;

(2) The inclusion of information regarding infection prevention and control in the documentation that the long-term care facility provides to residents regarding their rights while in the facility;

(3) Participation as a member of the long-term care facility's infection prevention and control committee; and

(4) The provision of training on infection prevention and control methods to supplemental or replacement staff of the long-term care facility in the event an infectious disease outbreak or other situation reduces the facility's staffing levels.

Sec. 2. (NEW) (*Effective October 1, 2021*) The administrative head of each long-term care facility shall participate in the development of the emergency plan of operations of the political subdivision of this state in which it is located which is required pursuant to the Intrastate Mutual Aid Compact made and entered into under section 28-22a of the general statutes.

Sec. 3. (NEW) (*Effective October 1, 2021*) (a) Not later than six months after the termination of a public health emergency declared by the Governor pursuant to section 19a-131a of the general statutes, (1) the Department of Public Health shall have and maintain at least a three-month stockpile of personal protective equipment, including, but not limited to, gowns, masks, full-face shields, goggles and disposable gloves as a barrier against infectious materials, for use by long-term care facilities, and (2) the administrative head of each long-term care facility shall ensure that the facility acquires from the department and maintains at least a three-month supply of personal protective equipment for its staff. The administrative head of each long-term care

facility shall ensure that the personal protective equipment is of various sizes based on the needs of the facility's staff. The personal protective equipment (A) shall not be shared amongst the facility's staff, and (B) may only be reused in accordance with the strategies to optimize personal protective equipment supplies in health care settings published by the National Centers for Disease Control and Prevention. The administrative head of each long-term care facility shall hold quarterly fittings of his or her staff for N95 masks or higher rated masks certified by the National Institute for Occupational Safety and Health.

(b) On or before January 1, 2022, the Department of Emergency Management and Homeland Security, in consultation with the Department of Public Health, shall establish a process to evaluate, provide feedback on, approve and distribute personal protective equipment for use by long-term care facilities in a public health emergency.

Sec. 4. (NEW) (*Effective October 1, 2021*) The administrative head of each long-term care facility shall ensure that there is at least one staff member during each shift who is licensed or certified to start an intravenous line.

Sec. 5. (NEW) (*Effective October 1, 2021*) Each long-term care facility's infection prevention and control committee shall meet (1) at least monthly, and (2) during an outbreak of an infectious disease, daily, provided daily meetings do not cause a disruption to the operations of the facility, in which case the committee shall meet at least weekly. The prevention and control committee shall be responsible for establishing infection prevention and control protocols for the long-term care facility. Not less than biannually and after every outbreak of an infectious disease in the facility, the prevention and control committee shall evaluate the implementation and analyze the outcome of such protocols.

Sec. 6. (NEW) (*Effective October 1, 2021*) On or before January 1, 2022, every administrator and supervisor of a long-term care facility shall

complete the Nursing Home Infection Preventionist Training course produced by the National Centers for Disease Control and Prevention in collaboration with the Centers for Medicare and Medicaid Services.

Sec. 7. (NEW) (*Effective October 1, 2021*) Each long-term care facility shall, during an outbreak of an infectious disease, test staff and residents of the facility for the infectious disease at a frequency determined by the Department of Public Health as appropriate based on the circumstances surrounding the outbreak and the impact of testing on controlling the outbreak.

Sec. 8. (NEW) (*Effective October 1, 2021*) On or before January 1, 2022, the administrative head of each long-term care facility shall facilitate the establishment of a family council to encourage and support open communication between the facility and each resident's family members and friends. As used in this section, "family council" means an independent, self-determining group of the family members and friends of a long-term care facility's residents that is geared to meeting the needs and interests of the residents and their family members and friends.

Sec. 9. (NEW) (*Effective October 1, 2021*) (a) On or before January 1, 2022, the administrative head of each long-term care facility shall (1) ensure that each resident's care plan addresses (A) the resident's potential for isolation, ability to interact with family members and friends and risk for depression, (B) how the resident's social and emotional needs will be met, and (C) measures to ensure that the resident has regular opportunities for in-person and virtual visitation, (2) disclose the facility's visitation protocols, any changes to such protocols and any other information relevant to visitation in a form and manner that is easily accessible to residents and their family members and friends, (3) advise residents and their family members and friends of their right to seek redress with the Office of the Long-Term Care Ombudsman under section 17a-410 of the general statutes when the resident or a family member or friend of the resident believes the facility has not complied with its visitation protocols, and (4) establish a timeline by which the facility will ensure the safe and prompt

reinstatement of visitation following the termination of the public health emergency declared by the Governor in response to the COVID-19 pandemic and a program to monitor compliance with such timeline. As used in this section "COVID-19" means the respiratory disease designated by the World Health Organization on February 11, 2020, as coronavirus 2019, and any related mutation thereof recognized by the World Health Organization as a communicable respiratory disease.

(b) On or before January 1, 2021, the administrative head of each long-term care facility shall ensure that its staff is educated regarding (1) best practices for addressing the social, emotional and mental health needs of residents, and (2) all components of person-centered care.

Sec. 10. (NEW) (*Effective October 1, 2021*) On or before January 1, 2022, the Department of Public Health shall establish an essential caregiver program for implementation by each long-term care facility. The program shall (1) set forth visitation requirements for essential caregivers of long-term care facility residents, and (2) require the same infection prevention and control training and testing standards for an essential caregiver of a resident of the facility that are required for the facility's staff. As used in this section "essential caregiver" means a person deemed critical, as determined by a long-term care facility, to the daily care and emotional well-being of a resident of the facility.

Sec. 11. (*Effective from passage*) On or before October 1, 2021, the Public Health Preparedness Advisory Committee established pursuant to section 19a-131g of the general statutes shall amend the plan for emergency responses to a public health emergency prepared pursuant to said section to include a plan for emergency responses to a public health emergency in relation to long-term care facilities and providers of community-based services to residents of such facilities.

Sec. 12. (NEW) (*Effective from passage*) (a) On and after July 1, 2021, each long-term care facility shall permit a resident to use a communication device, including a cellular phone, tablet or computer, in his or her room, in accordance with the requirements established

under subsection (b) of this section, to remain connected with their family members and friends and to facilitate the participation of a resident's family caregiver as a member of the resident's care team.

(b) On or before June 30, 2021, the Commissioner of Public Health shall (1) establish requirements regarding the use of communication devices by long-term care facility residents under subsection (a) of this section to ensure the privacy of other long-term care facility residents, and (2) communicate such requirements to each long-term care facility.

Sec. 13. (NEW) (*Effective October 1, 2021*) (a) As used in this section, "nursing home" means (1) any chronic and convalescent nursing home or any rest home with nursing supervision that provides nursing supervision under a medical director twenty-four hours per day, or (2) any chronic and convalescent nursing home that provides skilled nursing care under medical supervision and direction to carry out nonsurgical treatment and dietary procedures for chronic diseases, convalescent stages, acute diseases or injuries.

(b) On or before January 1, 2022, the Department of Public Health shall (1) establish minimum staffing level requirements for nursing homes of at least four and one-tenth hours of direct care per resident, including three and three-quarter hours of care by a registered nurse, fifty-four hundredth hours of care by a licensed practical nurse and two and eighty-one hundredth hours of care by a certified nurse's assistant, (2) modify staffing level requirements for social work and recreational staff of nursing homes such that the requirements are lower than the current requirements, as deemed appropriate by the Commissioner of Public Health, and (3) eliminate the distinction between a chronic and convalescent nursing home and a rest home, as defined in section 19a-490 of the general statutes, as such distinction relates to nursing supervision, for purposes of establishing a single, minimum direct staffing level requirement for all nursing homes.

(c) On and after January 1, 2022, each nursing home shall offer its staff the option to work twelve-hour shifts.

(d) The commissioner shall adopt regulations in accordance with the provisions of chapter 54 of the general statutes that set forth nursing home staffing level requirements to implement the provisions of this section.

Sec. 14. (NEW) (*Effective October 1, 2021*) (a) For purposes of this section: (1) "Ombudsman" means the Office of the Long-Term Care Ombudsman established pursuant to section 17a-405 of the general statutes; (2) "electronic monitoring" means the placement and use of an electronic monitoring device by a nonverbal resident or his or her resident representative in the resident's room or private living unit in accordance with this section; (3) "electronic monitoring device" means a camera or other device that captures, records or broadcasts audio, video, or both, and may offer two-way communication over the Internet that is placed in a nonverbal resident's room or private living unit and is used to monitor the nonverbal resident or activities in the room or private living unit; (4) "nursing home facility" has the same meaning as provided in section 19a-490 of the general statutes; (5) "nonverbal resident" means a resident of a nursing home facility who is unable to verbally communicate due to physical or mental conditions, including, but not limited to, Alzheimer's disease and dementia; and (6) "resident representative" means (A) a court-appointed guardian, (B) a health care representative appointed pursuant to section 19a-575a of the general statutes, or (C) a person who is not an agent of the nursing home facility and who is designated in a written document signed by the nonverbal resident and included in the resident's records on file with the nursing home facility.

(b) A nonverbal resident or his or her resident representative may install an electronic monitoring device in the resident's room or private living unit provided: (1) The purchase, installation, maintenance, operation and removal of the device is at the expense of the resident, (2) the resident and any roommate of the resident, or the respective resident representatives, sign a written consent form pursuant to subsection (c) of this section, (3) the resident or his or her resident representative places a clear and conspicuous note on the door of the room or private

living unit that the room or private living area is subject to electronic monitoring, and (4) the consent form is filed with the nursing home facility not less than seven days before installation of the electronic monitoring device except as provided in subsection (e) of this section.

(c) No electronic monitoring device shall be installed in a nonverbal resident's room or living unit unless the resident and any roommate of the resident, or a resident representative, has signed a consent form that includes, but is not limited to:

(1) (A) The signed consent of the nonverbal resident and any roommate of the resident; or (B) the signed consent of a resident representative of the nonverbal resident or roommate if the nonverbal resident or roommate lacks the physical or mental capacity to sign the form. If a resident representative signs the consent form, the form must document the following:

(i) The date the nonverbal resident or any roommate was asked if the resident or roommate wants electronic monitoring to be conducted;

(ii) Who was present when the nonverbal resident or roommate was asked if he or she consented to electronic monitoring;

(iii) An acknowledgment that the nonverbal resident or roommate did not affirmatively object to electronic monitoring; and

(iv) The source of the authority allowing the resident representative of the nonverbal resident or roommate to sign the consent form on behalf of the nonverbal roommate or resident.

(2) A waiver of liability for the nursing home facility for any breach of privacy involving the nonverbal resident's use of an electronic monitoring device, unless such breach of privacy occurred because of unauthorized use of the device or a recording made by the device by nursing home facility staff.

(3) The type of electronic monitoring device to be used.

(4) A list of conditions or restrictions that the nonverbal resident or any roommate of the resident may elect to place on the use of the electronic monitoring device, including, but not limited to: (A) Prohibiting audio recording, (B) prohibiting video recording, (C) prohibiting broadcasting of audio or video, (D) turning off the electronic monitoring device or blocking the visual recording component of the electronic monitoring device for the duration of an exam or procedure by a health care professional, (E) turning off the electronic monitoring device or blocking the visual recording component of the electronic monitoring device while the nonverbal resident or any roommate of the resident is dressing or bathing, and (F) turning off the electronic monitoring device for the duration of a visit with a spiritual advisor, ombudsman, attorney, financial planner, intimate partner or other visitor to the nonverbal resident or roommate of the resident.

(5) An acknowledgment that the nonverbal resident, roommate or the respective resident representative shall be responsible for operating the electronic monitoring device in accordance with the conditions and restrictions listed in subdivision (4) of this subsection unless the resident, roommate or the respective resident representative have signed a written agreement with the nursing home facility under which nursing home facility staff operate the electronic monitoring device for this purpose. Such agreement may contain a waiver of liability for the nursing home facility related to the operation of the device by nursing home facility staff.

(6) A statement of the circumstances under which a recording may be disseminated.

(7) A signature box for documenting that the nonverbal resident or roommate of the resident, or the respective resident representative, has consented to electronic monitoring or withdrawn consent.

(d) The ombudsman, within available appropriations, shall make available on the ombudsman's Internet web site a downloadable copy of a standard form containing all of the provisions required under

subsection (c) of this section. Nursing home facilities shall (1) make the consent form available to nonverbal residents and inform such residents and the respective resident representatives of their option to conduct electronic monitoring of their rooms or private living units, (2) maintain a copy of the consent form in the nonverbal resident's records, and (3) place a notice in a conspicuous place near the entry to the nursing home facility stating that some rooms and living areas may be subject to electronic monitoring.

(e) Notwithstanding subdivision (4) of subsection (b) of this section, a nonverbal resident or his or her resident representative may install an electronic monitoring device without submitting the consent form to a nursing home facility if: (1) The nonverbal resident or the resident representative (A) reasonably fears retaliation against the nonverbal resident by the nursing home facility for recording or reporting alleged abuse or neglect of the resident by nursing home facility staff, (B) submits a completed consent form to the ombudsman, and (C) submits a report to the ombudsman, the Commissioner of Social Services, the Commissioner of Public Health or police, with evidence from an electronic monitoring device that suspected abuse or neglect of the nonverbal resident has occurred; (2) (A) the nursing home facility has failed to respond for more than two business days to a written communication from the nonverbal resident or his or her resident representative about a concern that prompted the resident's desire for installation of an electronic monitoring device, and (B) the nonverbal resident or his or her resident representative has submitted a consent form to the ombudsman; or (3) (A) the nonverbal resident or his or her resident representative has already submitted a report to the ombudsman, Commissioner of Social Services, Commissioner of Public Health or police regarding concerns about the nonverbal resident's safety or well-being that prompted the resident's desire for electronic monitoring, and (B) the nonverbal resident or his or her resident representative has submitted a consent form to the ombudsman.

(f) If a nonverbal resident is conducting electronic monitoring and a new roommate moves into the room or living unit, the nonverbal

resident shall cease use of the electronic monitoring device unless and until the new roommate signs the consent form and the nonverbal resident or his or her resident representative files the completed form with the roommate's consent to electronic monitoring with the nursing home facility. If any roommate of a nonverbal resident wishing to use electronic monitoring refuses to sign the consent form, the nursing home facility shall reasonably accommodate the nonverbal resident's request to move into a private room or a room with a roommate who has agreed to consent to such monitoring, if available, not later than thirty days after the request. The nonverbal resident requesting the accommodation shall pay any difference in price if the new room is more costly than the resident's previous room.

(g) Subject to applicable rules of evidence and procedure, any video or audio recording created through electronic monitoring under this section may be admitted into evidence in a civil, criminal or administrative proceeding.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2021*	New section
Sec. 2	*October 1, 2021*	New section
Sec. 3	*October 1, 2021*	New section
Sec. 4	*October 1, 2021*	New section
Sec. 5	*October 1, 2021*	New section
Sec. 6	*October 1, 2021*	New section
Sec. 7	*October 1, 2021*	New section
Sec. 8	*October 1, 2021*	New section
Sec. 9	*October 1, 2021*	New section
Sec. 10	*October 1, 2021*	New section
Sec. 11	*from passage*	New section
Sec. 12	*from passage*	New section
Sec. 13	*October 1, 2021*	New section
Sec. 14	*October 1, 2021*	New section

Statement of Purpose:

To implement the recommendations of the Nursing Home and Assisted Living Oversight Working Group regarding long-term care facilities and make other revisions to the long-term care facility statutes.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]

Exhibit 2

Connecticut Department of Public Health

Connecticut Department of Public Health

Testimony Presented Before the Public Health Committee

March 17, 2021

Acting Commissioner Deidre S. Gifford, MD, MPH
860-509-7101

Senate Bill 1030, An Act Concerning Long Term Care Facilities

The Department of Public Health (DPH) provides the following information regarding Senate Bill 1030, which will implement the recommendations for long-term care facilities of the Nursing Home and Assisted Living Oversight Working Group in addition to revising specific long-term care facility statutes. Thank you for the opportunity to testify on this important bill.

It was our honor to serve the Nursing Home and Assisted Living Oversight Working Group, which has been jointly led by members of the General Assembly and representatives of the Department of Public Health, the Department of Social Services, and the Office of Policy and Management. We are grateful to the leaders and members of each of the subcommittees for the significant time and attention they have devoted to the work of the group.

Section 1 defines a long-term care facility as a nursing home (NH), residential care home (RCH), home health agency (HHA), assisted living services agency (ALSA), intermediate care facility for individuals with intellectual disabilities (ICF/IID), chronic disease hospital, or hospice agency for the purposes of Sections 2-12 of the bill. Since ICF/IID facilities are licensed by the Department of Developmental Services (DDS), DPH would defer to DDS for comments regarding such facilities.

This section also requires a long-term care facility, as defined in the bill, to employ a full-time infection preventionist. Over the past year, the Department has had several findings in these healthcare settings, with the vast majority in nursing homes, that relate to infection control. We often found that the individual in charge of infection prevention was handling multiple positions or working part time and was unable to provide the support needed during the COVID-19 pandemic. The Department supports this initiative in the nursing home setting. It is important to note that ICF/IIDs, RCHs, HHAs, ALSAs, and agencies providing hospice care are not medical models and they do not have the same staffing levels as a NH or chronic disease hospital. The requirement for a full-time infection preventionist may not be appropriate in these settings. However, these facilities should have policies and procedures in place to address infection prevention and control measures. Additionally, the Department would be happy to collaborate with DDS on reviewing appropriate procedures for ICF/IID facilities.

Section 2 requires the administrative head of each long-term care facility to participate in the development of the emergency plan of operations of the Intrastate Mutual Aid Compact pursuant to C.G.S. Section 28-22a. The Department is supportive of the concept outlined in this section and requests further discussion with the proponents of the bill and the Department of Emergency Services and Public Protection to determine the best approach for long-term care facilities to be involved in emergency response planning. For your information, the Centers for Medicare & Medicaid Services (CMS) issued a Final Rule in September 2016 to establish national emergency preparedness requirements to ensure adequate planning for both natural and man-made disasters, and coordination with state, and local emergency preparedness systems. Guidance on these requirements was issued to impacted entities. The federal rule applies to 17 healthcare provider and supplier types, including long-term care facilities. Each provider has its own set of regulations and conditions or requirements for certification. Such healthcare providers and suppliers must be in compliance with the federal emergency preparedness regulations to participate in the Medicare and Medicaid programs.

Section 3 requires DPH to have and maintain at least a three-month stockpile of personal protective equipment (PPE) not later than six months after the termination of a public health emergency. Additionally, it requires the administrative head of each long-term care facility to acquire from the Department and maintain a three-month supply of PPE. Lastly, it requires the administrator for each long-term care facility to fit test their staff for N95 masks on a quarterly basis.

Occupational Safety and Health Administration (OSHA) standards require that persons who use N95 equipment be fit tested on a yearly basis. The Department recommends that long term care facilities adopt OSHA standards, which includes a plan to ensure these individuals are appropriately fit tested. During the pandemic, DPH was provided federal funds, which were used to provide PPE to facilities. There were some instances of PPE shortages and mitigation strategies involving multiple use of PPE had to be put in place. These strategies were recommended by the Centers for Disease Control and Prevention (CDC).

DPH recognizes the importance of PPE while caring for a patient with an infectious disease to protect the health and safety of the workers. During the pandemic, the Commissioner put forward a commissioner's order that required nursing homes to have a reserve stockpile of enough PPE and hand sanitizer to manage an outbreak of twenty percent of the facility's average daily census for a thirty-day period. Facilities were required to fill out an online attestation acknowledging they had implemented the requirements of the commissioner's order. The Department notes that PPE has expiration dates and also may be unused if an outbreak is not taking place. Additionally, PPE is stored in large boxes, which means it may be difficult for a facility to find storage. It is the facility's responsibility, however, to ensure they have enough PPE to appropriately protect their staff on a day to day basis. The Department agrees that a comprehensive strategy needs to be in place during extraordinary circumstances such as the COVID-19 pandemic. However, the Department does not think that legislation is needed; often

such a statute may diminish our ability to be flexible in responding to an emergency that is ever evolving.

Section 4 requires each long-term care facility to have at least one staff person per shift that can start an intravenous line. While well-intentioned, this requirement may be onerous for a long-term care facility as defined, with the exception of a chronic disease hospital. These settings do not use intravenous lines frequently enough to retain their skills in starting and maintaining intravenous lines. Most of these facilities enter into a contract for this service with an infusion company to care for their residents with intravenous lines. Additionally, an order would have to be given from an independent practitioner to prescribe what medication would be delivered through an intravenous line. DPH would welcome a discussion with the proponents of the bill about the requirements in Section 4 as there are many factors to consider in determining how an intravenous line should be introduced to a patient.

Section 5 requires each long-term care facility to have an infection prevention and control committee that meets monthly; and daily during an outbreak. This committee will be responsible for establishing, implementing and reviewing infection prevention and control protocols for the facility. The Department is supportive of measures that can be put in place to mitigate the impact of an infectious disease outbreak in a facility.

Section 6 requires every administrator and supervisor of a long-term care facility to complete the Nursing Home Infection Preventionist training course produced by CDC in collaboration with CMS. The Department is supportive of training in infection control and prevention core activities to reduce the spread of an infectious disease for administrators and supervisors of long-term care facilities. During the COVID-19 pandemic, the Department identified that when the infection preventionist was out sick or on leave, they needed other personnel to fill in for their duties. These individuals included the administrator and the director of nursing. However, we think the CDC course may not provide the most appropriate training. In lieu of the CDC training course, the Department recommends inserting language that would require a nursing home administrator to have a minimum of four contact hours of continuing education on "infection control and the prevention of infections associated with antimicrobial use, including antimicrobial resistant infections" within subsection (b) of C.G.S. Section 19a-515. These CEU's would allow the administrator to continually train on the best practices for infection prevention and control.

Section 7 requires DPH to provide each long-term care facility with a frequency for testing staff and residents during an outbreak of an infectious disease. Such frequency will be based on the circumstances surrounding the outbreak and the impact of testing on controlling the outbreak. During an outbreak, the Department may look to CDC for guidance on best practices in the treatment and mitigation of an infectious disease, which may include testing. Some infectious diseases do not require regular testing. As an outbreak evolves, guidance is modified to appropriately adapt to the situation. DPH already provides guidance to long-term care facilities

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that reflects recommendations supported by CDC pertaining to appropriate prevention and control approaches to mitigating an infectious disease. The Department recommends not moving forward with this section of the bill.

Section 8 requires each long-term care facility to establish a "family council" to enhance communication between the facility, its residents and their families or representatives. The Department supports this effort to facilitate communication between facilities, families and residents as this communication is imperative to the well-being of the resident. We learned during the COVID-19 pandemic, when visitation was restricted, that virtual and other means of communication with representatives and family was crucial.

Section 9 requires each long-term care facility to ensure that a resident's care plan addresses provisions related to the health and well-being of the resident, to include social and emotional needs being met and that visitation by any means is provided. Additionally, the bill requires the facility to establish a timeline for the reinstatement of visitation following the termination of a public health emergency as declared by the Governor. Nursing homes are required to follow CMS guidance relating to visitation, which is revised as new information arises. While visitation is critically important to a long-term care facility resident's physical, mental and psychosocial well-being, it is also important to balance visitation with control measures to reduce the transmission of an infectious disease. The Department's goal is to ensure the safety of the residents and staff, however, balancing this at all times with resident rights.

Section 10 requires the Department to establish an essential caregiver program for implementation by each long-term care facility, which includes standards for infection prevention and control training and testing. DPH is currently working with the State Long Term Care Ombudsman and other stakeholders on developing an essential support person program.

Section 11 requires the Department's Public Health Preparedness Advisory Committee to amend the plan for emergency responses to a public health emergency to include a plan for long-term care facilities and providers of community-based services. The Department supports this recommendation and will work with our Office of Public Health Preparedness to review the Public Health Emergency Response Plan to determine the best way to incorporate long-term facility emergency planning during a disaster. The aforementioned CMS Final Rule establishes national emergency preparedness requirements through CMS to ensure adequate planning for both natural and man-made disasters as well as coordination with state and local emergency preparedness systems. Guidance on these requirements was issued to impacted entities. The federal rule applies to 17 healthcare provider and supplier types, including long-term care facilities. Each provider has its own set of regulations and conditions or requirements for certification. Such healthcare providers and suppliers must be in compliance with the federal emergency preparedness regulations to participate in the Medicare and Medicaid programs.

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Section 12 requires each long-term care facility to permit a resident to use a communication device to connect with family members and friends and to facilitate the participation of a resident's family caregiver as a member of the resident's care team. This section also requires DPH to establish requirements for the use of these communication devices by July 1, 2021. The Department supports efforts that connect the resident with their family, friends and representatives. In May 2020, the Department, through the use of Civil Money Penalty Reinvestment Funds, provided each of Connecticut's nursing homes with at least two electronic devices, which will support this effort. The Department respectfully requests that the timeline to develop policies regarding the use of communication devices be extended until December 2021.

Section 13 requires DPH to establish minimum staffing level requirements for nursing homes and eliminates the distinction between a chronic and convalescent nursing home (CCNH) and a rest home with nursing services (RHNS) to ensure a minimum staffing level requirement for all nursing homes. The Department recommends all facilities have adequate staffing with the appropriate competencies and skill sets to provide nursing and related services, based on a facility assessment, to assure resident safety and attain or maintain the highest practicable level of physical, mental, and psychosocial well-being of each resident. The facility assessment uses individual resident assessments and plans of care to ascertain the number, type of diagnoses, and acuity of the facility's resident population. In the nursing home setting, regulations require that the administrator and director of nursing meet monthly to determine adequate staffing levels using a tool based on the acuity of their current resident census.

Thank you for your consideration of this information. DPH encourages committee members to reach out with any questions.

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Exhibit 3

CAHCF/CCAL

Connecticut Association of Health Care Facilities
Connecticut Center for Assisted Living

March 17, 2021

Written testimony of Matthew V. Barrett, President/CEO of the Connecticut Association of Health Care Facilities and the Connecticut Center For Assisted Living (CAHCF/CCAL)

Good afternoon Senator Abrams, Representative Steinberg, and to the distinguished members of the Public Health Committee. My name is Matt Barrett. I am the President and CEO of the Connecticut Association of Health Care Facilities (CAHCF), our state's trade association and advocacy organization of one-hundred and sixty skilled nursing facilities and assisted living communities. Thank you for this opportunity to submit testimony concerning **S.B. No. 1030 (RAISED) AN ACT CONCERNING LONG-TERM CARE FACILITIES.**

As the committee further deliberates on the legislation, CAHCF/CCAL has the following recommendations for your consideration.

Infection Prevention and Control Specialist (Sec 1)

CAHCF/CCAL agrees in elevating that status of Infection Preventionists (IPs) in our Connecticut nursing homes. Effective infection prevention and control programs can decrease infection rates and health care acquired infections, improve attention to hand hygiene and transmission-based precautions, improve employee health, and reduce hospitalizations and adverse events among nursing home residents.

While most Connecticut nursing homes have designated full time IPs, others have one or more part-time, specially trained IPs with additional duties. Prior to COVID-19, nursing homes already experienced a nationwide shortage of registered nurses (RNs) and other challenges in recruiting qualified staff, including IPs. The pandemic has only exacerbated these workforce challenges. The increased demand for resources and dedicated, specifically trained IPs, which are most often fulfilled by an RN, remain a challenge, especially for smaller nursing homes. For these reasons, we recommend:

- The amount of time required for an IP be adjusted based on each facility's bed count, demographics of the facility's surrounding area, individual factors contributing to infection control risk levels, and flexibility for smaller facilities.
- A phased-in requirement to give nursing homes time to recruit and train the new IPs.

We also recommend that infection prevention training requirements have the flexibility to be met by training materials prepared by CAHCF/CCAL's national affiliate, the American Health Care Association (AHCA), include funds to cover any training costs, and that the intent of training language be clarified to mean the training applies to the administrator and RN supervisor.

Personal Protective Equipment Requirements (Sec 3)

CAHCF/CCAL appreciates that the proposed PPE stockpile requirements seek to establish a statewide stockpile acquired and managed by the Department of Public Health equal to a three months PPE supply level for use by nursing homes. We would like to point out that storing a three-month supply of PPE on site at the facility will present great challenge for many nursing homes with insufficient storage capabilities. Therefore, we are asking that the legislation provide the option for the PPE to be earmarked for a specific nursing home, but actually housed in a central storage site managed by the state and accessed as needed by the nursing homes. We also recommend that quarterly N-95 fit testing be available for new employees and that an annual fit testing be the standard for existing employees according to OSHA standards.

Licensed and Certified Staff to Start Intravenous Lines (Sec. 4)

CAHCF/CCAL is asking the committee to recognize that due to RN staffing shortages, most nursing homes must contract with a long-term pharmacy to secure qualified staff to start intravenous lines. Accordingly, we recommend that the language be modified to include IV starts by contracted staff, including a 24-hour remote coverage by the external contracted service provider, in addition to staff employed by the nursing homes.

Establishment of a Family Council (Section 8)

We recommend that this provision include a cross reference to federal rules concerning the establishment of family councils to assure consistency and compliance with federal requirements.

Increased Nursing Home Staffing (Sec 13)

As reported by the Staffing Levels Subcommittee of the Nursing Home and Assisted Living Oversight Work Group (NHALOWG) in January 2021: "Adequate numbers of qualified, trained, appropriately compensated, and caring staff are integral to support the needs of nursing home residents in a holistic and person-centered manner." There is no disagreement from CAHCF/CCAL on the policy goals expressed by the subcommittee. Further, the subcommittee acknowledged that achieving this result necessarily involves diverse strategies, including, but not limited to: Establishing a daily minimum staffing ratio of at least 4.1 hours of direct care per resident, composed of: ▪ .75 hours Registered Nurse ▪ .54 hours Licensed Practical Nurse ▪ 2.81 hours Certified Nurse Assistant. To help inform the implications of increasing staffing in this manner, CAHCF/CCAL obtained the support of the *Center for Health Policy Evaluation in Long Term Care* ("The Center") to provide a framework for estimating the costs of increasing minimum staffing ratios in Connecticut nursing homes. The full report is attached.

In this initial and preliminary framework, the *Center* reviewed creating minimum nurse staffing to resident thresholds in nursing homes (RN = 0.75, LPN = 0.54, and CNA = 2.81) for a Total Nursing Staffing of 4.1. In the report, the Center characterized the facilities currently below this threshold and calculated the number of additional staff and labor costs needed to achieve the proposed minimum staffing. They used staffing levels collected by the Center for

Medicare and Medicaid Census (CMS) from nursing home payroll data. To estimate total labor costs, they used average state labor costs, fringe benefits, and payroll tax rates. Further, the Center observed.

> Based on Q3 2020 staffing data, 181 (88.7%) of nursing homes in Connecticut are below the proposed minimum staffing threshold. The analysis was repeated using pre-COVID Q4 2019 staffing census data. Under pre-COVID conditions, the number of nursing homes below the minimum staffing threshold rose to 199 (97.5%). A big driver for this increase was a higher census pre-COVID. The average Connecticut nursing home census in Q4 2019 was 104 compared to 86 in Q3 2020. This is a 17% decline, which exceeds the national average decline of 14%. On average, Connecticut nursing homes below the staffing threshold are larger and have more Medicaid residents than the others. Their November 2020 Five-Star ratings were on average lower.
>
> For Connecticut to implement minimum staffing ratios, we estimate it will require between 1,793-3,364 FTEs and cost $140.9-$273.9 million dollars. The exact figure will depend on resident census.
> To get the current 181 nursing homes above the proposed minimum staffing threshold, 1,793 FTEs would be needed statewide at a total annual cost of $140.9 million, including fringe benefits and payroll taxes. CNAs make up most of the needed FTEs (1,426) and cost ($95.0 million). This assumes census stays the same as it is now, which is much lower than before the COVID pandemic.
> To estimate the costs when census increases, our simulation was repeated using pre-COVID-19 Q4 2019 PBJ staffing census data. In this analysis, the number of nursing homes below the minimum threshold rose to 199 (97.5%). Also increasing were the number of needed FTEs (3,364) and costs ($273.9 million) to meet the minimum staffing.

As census returns over the next 18 months, we can anticipate these costs to increase further, necessitating accompanying reimbursement increases.

- CAHCF/CCAL supports the effort to ensure adequate staffing at all nursing homes and to compensate all nursing home caregivers and employees at a level that recognizes their value. However, we favor a focus on elevating the status and importance of long-term care staff through recruitment and retention strategies and providing long underfunded nursing homes with the financial resources needed to address these staffing issues. A significant state and federal investment will be required to increase staffing requirements, minimum staffing ratios, or minimum wages during or after the pandemic when there are limited trained individuals to fill the positions and not enough resources to cover additional, unfunded costs.

- We do not support a recommendation to establish a minimum percentage of reimbursement to be spent on staffing without further study of the issue in the context of planned shifts in reimbursement structure to an acuity-based system and more thorough consideration of potential impacts of such a requirement. Finally, nursing homes should be given the flexibility on where to direct the percentage of staffing resources to RNs, LPNs and CNAs to address the specific care needs of the individual nursing homes.

Essential Support Caregiver or Support and Video Monitoring and Technology

CAHCF/CCAL will to continue to review and offer our recommendations on the use of technology to facility visitation and monitoring in nursing homes to both the Public and Health Committee and the Aging Committee, where legislation has now been favorably reported (HB 6552) on this matter, and is also addressed in **Section 12 and 14 of SB 1030**. Similarly, we will continue to review and offer our recommendations concerning an Essential Support Person initiative to the Public Health Committee and the Human Services Committee where legislation is under consideration (HB 6634) and is also addressed in **Section 10 of SB 1030**. At this time, because visitation in nursing homes unrestricted outside of a public health emergency, any provisions for essential caregivers or essential support persons should apply only when visitation is actually restricted by federal or state rules. Finally, additional training requirements on nursing homes, if adopted, to implement an essential caregiver or support person initiative must include additional funds for this purpose.

Thank you again for this opportunity to testify on the bill as drafted. I would be happy to answer any questions you may have.

For additional information, contact: Matthew V. Barrett, *mbarrett@cahcf.org* ***or 860-290-9424.***

Exhibit 4

Testimony to the Public Health Committee

Presented by Mag Morelli, President of LeadingAge Connecticut

March 17, 2021

Regarding

Senate Bill 1030, An Act Concerning Long Term Care Facilities

Good afternoon Senator Abrams, Representative Steinberg and members of the Public Health Committee. My name is Mag Morelli and I am the President of LeadingAge Connecticut, a statewide membership association representing not-for-profit provider organizations serving older adults across the continuum of aging services, including not-for-profit skilled nursing facilities, residential care homes, home health care agencies, hospice agencies, adult day centers, assisted living communities, senior housing and life plan communities. As an association, we encourage the state and federal government to value aging by investing in quality.

On behalf of LeadingAge Connecticut I am pleased to provide testimony on *Senate Bill 1030, An Act Concerning Long Term Care Facilities*.

Over the past year, the aging services field has been at the center of the global Covid-19 pandemic. Covid-19 is a virus that has targeted the very people we serve. As such, our member organizations have been uniquely impacted by the pandemic, unlike any other health care provider sector. And we are proud of our efforts. LeadingAge Connecticut members have faced this pandemic head on and continue to do so as we protect and compassionately care for the most vulnerable older adults in our state.

The bill before you today reflects many of the recommendations that came out of the Nursing Home and Assisted Living Oversight Working Group (NHALOWG). The NHALOWG was formed to make recommendations on proposed legislation for the 2021 session addressing lessons learned from COVID-19, based upon the Mathematica final report (A Study of the COVID-19 Outbreak and Response in Connecticut Long-Term Care Facilities) and other related information, concerning structural challenges in the operation and infrastructure of nursing homes and assisted living facilities; and changes needed to meet the demands of any future pandemic.

LeadingAge Connecticut was represented on NHALOWG and actively participated in the four subcommittees. While we support many of the recommendations that resulted from the valuable work done by NHALOWG, we do disagree with elements of some of them. Today's hearing provides us the opportunity to present our perspective, opinion and alternative language for

those sections of the bill and allows us to offer our assistance to the Committee as you work on this and other bills related to aging services.

Our first request is that the Committee consider adding the recommendations related to the NHALOWG's Subcommittee on Infrastructure and Capital Improvements into this bill. We have linked that subcommittee's report and recommendations to our testimony here and specifically, we would ask for the Committee's support of the following financing and funding options to enable necessary maintenance and improvements in the nursing home physical plant:

- Establishment of a state backed loan guarantee program,
- Establishment of a forgivable loan program for nursing homes,
- Establishment of a long-term bonding or direct lending program.

Our specific comments on Senate Bill 1030 are as follows:

Section 1

This bill begins by stating that Sections 1 through 12, if passed, would apply not only to nursing homes, but also to six other licensed settings including assisted living service agencies, residential care homes, intermediate care facilities for individuals with intellectual disability, chronic disease hospitals, home health care agencies, and hospice agencies. Each type of provider listed is unique in their service delivery and is regulated through separate state and/or federal laws and regulations. **We do not believe that all of the sections of this bill should apply to all of these settings and we will point this out as we go through each section of the bill.** (*Please note that we will not provide any comment on the relevance of the proposed bill to the intermediate care facility for individuals with intellectual disability setting as we do not represent that category of provider.)*

Subsection 1b would require that a full-time *infection prevention and control specialist* be employed by providers in each of the seven categories of licensed entities listed in Section 1a. An *infection preventionist* is a position defined and required by the federal Centers for Medicare and Medicaid (CMS) for all nursing homes and for which an on-line training course was established by CMS in collaboration with the Centers for Disease Control (CDC). The course is approximately 19 hours long, is made up of 23 modules and submodules, and is focused on the nursing home setting.

CMS has required the infection preventionist position in nursing homes since 2019. Currently CMS requires the infection preventionist to work at least part-time at the facility, but we understand that this requirement is under review in light of the pandemic. DPH has asked that each nursing home have an infection preventionist on staff for 32 hours per week and has advised that this function can be shared by two part-time individuals. **We have voiced our request to DPH that the infection preventionist hours be scaled to the size of the facility and that the individual be allowed to serve other functions within the building such as staff development**. We ask that the Committee consider this request.

While the specific position of infection preventionist is defined and required on the federal level for a nursing home, the other settings included in this proposal are not included in that CMS requirement. Similar to nursing homes, chronic disease hospitals as well as home health care, hospice and assisted living service agencies are all required to address infection control and prevention by state and federal regulation. **We do not think it is necessary to impose the specific infection preventionist position onto those provider entities.**

Regarding the residential care home, while licensed by the Department of Public Health, this is not a health care setting and therefore this full-time clinical position is not appropriate or practicable.

Section 2

We do not support this proposal which would require each of these licensed healthcare entities to participate in the actual *development* (line 32) of their municipal emergency operations plans. This is not their responsibility. We do agree, however, that the healthcare entities should inform the town or city emergency manager in the community where they are located of their own emergency preparedness plans and participate in ongoing emergency preparedness efforts in their community.

Section 3

Nursing homes are currently required through a DPH Commissioner's Order to stockpile a 30-day supply of personal protective equipment (PPE). The increase to a 90-day stockpiled supply raises the concern of adequate storage space in already space challenged nursing home floor plans. The nursing home would need to store this 90-day stockpile in addition to the operational supply of PPE that is being stored for daily use. This would be the same concern for the other provider entities included in this bill.

- **We request clarity** for the provision that seems to require the provider entities to purchase their PPE from the Department for Public Health. (Lines 44-47)
- **We do not understand** why the bill would require quarterly fit testing of N95 masks (line 55) when annual fit testing is what is the current federal requirement. This appears to be an unnecessary utilization of resources.
- While the early, severe shortages of PPE are now behind us, there continues to be sporadic shortages of various types and sizes of PPE in the market place. **We would hope that these types of situations would be recognized within the stockpiling requirement.**

Section 4

We oppose this section of the bill that would require that every provider listed in Section 1a be able to ensure that a licensed health care professional (in most cases that would be a registered nurse), who is certified to initiate an intravenous line, is scheduled on every shift. We cannot support this requirement because we simply do not understand why it is being proposed and what gap in long term care it is attempting to address.

While there is always a registered nurse on duty in Connecticut nursing homes, and technically the start of an intravenous line is within their licensed scope of practice, there is also a

competency standard that requires a continuous practice of this licensed function. The nursing home setting does not see the volume of intravenous therapy that would support this continuous practice. Rather, most nursing homes contract with a professional service to initiate intravenous therapy when and if it is needed. However, most nursing homes never have to provide this service, and those that do, specialize in it. Again, we do not understand why this requirement is being proposed and absent a logical reason, we cannot support it.

Regarding the other providers in this bill, assisted living service agencies are not staffed to the degree of nursing homes, and they would need to add a significant number of registered nurses to their schedule if they were to meet this requirement. Home care and hospice agencies which choose to provide IV therapy would be staffed appropriately to provide this service and this additional requirement would be unnecessary. Residential care homes are not a health care setting and therefore this requirement is not applicable or practicable.

Section 5

Regarding nursing homes, the Public Health Code requires that each facility have an infection control committee that meets quarterly. This section of the bill would require that this committee meet at least monthly and daily during an outbreak. This is more specific than the current federal requirements for nursing homes and we do not feel that it is necessary. The nursing home conducts daily infection control clinical surveillance under the guidance and direction of the director of nursing, medical director and infection preventionist. The quarterly meeting of the full committee is inclusive of this team and other medical and nursing staff, as well as consultants. **The nursing homes are of the opinion that a quarterly meeting schedule for the formal infection control committee is a sufficient minimum requirement to address the infection control needs of the facility** and that the frequency can be increased when necessary.

This specific committee is not currently a public health code requirement for the other health care providers addressed in the bill and is inappropriate for the residential care home setting.

Section 6

We have concerns regarding several aspects of this section. First, the mandated training course is specific to nursing homes, yet it would apply to all of the provider entities listed in the bill. It is not appropriate to require nursing home specific training of non-nursing home providers.

Second, we request that this section be clarified to specify exactly who is expected to take the course as the term "supervisor" is very broad and could be applied to several staff members throughout the nursing home. This specific course is currently a 19-hour, 23-module course that is designed for a clinically trained person. This would not be the appropriate training course for all levels of supervisor within the facility.

Finally, if we assume that the intent is to apply this section just to the nursing home setting, **we would suggest that instead of prescribing the specific training course within the statute, that the Committee rely upon the infection preventionist to determine the appropriate training for the nursing home staff members.** Section 1a of this bill would place the responsibility for ongoing

training of all employees of the facility on the infection preventionist. We would propose that the responsibility for selecting the appropriate training material should remain with the infection preventionist.

Section 7

The availability of testing was a pivotal milestone in the fight against the Covid-19 virus. Ensuring that the Department of Public Health has a role in determining the frequency and appropriateness of testing ensures that this statutory requirement remains timely and relevant.

Section 8

Specifically addressing the nursing home setting, these settings must adhere to federal OBRA regulations which currently allow for family councils to be established and require that nursing homes provide an advisor or liaison to the council, as well as meeting space and other assistance if requested. We believe the federal guidelines were designed to promote the independence of the council and we further believe the OBRA regulations to be sufficient for the nursing home setting. **We are also happy to work with our members to ensure that families are aware of the opportunity.**

We are concerned that if a nursing home or any other provider included in this bill is *mandated* to establish a family council (line 90: "...shall facilitate the establishment..."), that they would then have a statutory obligation to create an entity that families may not be interested in participating in; indeed, some of our members have found that to be the case. Family participation is something that the provider cannot force, and therefore we would oppose the mandated aspect of this section. While a provider may be required to assist upon request and even encourage the establishment of such a council, it should not be required to force its establishment.

Section 9

Again, it appears that this section is specifically addressing the nursing home setting. As such, we would agree that addressing a resident's psychosocial needs as outlined in lines 97 through 107 is appropriate, **but we request that the words "seek redress with" in line 108 be replaced with the word "contact."** Residents and families are encouraged to contact the Office of the Long-Term Care Ombudsman for guidance and advocacy, but there is not a mechanism to seek *redress* through that office.

We also request that the wording addressing reinstatement of visitation in lines 111 – 119 be removed as this references a federal restriction specific to the Covid-19 pandemic that was placed on nursing homes and will hopefully be outdated by the January 1, 2022 deadline in the bill.

Section 10

We have been supportive of the establishment of an essential caregiver or essential support person program that can be activated during a public health emergency when visitation to a long-term care facility is restricted. It is our understanding that this program would be most applicable to the nursing home setting.

Section 11
We support this section.

Section 12
We have been involved in discussions with the Aging Committee on another, similar legislative proposal regarding the use of communication technology specifically within the nursing home setting. **We reference that because we strongly support the need for privacy provisions for the use of communication devices for visitation as articulated in this proposal (lines 148 – 152);** the current Aging Committee bill does not contain privacy provisions related to the use of technology for virtual visitation. We would encourage the inclusion of this requirement in any bill focused on the use of communication technology in a long-term care setting.

This section of the bill may be more appropriate for the nursing home, chronic disease hospital and residential care setting where residents reside within a communal setting. For persons receiving care from an assisted living service agency or home health care agency, they would be residing in their own homes and would not need the protections afforded by this section of the bill.

Section 13
LeadingAge Connecticut understands the interest in raising the minimum nursing home staffing requirements that are currently listed in the Public Health Code for licensed and certified nursing staff. We do, however, want to reassure the Committee that both the Public Health Code and federal oversight regulations currently require nursing homes **to staff at a level that meets the needs of residents**. These same regulations authorize the Department of Public Health to assess penalties in certain cases when facilities fall short of staffing requirements and fail to employ sufficient staff to meet resident needs.

This bill proposes 4.1 hours of direct care per resident day minimum, **but it also proposes specific ratios per licensure category within that overall direct care minimum and we cannot support those specific ratios** (Lines 163 -166). To mandate specific ratios of CNA, RN and LPN within an overall minimum staffing level goes against the concept of flexing your staffing to meet the needs of the resident and flies in the face of our new acuity-based reimbursement system which is expected to be implemented later this year. These specific ratios* are based on a 20-year-old national study that does not recognize this states' 24 hour registered nurse requirement nor our strong use of the LPN in our nursing homes. More importantly, of the approximately sixty nursing homes that currently staff above a 4.1 hours per patient day, most would need to reduce the hours of licensed RN and LPN direct care staff (not administrative staff) in order to hire additional CNAs to meet those internal ratios. *(*We note that we believe there is a drafting error in the printing of these ratios and that they are intended to propose .75 hours of care by a registered nurse.)*

Nursing care is important. The direct care provided to a nursing home resident is not just personal care. Residents also receive direct nursing care such as medication administration and

treatments as well as nursing assessments. Nursing care must be provided by a registered nurse (RN) or licensed practical nurse (LPN). In fact, only a registered nurse is authorized to perform the actual nursing assessment; an LPN can examine the resident and provide information to the registered nurse, but the actual assessment must be done by the registered nurse. Nursing assessments are important, and required, components of the resident's overall care. Assessments determine the individualized care plan and must be conducted whenever there is a significant change of condition, and when required to be updated under state and federal requirements. Some nursing homes have chosen to staff nursing positions with more highly qualified registered nurses. Nursing homes that provide a strong level of direct registered nursing care are to be commended, not discounted, and we strongly object to any minimum staffing levels that disregard the importance of direct resident care that is provided by a registered nurse.

A very important issue that must be addressed is the Medicaid reimbursement with regard to nursing home staffing. Quality nursing home providers staff to meet the needs of their residents and many homes are staffing near or above the proposed 4.1 hours of direct care per resident day, but the Medicaid reimbursement rate does not cover the cost of this higher staffing. The vast majority of nursing homes that show high levels of staffing are also showing significant differentials between what the state Medicaid system is supposed to pay them according to their costs – and what the Medicaid system is actually paying them. **Very simply, they are not being reimbursed for their staffing costs.** As a result, we have a reimbursement system that is vastly underfunding the cost of staffing – at a time when the state is planning to transition to a staffing dependent acuity-based rate system – and without a plan to increase the funding. **We therefore urge the Committee to insist that any legislation implemented to raise the minimum staffing levels also must address the need to fully fund the reimbursement system.**

We would also be remiss if we did not raise our concern regarding the ability to recruit and retain an aging services workforce that can meet the needs and demands of our aging population. **We ask that the Committee support efforts to enhance the long-term services and supports workforce through expanded training opportunities, increased funding for reimbursement rates, and other efforts aimed at attracting and retaining workforce talent within the field of aging services**. Workforce competition has intensified with the increase in the minimum wage and recruitment efforts in the field of aging services have been dramatically impacted by the pandemic. **We need a long-term investment in aging services provider rates to assist providers with recruitment and retention of a strong and skilled workforce that is urgently needed as our state rapidly ages.**

This section of the bill also proposes a requirement for the Department of Public Health to modify staffing levels for social work and recreational staff of nursing homes (lines 167 – 169. We believe the intent may be to raise the levels, but as written would lower the required levels; we believe that this must be a drafting error. We agree that social work and recreational staff are critical to the overall resident experience within a nursing home. These positions, however, have never been categorized as direct care by the state and as such, have not received previously

legislated wage enhancements and other resources that have been directed to that category of the workforce. We are pleased to see these important services recognized.

This section of the bill also proposed to eliminate the Rest Home with Nursing Supervision (RHNS) level of care licensure (lines 170 -174). This is a licensure category defined in the Public Health Code and designed to care for a lower acuity level of resident. While most of these beds were converted many years ago to the higher licensure level of Chronic and Convalescent Nursing Home (CCNH), there are currently ten nursing homes that have beds licensed in this category. Three of the ten are non-profit, LeadingAge Connecticut members who have both levels of licensure within their buildings.

We must insist that if RHNS beds are required to be converted to the higher level Chronic and Convalescent Nursing Home (CCNH) licensure, that the Medicaid rates for those beds be increased to meet the additional staffing requirements and costs of the CCNH level. For a nursing home that currently has both levels of care, any rate adjustment must not be achieved through the "blending" of the RHNS and CCNH bed rates - which has been the state's previously proposed approach. Those homes that have sought to convert the beds in the last several years have been told that they must combine their RHNS and CCNH rates to create a blended rate for all of the beds and which would mean lowering their CCNH rate in order raise the RHNS rate. As a result, they have not converted the beds because it was not financially feasible. **Therefore, we ask that this bill specifically address this issue and require an increase in the RHNS rate without lowering the CCNH rate.**

This section of the bill also includes a definition of "nursing home" on lines 153 – 160 that we do not agree with and which seems to have been newly created. The reference should simply be: *A nursing home, as defined in section 19a-490 of the general statutes.*

Finally, this section (lines 175 – 176) would mandate nursing homes always offer a 12-hour shift option to all staff. While the option of utilizing a 12- hour shift during a workforce crisis brought on by the virus was discussed, we do not believe it was the intent of the working group to mandate that all nursing homes always offer this option to all of their work force. **Many nursing homes would find this mandate to be unworkable and we cannot support it**.

Section 14.

We support the establishment of a comprehensive statutory framework to govern and facilitate the use of technology by residents in nursing homes. It is important to establish good public policy on this important issue - and we need to do it right.

Allowing resident access to and use of technology for the purpose of visitation and socialization was an issue raised and discussed in the NHALOWG subcommittees. After years of debate here in the General Assembly, we knew there would be an interest in not only permitting access, but also enabling surveillance. As a result, we updated our comprehensive analysis of all the state statutes that had been passed over the last several years in this regard and drafted what we

considered to be a comprehensive approach to the entire issue of communication technology in a nursing home setting

We have been involved in discussions with the Aging Committee on this issue as they raised a related bill earlier in the session. We provided extensive written comments on their initial proposal with the intent of assisting in the development of a statute that addresses the many complex needs and concerns of ensuring resident rights within this highly regulated setting and in consideration of the common situations that impact many nursing home residents. Many of our comments were accepted and we plan to continue to work with the Committee to help shape the legislation. We have included this link to our comments in this testimony.

Our priority goal is to ensure the self-determination, privacy and dignity of the nursing home resident. The proposal in the bill before you would apply only to "nonverbal" residents, but we would prefer and strongly suggest a more comprehensive statute that is inclusive of all situations. We would be eager to work with this Committee as well as others to ensure that any statute that enacted creates good public policy for all those residing within the nursing home.

Thank you for this opportunity to testify on this bill. We know we have made extensive comments on several sections of the bill and we would be happy to provide suggested substitute language if that would be helpful to the Committee.

Respectfully submitted,

Mag Morelli, President of LeadingAge Connecticut
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Exhibit 5

CT Comm. Tran., PH 3/17/2021


Image 1 within document in PDF format.

Connecticut Public Health Committee Transcript, March 17, 2021

March 17, 2021
Public Health
2021

March 17, 2021

df/si PUBLIC HEALTH COMMITTEE 9:00 A.M.

CHAIRPERSONS:	Senator Mary Daugherty Abrams, Representative Jonathan Steinberg
SENATORS:	Anwar, Kushner, Haskell, Hwang, Kasser, Moore, Somers
REPRESENTATIVES:	Arnone, Berger-Girvalo, Betts, Carpino, Cook, Dauphinais, Demicco, Foster, Genga, Green, Gilchrest, Kavros DeGraw, Kennedy, Klarides-Ditria, Linehan, McCarty, Parker, Petit, Ryan, Tercyak, Young, Zupkus

REP. STEINBERG (136TH): Good morning.This is the Public Health Committee, in case you tuned into the wrong station this morning.I am State Representative Jonathan Steinberg, Co-Chair of the Public Health Committee, and I'm here today with my wonderful Co-Chair Senator Mary Daugherty Abrams, who hails from Ireland, at least going back some generations, as I imagine many of us on the call are today.

We have a number of Bills for today's Public Hearing.We have a good number of speakers, and let us get to the business at hand.I will turn it over to my Co-Chair for any opening comments.

SENATOR DAUGHERTY ABRAMS (13TH): I am Senator Mary Daugherty Abrams, and the Co-Chair of Public Health, and I'm excited today to hear the feedback on these Bills and to make them the best that they can possibly be.Thank you very much, and hope we have a great day.Jonathan, you're muted.

REP. STEINBERG (136TH): I don't remember muting myself.Happy St. Patrick's Day.Representative Petit.

REP. PETIT (22ND): Thank you, Mr. Chairman.A busy day in front of us with five Bills and almost 130 people signed up, so I hope we will get to the point and ask incisive questions and do the best we can to determine whether any or all of these Bills need to proceed forward.Happy St. Patrick's Day to everybody.We will probably see you tonight around 10:00 P.M.

SENATOR STEINGBERG (136TH): Well I hope you're wrong about that. Representative.Senator Hwang.

SENATOR HWANG (28TH): Thank you, Mr. Chair and Happy St. Patrick's Day to all.I am eager to hear the testimony as well, particularly a number of the Bills, but particularly on theSenate Bill 1, on the mental health, behavioral and physical health during this pandemic.And it is critical and I want to be able to offer that this is a concept that has true bipartisan support.And through the Public Hearing process and input from various shareholders that we can indeed craft a Bill meeting that goal.

So I'm eager to learn more, but I also wanted to share that there are many other Committee hearings going on via Zoom, that there may be many of our colleagues that are going in and out.Knowing that this is of very strong interest, I know they're going to be very engaged but I wanted to acknowledge that.

REP. COOK (66TH): And so what would be the difference between what was currently a Statute and what would we are proposing moving forward?Because my understanding was every facility was already supposed to have an infectious disease specialist and they were not.So why would we think, and I'm all about it, so but shy would we think that this legislation is going to change that?How are we going to look at accountability?

CHIEF ADELITA OREFICE: So the infection preventionist requirement currently is required by CMS, the Centers for Medicare and Medicaid Services, and I might ask Carbara Cass, who I think is on as well, to talk in more detail about that.But that requirement didn't compel facilities to have a fulltime infection preventionist and nor did it require the infection preventionist to sort of be, you know sort of exclusive to this, to the rule.

And so what we found through the pandemic is people in multiple hats playing that role.And clearly during the pandemic that, that part-time aspect of it didn't, didn't appear for a lot of facilities to be enough.

I know that the Bill in front of you also includes training for other senior leadership in the facilities on like the administrator on infection prevention and protocols.And that is in part to, you know have that larger foundation or stronger foundation with infection prevention throughout the leadership and management on team of a facility because even if you have, you know the full-time infection preventionist in your, your team of shift coaches, what we saw also during the pandemic is sometimes the infection preventionist was the one who got sick.

And then you needed to have a backup.You needed to have enough of a safety net of competency in the facility to cover that.

REP. COOK (65TH): Thank you for that.I think it's extremely important, obviously, from what we've learned and then you know the shortcomings of our facilities in this area, so I want to thank you for that and I do want to ensure that we figure out a way to, to look at some type of oversight in that area.Even though we are supposed to have part-time folks, we know that they didn't and so it's extremely important that we start holding these facilities accountable for their shortcomings because they are putting lives in, you know we're costing lives quite frankly.

The other thing I would like to address would be the staffing levels.I'm sure that you figured that where I would be I would be going to when we're looking at the staffing levels, I want to thank you all for your support in that regard and I know that we had suggested a variety of different opportunities for shift options and so forth and so on.

Is the Department, and I heard your testimony but I didn't hear your say one way or another, are you in complete support of what we're, where we are or are you looking at alterations from the recommendations that we have for staffing level ratios, etcetera?

COMMISSIONER GIFFORD: Representative, I think the Department would like to continue to have the conversation of minimum staffing ratios.We certainly understand the impetus behind it and ensuring that there is always adequate staff to meet the needs of the residents based on their acuity.

Well I think we would also want to talk about the implications of the minimum staffing ratios or financial support of the facility, so I think we probably are aligned on the intent and want to just engage you a little bit more on the specifics and how it would be implemented and supported.

REP. COOK (66TH): And I'm happy to continue this conversation.It's a conversation that I have been having with the Departments for many, many year's pre, you know pre-pandemic and I'm sure it will go on post-pandemic.

My, my fear is that if we do not figure out a way to invest in and hold our facilities accountable, especially the for profit facilities when their owners and operators are taking a very nice salary and we are short changing our residents.That for me is, is criminal.

We have seen a significant amount of lives lost because of the pandemic but I don't believe that all the lives that were lost during the pandemic are lives that should have been lost for a variety of reasons, and I don't think there's anybody here that would argue that point.

Exhibit 6

OFFICE OF FISCAL ANALYSIS
Legislative Office Building, Room 5200
Hartford, CT 06106 ◇ (860) 240-0200
http://www.cga.ct.gov/ofa

sSB-1030
AN ACT CONCERNING LONG-TERM CARE FACILITIES.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 22 $	FY 23 $
Public Health, Dept.	GF - Cost	5.4 million	2.4 million
State Comptroller - Fringe Benefits[1]	GF - Cost	82,130	84,600
Social Services, Dept.	GF - Cost	See Below	See Below

Note: GF=General Fund

Municipal Impact: None

Explanation

The bill results in cost to the Department of Public Health (DPH) and the Department of Social Services (DSS) associated with requirements for long-term care facilities to build infection control capacity and new minimum staffing levels for nursing homes.

Section 1 results in a cost of approximately $96,340 in FY 22 and $96,170 to DPH (with associated fringe of $38,160 in FY 22 and $39,310 in FY 23) for infection control training. The Healthcare-Associated Infections & Antimicrobial Resistance (HAI-AR) Program provides technical assistance to healthcare facilities in infection control and prevention. HAI-AR will need an additional Nurse Consultant to support technical assistance with infection control to allow long-term care facilities to comply with the bill.

[1]The fringe benefit costs for most state employees are budgeted centrally in accounts administered by the Comptroller. The estimated active employee fringe benefit cost associated with most personnel changes is 41.3% of payroll in FY 22 and FY 23.

Primary Analyst: ES 4/13/21
Contributing Analyst(s): RDP, LD, CP

Section 3 results in a cost associated with requiring DPH to maintain a 90-day stockpile of personal protective equipment (PPE) that will be used to supply long-term care facilities during a public health emergency. Funding of approximately $106,460 in FY 22 and $109,660 in FY 23 (with associated fringe of $43,970 in FY 22 and $45,290 in FY 23) will support two Material Storage staff to help manage PPE. DPH will also incur costs of approximately $3.2 million in FY 22 and $200,000 in FY 23 associated with PPE supplies, storage, and an inventory management system. In addition, the bill results in a cost of approximately $2 million in FY 22 and FY 23 to support a maintenance contract with a vendor to resupply the needed PPE prior to expiration.

Section 13 results in a cost to DSS associated with revising nursing home staffing levels and eliminating the distinction between a chronic and convalescent nursing home and a rest home with nursing supervision.

Staffing ratio requirements will result in a significant cost to DSS to the extent nursing home staffing costs are reflected in future Medicaid payments. The bill specifies that a total of 4.1 hours of direct care be provided per resident per day, including 3.75 hours by a registered nurse (RN), 0.54 hours by a licensed practical nurse (LPN), and 2.81 hours by a certified nurse's assistant (CAN).

Based on 2019 nursing home staffing data, none of the approximately 200 homes can meet the bill's requirements for RNs (with an average of 0.70 hours of direct care provided per resident per day). Approximately 10% of homes do not meet the LPN staffing requirements, while approximately 80% do not meet the requirements for CNAs. The cost for nursing homes to staff at the proposed levels will depend on the actual number and level of staff required and their associated wages but is anticipated to be at least $200 million.

The Out Years

The annualized ongoing fiscal impact identified above would

continue into the future subject to inflation.

Exhibit 7

General Assembly

Amendment

January Session, 2021

LCO No. **9433**

Offered by:
SEN. DAUGHERTY ABRAMS, 13th Dist.
REP. STEINBERG, 136th Dist.

To: Subst. Senate Bill No. **1030** File No. 457 Cal. No. 281

"AN ACT CONCERNING LONG-TERM CARE FACILITIES."

Strike everything after the enacting clause and substitute the following in lieu thereof:

"Section 1. (NEW) (*Effective October 1, 2021*) (a) As used in this section and sections 2 to 11, inclusive, of this act:

(1) "Nursing home" means any chronic and convalescent nursing home or any rest home with nursing supervision that provides nursing supervision under a medical director twenty-four hours per day, or any chronic and convalescent nursing home that provides skilled nursing care under medical supervision and direction to carry out nonsurgical treatment and dietary procedures for chronic diseases, convalescent stages, acute diseases or injuries; and

(2) "Dementia special care unit" means the unit of any assisted living

facility that locks, secures, segregates or provides a special program or unit for residents with a diagnosis of probable Alzheimer's disease, dementia or other similar disorder, in order to prevent or limit access by a resident outside the designated or separated area, or that advertises or markets the facility as providing specialized care or services for persons suffering from Alzheimer's disease or dementia.

(b) Each nursing home and dementia special care unit shall employ a full-time infection prevention and control specialist who shall be responsible for the following:

(1) Ongoing training of all administrators and employees of the nursing home or dementia special care unit on infection prevention and control using multiple training methods, including, but not limited to, in-person training and the provision of written materials in English and Spanish;

(2) The inclusion of information regarding infection prevention and control in the documentation that the nursing home or dementia special care unit provides to residents regarding their rights while in the home or unit and posting of such information in areas visible to residents;

(3) Participation as a member of the infection prevention and control committee of the nursing home or dementia special care unit and reporting to such committee at its regular meetings regarding the training he or she has provided pursuant to subdivision (1) of this subsection;

(4) The provision of training on infection prevention and control methods to supplemental or replacement staff of the nursing home or dementia special care unit in the event an infectious disease outbreak or other situation reduces the staffing levels of the home or unit; and

(5) Any other duties or responsibilities deemed appropriate for the infection prevention and control specialist, as determined by the nursing home or dementia special care unit.

(c) Each nursing home and dementia special care unit shall require its infection and control specialist to work on a rotating schedule that ensures the specialist covers each eight-hour shift at least once per month for purposes of ensuring compliance with relevant infection control standards.

Sec. 2. (NEW) (*Effective October 1, 2021*) On or before January 1, 2022, the administrative head of each nursing home and each dementia special care unit shall provide its emergency plan of operations to the political subdivision of this state in which it is located for purposes of the development of the emergency plan of operations for such political subdivision of this state required pursuant to the Interstate Mutual Aid Compact made and entered into under section 28-22a of the general statutes.

Sec. 3. (NEW) (*Effective October 1, 2021*) (a) The administrative head of each nursing home shall ensure that (1) the home maintains at least a two-month supply of personal protective equipment for its staff, and (2) the personal protective equipment is of various sizes based on the needs of the home's staff. The personal protective equipment shall not be shared amongst the home's staff and may only be reused in accordance with the strategies to optimize personal protective equipment supplies in health care settings published by the National Centers for Disease Control and Prevention. The administrative head of each nursing home shall hold fittings of his or her staff for N95 masks or higher rated masks certified by the National Institute for Occupational Safety and Health, at a frequency determined by the Department of Public Health.

(b) On or before January 1, 2022, the Department of Emergency Management and Homeland Security, in consultation with the Department of Public Health, shall establish a process to evaluate, provide feedback on, approve and distribute personal protective equipment for use by nursing homes in a public health emergency.

Sec. 4. (NEW) (*Effective October 1, 2021*) The administrative head of each nursing home shall ensure that there is at least one staff member

or contracted professional licensed or certified to start an intravenous line who is available on-call during each shift to start an intravenous line.

Sec. 5. (NEW) (*Effective October 1, 2021*) Each nursing home's infection prevention and control committee shall meet (1) at least monthly, and (2) during an outbreak of an infectious disease, daily, provided daily meetings do not cause a disruption to the operations of the nursing home, in which case the committee shall meet at least weekly. The prevention and control committee shall be responsible for establishing infection prevention and control protocols for the nursing home and monitoring the nursing home's infection prevention and control specialist. Not less than annually and after every outbreak of an infectious disease in the nursing home, the prevention and control committee shall evaluate (A) the implementation and analyze the outcome of such protocols, and (B) whether the infection prevention and control specialist is satisfactorily performing his or her responsibilities under subsection (b) of section 1 of this act.

Sec. 6. (NEW) (*Effective October 1, 2021*) Each nursing home shall, during an outbreak of an infectious disease, test staff and residents of the nursing home for the infectious disease at a frequency determined by the Department of Public Health as appropriate based on the circumstances surrounding the outbreak and the impact of testing on controlling the outbreak.

Sec. 7. (NEW) (*Effective October 1, 2021*) On or before January 1, 2022, the administrative head of each nursing home and dementia special care unit shall encourage the establishment of a family council and assist in any such establishment. The family council shall facilitate and support open communication between the nursing home or dementia special care unit and each resident's family members and friends. As used in this section, "family council" means an independent, self-determining group of the family members and friends of the residents of a nursing home or dementia special care unit that is geared to meeting the needs and interests of the residents and their family members and friends.

Sec. 8. (NEW) (*Effective October 1, 2021*) (a) On or before January 1, 2022, the administrative head of each nursing home shall ensure that each resident's care plan includes the following:

(1) Measures to address the resident's social, emotional and mental health needs, including, but not limited to, opportunities for social connection and strategies to minimize isolation;

(2) Visitation protocols and any other information relevant to visitation that shall be written in plain language and in a form that may be reasonably understood by the resident and the resident's family members and friends; and

(3) Information on the role of the Office of the Long-Term Care Ombudsman established under section 17a-405 of the general statutes including, but not limited to, the contact information for said office.

(b) On or before January 1, 2022, the administrative head of each nursing home shall ensure that its staff is educated regarding (1) best practices for addressing the social, emotional and mental health needs of residents, and (2) all components of person-centered care.

Sec. 9. (*Effective from passage*) On or before October 1, 2021, the Public Health Preparedness Advisory Committee established pursuant to section 19a-131g of the general statutes shall amend the plan for emergency responses to a public health emergency prepared pursuant to said section to include a plan for emergency responses to a public health emergency in relation to nursing homes and dementia special care units and providers of community-based services to residents of such homes and units.

Sec. 10. (NEW) (*Effective October 1, 2021*) (a) On or before January 1, 2022, the Department of Public Health shall (1) establish minimum staffing level requirements for nursing homes of three hours of direct care per resident per day, and (2) modify staffing level requirements for social work and recreational staff of nursing homes such that the requirements (A) for social work are one full-time social worker per

sixty residents, and (B) for recreational staff are lower than the current requirements, as deemed appropriate by the Commissioner of Public Health.

(b) The commissioner shall adopt regulations in accordance with the provisions of chapter 54 of the general statutes that set forth nursing home staffing level requirements to implement the provisions of this section.

Sec. 11. (*Effective from passage*) The Department of Public Health shall seek any federal or state funds available for improvements to the infrastructure of nursing homes in the state. Not later than January 1, 2022, the Commissioner of Public Health shall report, in accordance with the provisions of section 11-4a of the general statutes, regarding the commissioner's success in accessing such federal or state funds available for infrastructure improvement to the joint standing committee of the General Assembly having cognizance of matters relating to public health."

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2021*	New section
Sec. 2	*October 1, 2021*	New section
Sec. 3	*October 1, 2021*	New section
Sec. 4	*October 1, 2021*	New section
Sec. 5	*October 1, 2021*	New section
Sec. 6	*October 1, 2021*	New section
Sec. 7	*October 1, 2021*	New section
Sec. 8	*October 1, 2021*	New section
Sec. 9	*from passage*	New section
Sec. 10	*October 1, 2021*	New section
Sec. 11	*from passage*	New section

Exhibit 8

OFFICE OF FISCAL ANALYSIS
Legislative Office Building, Room 5200
Hartford, CT 06106 ◇ (860) 240-0200
http://www.cga.ct.gov/ofa

sSB-1030
AN ACT CONCERNING LONG-TERM CARE FACILITIES.
AMENDMENT

LCO No.: 9433
File Copy No.: 457
Senate Calendar No.: 281

OFA Fiscal Note

See Fiscal Note Details

The amendment strikes the language in the underlying bill and the associated fiscal impact.

The amendment results in a cost to the Department of Social Services associated with eliminating the distinction between a chronic and convalescent nursing home and a rest home with nursing supervision and increasing minimum staffing level requirements in nursing homes.

The amendment requires the Department of Public Health (DPH) to establish a minimum staffing level of three hours of direct care per resident per day, by January 1, 2022. Based on 2019 cost report data, there are several homes providing less than three hours of direct care per resident per day. The total cost for these homes to meet the amendment's provisions is approximately $600,000 to $1 million. If the state supported those costs through increased rates, it would result in a state Medicaid cost of $300,000 to $500,000. The actual cost depends on the number and type of staff required.

The amendment also requires DPH to modify staffing requirements to (1) include one full-time social worker per sixty residents, and (2) reduce current staffing requirements for recreational staff. The net impact will depend on the adjusted staffing required for each home and the extent to which associated costs are reflected in Medicaid rates.

Primary Analyst: ES 5/27/21
Contributing Analyst(s): (FN)

The preceding Fiscal Impact statement is prepared for the benefit of the members of the General Assembly, solely for the purposes of information, summarization and explanation and does not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

Sources: 2019 Annual Cost Reports of Long Term Care Facilities per the Department of Social Services

Exhibit 9

CT S. Tran., 5/27/2021


Image 1 within document in PDF format.

Connecticut Senate Transcript, May 27, 2021

May 27, 2021
Connecticut Senate
2021

CONNECTICUT GENERAL ASSEMBLY

SENATE

Thursday, May 27, 2021

The Senate was called to order at 2:38 p.m., the President in the Chair.

THE CHAIR:

The Senate will please come to order.Give your attention to our guest Chaplain Kathy Zabel of Burlington.

ACTING CHAPLAIN KATHY ZABEL OF BURLINGTON:

Help us to live a creative life, to lose our fear of being wrong, and to let us find common ground with others.Let us know that in all things, we are not alone but are surrounded by the wisdom and kindness of our fellow man.

THE CHAIR:

Thank you very much, Madam Chaplain.We now invite Senator Winfield and Senator Berthel to come forward to lead us in the Pledge of Allegiance.

SENATOR WINFIELD (10TH) & SENATOR BERTHEL (32ND):

I pledge allegiance to the flag of the United States of America and to the republic for which it stands, one nation, under God, indivisible, with liberty and justice for all.

THE CHAIR:

Thank you very much to both Senators.Is there business on the Clerk's desk?

CLERK:

Good afternoon.The Clerk is in possession of Senate Agenda Item No. 1, dated Thursday, May 27th, 2021.

THE CHAIR:

Thank you, Mr. Clerk.Our distinguished Majority Leader, Senator Duff.

SENATOR DUFF (25TH):

Thank you, Mr. President.Good to see you this afternoon.Mr. President, I move all items on Senate agenda No. 1, dated Thursday, May 27th, 2021, be act upon as indicated and that the Agenda be incorporated by reference into Senate Journal and Senate Transcripts.

Good evening Senator.

SENATOR DAUGHERTY ABRAMS (13TH):

Good evening, Madam President.I move acceptance of the Joint Committee's favorable report and passage of the Bill.

THE CHAIR:

And the question is on passage, will you remark?

SENATOR DAUGHERTY ABRAMS (13TH):

Thank you, Madam President, the Clerk is in possession of LCO No. 9433.I ask that the Clerk please call it.I move the Amendment and ask leave to summarize.

THE CHAIR:

Mr. Clerk.

CLERK:

LCO No. 9433 Senate Schedule "A"

THE CHAIR:

And please do proceed to summarize and the question is on adoption of the Amendment.

SENATOR DAUGHERTY ABRAMS (13TH):

Thank you very much, Madam President.I cannot begin to talk about this Bill or this Amendment without remembering first the thousands of people, grandparents, mothers, fathers, sisters, brothers, residents of nursing home in assisted care living facilities who lost their lives due to COVID.Also, the staff members who put themselves and their family members at risk to take care of our most vulnerable citizens.These are the sacrifices that we must never forget.

For me, this legislation is an acknowledgment of that sacrifice.It is the most sincere hope that this Bill honors them by acting on our commitment to do better.This amended Bill is a culmination of the work of stakeholders, the Department of Public Health, the Chairs and Ranking Members of Public Health, Human Services and Appropriations Committees who held workgroups through the fall and into the winter to consider the recommendations of the Mathematica report and to evaluate current practices in nursing homes and assisted living facilities.

The Bill, as amended from the -- was amended from the original Bill because some parts of the original Bill have been taken up in other Committees.In Human Services and in the Aging Committee.In addition, changes have been made to address the fiscal note and feedback from various stakeholders.

This Bill, as amended, codifies the role of the infection preventionist.It's previously been in statute but not clearly defined.This legislation would ask that that person be full-time.They can be assigned to other duties, however.And would be asked to have a rotating schedule monthly so that they can see what is happening in the facility during all times of the day.They'd be responsible for training all administrators and staff on infection prevention and control using multiple training methods, including in-person training.They be responsible for written materials and resident documents and -- written materials that would be posted in the building that would show best practices in infection prevention.They would participate as a member of the Infection Prevention Control Committee to report on their activities.

The Infection Prevention and Control Committee would also ask to meet monthly, daily during an outbreak.They would be responsible for establishing infection prevention and control protocols, evaluate those protocols at least annually, and always after an outbreak.

We also address in this Bill PPE.Nursing homes would be asked to have a two month supply in various sizes that reflect the needs of their staff.There would be no sharing or reuse, only to -- only if it would be recommended by the CDC. It also asks that every nursing home have at least one staff member or contract professional to start an IV line available during every shift.It addresses the testing of staff and residents.It ask that nursing homes and assisted living facilities help to create family councils.It ask that the resident care plan address the social emotional needs of residents, training for staff on all components of the person centered care plan, and the social-emotional needs of the residents as well.

Staffing would be increased.Currently it's 1.9 hours per resident per day.This would increase that to 3.0.It would also increase the ratio of social workers from one to 120, to one to 60, and increase -- and increase recreational staff as determined by the public health department.

Social workers are responsible for the intake and discharge of patients for working with families and for really creating those residential care plans that address the social emotional needs of residents.We also ask in this legislation that DPH be charged to seek state and federal funds to support improvements to the infrastructure of our nursing homes.

When this pandemic began I was on weekly, sometimes daily calls regarding long-term care facilities and how we could mitigate the impact of COVID on those residents.I remember hearing that these facilities knew how to respond to infectious outbreaks.The pandemic certainly tested their ability to do that, and what we found is that we must do better.

In passing this Bill we will be doing better, so I encourage all members of the Chamber to support this Bill.Thank you.

THE CHAIR:

Thank you very much.Will you remark further?Will you remark further?Senator Somers.

SENATOR SOMERS (18TH):

Yes, good evening, Madam President.And I rise in full support of this Bill.In fact, I think it's one of the most important pieces of legislation that we will pass in this session.I should say I hope we pass this session.

One thing that the COVID pandemic has clearly shown us here in the State of Connecticut is the voids in the system that we have for caring for our elderly and long-term care in assisted living facilities.There is not one of us, I believe, in this circle that was not contacted by a family member of a loved one who was in a long-term care facility, or an assisted living facility during the COVID pandemic and during the unfortunately large loss of life that we saw here in the State of Connecticut.

I have to say that the people that work in these facilities really do God's work.It is not an easy job, and they do it with care and love and a true dedication for those who are a little more advanced in age than most of us here in the circle.

One of the things that is very clear is that this industry has -- needs some attention from our state.I think they did the best job they could under the circumstances.We all know that PPE was short in supply.We didn't realize how the virus could be transmitted at first, and unfortunately, we even had at times the National Guard going into our facility to help, but without actually being tested for COVID themselves because at that time we didn't understand the transmission.

I too received calls, sometimes on an hourly basis from some of our facilities asking for help, from family members of loved ones that felt that they were locked inside and couldn't have contact with the outside world, but most of our facilities did a great job in trying in the best of their ability to keep that contact going, whether it was through tablets that they could have, waving out the window.I know I myself, I personally visited many of these facilities obviously on the outside waiving to the individuals inside where just seeing somebody new could really brighten their day.

We saw a lot of mental health issues coming out of being isolated during the pandemic where the elderly in particular, especially those that have dementia or Alzheimer's were severely affected by this pandemic because they were moved out of their original routines.And not being able to see or have the contact with the person they were used to took its toll on so many individuals.I do believe that this industry and the long-term care that we'll see in the State of Connecticut is going through a significant change and we will see long-term care being delivered in a different way than we're seeing it now in the future.

But what this Bill does is it starts the beginning of the process, I believe, a process to improve the long-term care that we can provide to our citizens in the State of Connecticut.It looks at infection prevention, infection control, it looks at staffing levels that are reasonable and are affordable.It looks at emergency plan.It deals with visitation of loved ones.It deals with patients' rights.It deals -- also talks about testing and the necessity to make sure that our patients social and emotional needs are met the best they can.

I want to thank all of those who were engaged, including Madam President in this process of reviewing the Mathematica report of breaking out into individual workgroups, of working with the stakeholders and those who are actually working in this -- in these facilities because those truly are the people that can give us the best information so that we can adequately and strategically implement policies that can benefit the residents that live in these facilities here in the State of Connecticut.

So I ask that my colleagues in the Senate join myself and the Chair of public health, Senator Abrams, and support this very important and critical legislation that I do believe is one of the most important Bills that we could look at passing in this session.Thank you, Madam President.

THE CHAIR:

Thank you very much, Senator Somers.Will you remark further?Will you remark further?Senator Hwang.

SENATOR HWANG (28TH):

Thank you, Madam President.I rise in support of the strike-all Amendment.And I want to commend the Chair in the Senate along with the Chair of the House, Representative Steinberg, as well as the House Ranking Member Dr. Petit, and has mentioned before, I want to echo those terms because the uniqueness of the COVID challenge that we went through has raised significant awareness and sensitivity.And I hope this is a valuable lesson that we garnered from this in looking at this Bill and addressing staffing levels and reporting.It is an important and critical element that I hope we will continue as we head into the new normal, post-COVID dynamic that we're experiencing.

But that being said, I also want to commend the fact that our nursing facilities came to the table and collaborated and worked and understood the need to up their game so to speak in meeting the requirements of proper care, proper ratios, and proper reporting.So I think this is a Bill that is a great template for moving forward, as we look at public-private dynamics and us as a state looking to ensure the highest and best care for our loved ones that are at these facilities but also ensuring that we are working with our business partners to provide the highest and best care and sustainability and being in this state and doing business.

So I thank the good Chair for her efforts and collaboration and I urge supporter as well, ma'am.

THE CHAIR:

Thank you very much.Will you remark further?Will you remark further?Senator Looney.

SENATOR LOONEY (11TH):

Thank you, Madam President.Speaking in support of the Bill, rather the Amendment, want to commend the Public Health Committee for all of its works, Senator Daugherty Abrams on this Bill as so many others.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

PETITION OF CONNECTICUT ASSOCIATION OF HEALTH CARE FACILITIES, INC. FOR DECLARATORY RULINGS AS TO THE APPLICABILITY OF MINIMUM STAFFING REQUIREMENTS UNDER CONN. GEN. STAT. § 19a-563h	:

AFFIDAVIT OF JENNIFER M. DELMONICO

I, Jennifer M. DelMonico, being duly sworn, depose and say:

1. I am over eighteen years of age and believe in the obligations of an oath.

2. I am a partner at the law firm of Murtha Cullina LLP representing the Connecticut Association of Health Care Facilities, Inc. ("CAHCF") and, as such, am personally familiar with the subject matter of this petition for declaratory rulings.

3. Pursuant to Conn. Agencies Regs. § 19a-9-12, I certify that on February 28, 2003, I provided notice to the persons CAHCF knows or has reason to believe may be substantially affected by the subject matter of the petition for declaratory rulings by: (a) sending notice via email to CAHCF at mbarrett@cahcf.org, and requesting CAHCF to send notice via email to its nursing home members; and (b) providing notice via email to Leading Age of Connecticut at mmorelli@leadingagect.org, and requesting that Leading Age of Connecticut send notice to its nursing home members.

4. I further certify that CAHCF's notice contains the petition for declaratory rulings, and a detailed statement of the nursing homes' interest in the petition for declaratory rulings.

5. I certify that the petition for declaratory rulings submission conforms to the requirements of Conn. Agencies Regs. § 19a-9-6(a).

Jennifer M. DelMonico
Murtha Cullina LLP
265 Church Street, 9th Floor
New Haven, CT 06510
203.772.7700
jdelmonico@murthalaw.com

Subscribed and sworn to before me this 28th day of February, 2023.

Eleanor W. Nelson
Notary Public
My Commission Expires: 1/31/28

Cheshire House
Nursing and Rehabilitation Center

July 27, 2023

Comments on DPH Proposed Regulation (PR2022-32)

To the Department of Public Health:

My name is Craig Dumont. I am The Administrator at Cheshire House in Waterbury, Connecticut. Cheshire House has been providing nursing home care in our community for over 30 years. We are a 75 bed nursing home, and we have 132 employees working at our facility.

We are not opposed to the increase in Connecticut's direct care staffing minimum from 1.9 to 3.0, but we are strongly opposed to how specifically DPH has interpreted this state legislative requirement in the proposed regulations, how the proposed regulation lacks the current reimbursement funding to make the staffing numbers sustainable and still provide quality homelike environment updates in other regulations enforced by DPH, and how DPH is currently implementing, enforcing, and issuing violations to the requirement in the current nationwide labor shortage.

There are four main areas of concern:

THE PROPOSED REGULATION BLINDLY INCREASES THE CNA MINIMUMS FROM 1.26 TO 2.16 HOURS OF PER DAY. This one-size fits all approach completely prohibits Cheshire House's Medical team to provide care that is assessed in assigning staff to address unit specific acuity levels and the specific care needs of our residents…. We pride ourselves in knowing the specific needs of all our residents. DPH Can not in the "interest of public safety" make remote and arbitrary decisions on what's best for a population they do not intimately know or provide care for daily.

THE PROPOSED REGULATION REVERSES THE PUBLIC HEALTH CODE RULE THAT APPROPRIATELY COUNTED DIRECT CARE LICENSED STAFF AND CNA STAFF TOWARD MEETING THE MINIMUM STAFFING STANDARD. It won't lead to better care and will likely worsen the situation by writing the rule this way….

THE PROPOSED RULE DOESN'T REFLECT NURSING HOME STANDARD STAFFING PATTERNS AND IT DOESN'T COUNT ALL THE STAFF THAT ARE PROVIDING DIRECT CARE. According to the Proposed regulation, it separates CNAs shifts into 14 hours and 8 hours of care. There is NO staffing pattern in the State or the U.S. that uses this model. It is either am/pm/nights (three 8-hour shifts) OR Two 12-hour shifts. With a 14-hour window of care DPH pattern becomes dangerously close to forcing facilities to Violate Ct Department of Labor maximum daily hours worked and creates the need for a bridge shift pattern that is essentially unfillable due to the hours needed/the Union contracted hours shifts, and the unusual nature of the shift no one in healthcare uses due to staff quality of life considerations. Also, in addition to the CNAs, and direct care provided by licensed nurses there are many more positions that should be included, such as…. Housekeeping care workers, laundry care workers, Foodservice care workers, Physical Therapy, Speech Therapy, Occupational Therapy, Psychiatry, Social Services, Recreation care workers and RN Management staff. These departments also provide daily direct care and assistance to our residents and are not accounted for. Direct care for residents goes beyond bedpans and pill passing. Direct Care is advocating, exercising, communication with outpatient referrals, family meetings, feeding, entertaining, and just sitting with them that makes our residents directly cared for.

THE AMOUNT OF MEDICAID RESOURCES THE STATE MADE AVAILABLE FOR COMPLIANCE WITH THE DPH INCREASED MINIMUM STAFFING RULE IS SIGNFICANTLY INADEQUATE. There has been no cost-of-living rate adjustment in 5 years. We thought that the state legislature was making sufficient Medicaid resources available to the Department of Social Services to assure those residents…. the living poor… our citizens in the greatest need…Your Voting constituents…who have the unfortunate situation of needing full time medical care but cannot afford private care and must rely on the state to provide their help… Are NOT Getting the Funds they deserve. If Nursing homes had the resources to comply with the anticipated DPH minimum staffing rule, we could provide everything these citizens deserve. Better Food,

Improved Homelike Environment, much needed facility upgrades, better access entertainment, better access to technology, and overall better compassionate care that your most unfortunate and health compromised constituents deserve.

If this is unrealistically Regulated, Underfunded, and not Resident centered there is one inevitable result… System Failure. Those facilities that cannot sustain will close. Closing will overpopulate hospitals with three times the daily costs to Medicaid and Medicare for acute care stays. Increase Unemployment costs and state supportive assistance costs to displaced workers. Further loss of Income tax revenue, sales tax revenue, property tax revenue, and all the venders that support the facilities will lose business…and the Living Poor in the state who are health compromised will be forces out of choice for care and placed in an already taxed system.

Rushed and inadequate planning…uneducated, unsubstantiated, eyes off and remote decision making on a population not known buy the decision makers… lack of industry specific consultation… arbitrary clinical assumptions… regulation created without the proper staffing available, funding and support needed to sustain it… These actions made by DPH resulted in some of the greatest losses of life and decimation of care to the most vulnerable of our state's population in nursing homes just a short time ago during the pandemic. One would hope lessons would be learned from the past and not repeat them in the future.

Please make substantial changes to this proposed regulation.

Thank you.

Craig Dumont, RD, LNHA
Cheshire House Administrator.

Touchpoints
Rehab at Manchester

August 8, 2023

To whom it may concern,

My name is Cristina Lazure and I am the current Director of nursing services at Touchpoints at Manchester, located in Manchester, CT. I have worked here for 12 years and in SNF's for 14 years. I wanted to become a nurse because I love taking care of people, especially the geriatric population.

The population at Touchpoints at Manchester is not a typical long-term care facility. We have a a 66-bed secured behavioral unit that takes care of residents with multiple psychiatric diagnosis that are also aging in place and have multiple comorbidities. This population is very challenging but we have staff trained and dedicated to making this the best home for our residents. In addition, we have a short-term rehab that takes on highly medically complex residents that other SNF's cannot except or manage.

When Covid hit our facility, we were faced with challenges and loss that most will never see in a lifetime. To see our staff jump in instead of running away was inspiring to say the least. We somehow managed to still care for our residents despite no staff and no proper PPE to do our jobs. Staff were scared and worried about bringing it home to their families. We actually had a staff member lose her spouse because she brought it home to him, and she still showed up dedicated to care for our residents. The sacrifice our facility has made to ensure our residents are well cared for through the most challenging times is amazing.

I don't think anyone would disagree that having more staff to care for our residents is a bad idea, however implementing this staffing mandate is not the answer. A mandate of this magnitude requires a workforce that isn't there, no plan to fund it, and a timeframe that is unrealistic. This would cause SNF's across the country to close with no where for our most vulnerable residents to go. In addition, to not include other staff in the direct care numbers doesn't make sense. Myself, the charge nurses and my nursing mgmt. team provide direct care all the time, we make sure that we all do what we have to ensure our resident are cared for. I know I speak for everyone in the industry when we ask that you collaborate and carefully plan this out with those in the facilities that face these challenges on a daily basis. Thank you for your time.

Cristina Lazure, Director of Nursing Services of Touchpoints at Manchester

Part of the iCare Health Network

333 Bidwell Street, Manchester, CT 06040
Tel: 860-533-3086 Fax: 860-645-4888
www.touchpointsatmanchester.com

iCare HEALTH NETWORK | SILVER SPRINGS CARE CENTER

August 14, 2023

Comments on DPH Proposed Regulation (PR2022-32)

To the Department of Public Health:

My name is Emily Gonzalez. **I am** the Director of Nursing **at** Silver Springs Care Center **in** Meriden, **Connecticut.** Silver Springs **has been providing nursing home care in our community for** 49 **years. We are a** 158 bed **nursing home, and we have** 150 **employees working at our facility.**

There are major problems with how DPH has proposed increasing the direct care minimum staff from the outdated 1.9 hours to 3.0 hours of direct care staff per resident per day.

There are four main areas of concern:

THE PROPOSED REGULATION WRONGLY INCREASES THE CNA MINIMUMS FROM 1.26 TO 2.16 HOURS OF PER DAY.
This one-size fits all approach removes Silver Springs **flexibility in assigning staff to address the care needs of our residents….**

THE PROPOSED REGULATION REVERSES THE PUBLIC HEALTH CODE RULE THAT APPROPRIATELY COUNTED DIRECT CARE LICENSED STAFF AND CNA STAFF TOWARD MEETING THE MINIMUM STAFFING STANDARD.

THE PROPOSED RULE DOESN'T REFLECT MODERN NURSING HOME STAFFING BECAUSE IT DOESN'T COUNT ALL THE STAFF THAT ARE PROVIDING DIRECT CARE
In addition to the CNAs, and direct care provided by licensed nurses, many more positions should be included, such as Directors of Nursing, Asst Directors of nursing, Rehabilitation staff ,Recreation staff, Social Service staff, and Dietary staff as they all provide care in one way or the other.

THERE IS AN INSUFFICENT SUPPLY OF WORKERS
Our facility is facing the most significant staffing challenges we have ever experienced, We have worked tirelessly to recruit quality and sufficient staff to meet the needs of our residents. We have had to resort to use of Agency staff. There are simply not enough staff available to meet this new mandate.

THE AMOUNT OF MEDICAID RESOURCES THE STATE MADE AVAILABLE FOR COMPLIANCE WITH THE DPH INCREASED MINIMUM STAFFING RULE IS SIGNFICANTLY INADEQUATE
We thought that the state legislature was making sufficient Medicaid resources available to the Department of Social Services to assure nursing homes had the resources to comply with the anticipated DPH minimum staffing rule, but DPH put out a policy that requires significantly more

33 Roy Street, Meriden, CT 06450
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www.SilverSpringsCare.com

resources. For example, just consider the unfunded costs just for additional CNAs that the proposed rule requires our facility to hire or contract for. Facilities in Connecticut have faced significantly increased labor costs due to competition from other industries. To implement this as an unfunded mandate will cause many nursing homes to simply close, leaving needy residents with no place to receive the care they deserve.

In conclusion, this is why we are requesting the proposed DPH regulation be substantially revised to address these concerns.

Sincerely,

Emily Gonzalez, RN, DNS

Maple View
Health & Rehabilitation Center

7/27/2023

Comments on DPH Proposed Regulation (PR2022-32)

To the Department of Public Health:

My name is Lewis Abramson I am Administrator, at Maple View Health and Rehabilitation Center in Rocky Hill, Connecticut. Maple View has been providing nursing home care in our community for over 40 years. We are a 120 bed nursing home, and we have 130 employees working at our facility.

We are not opposed to increased Connecticut's direct care staffing minimum from 1.9 to 3.0, but we are strongly opposed to how specifically DPH has interpreted this state legislative requirement in the proposed regulations and how DPH is currently implementing the requirement.

There are major problems with how DPH has proposed increasing the direct care minimum staff from the outdated 1.9 hours to 3.0 hours of direct care staff per resident per day.

There are four main areas of concern:

THE PROPOSED REGULATION WRONGLY INCREASES THE CNA MINIMUMS FROM 1.26 TO 2.16 HOURS OF PER DAY.

This one-size fits all approach removes Maple View's flexibility in assigning staff to address the care needs of our residents....

THE PROPOSED REGULATION REVERSES THE PUBLIC HEALTH CODE RULE THAT APPROPRIATELY COUNTED DIRECT CARE LICENSED STAFF AND CNA STAFF TOWARD MEETING THE MINIMUM STAFFING STANDARD.

It won't lead to better care and will likely worsen the situation by writing the rule this way....

THE PROPOSED RULE DOESN'T REFLECT MODERN NURSING HOME STAFFING BECAUSE IT DOESN'T COUNT ALL THE STAFF THAT ARE PROVIDING DIRECT CARE

In addition to the CNAs, and direct care provided by licensed nurses, many more positions should be included, such as....

The rule should also include additional licensed staff that are providing direct care.

THERE IS AN INSUFFICENT SUPPLY OF WORKERS

Our facility is facing the most significant staffing challenges we have ever experienced....

THE AMOUNT OF MEDICAID RESOURCES THE STATE MADE AVAILABLE FOR COMPLIANCE WITH THE DPH INCREASED MINIMUM STAFFING RULE IS SIGNFICANTLY INADEQUATE

We thought that the state legislature was making sufficient Medicaid resources available to the Department of Social Services to assure nursing homes had the resources to comply with the anticipated DPH minimum staffing rule, but DPH put out a policy that requires significantly more resources. For example, just consider the unfunded costs just for additional CNAs that the proposed rule requires our facility to hire or contract for...

Please make substantial changes to this proposed regulation. It will make matters worse for our nursing facility, our staff, and our residents.

Lewis Abramson,

Administrator

856 Maple Street
Rocky Hill, CT 06067

P 860 563 2861
F 860 257 9128

mapleviewrehab.com

iCare HEALTH NETWORK | SILVER SPRINGS CARE CENTER

August 14, 2023

Comments on DPH Proposed Regulation (PR2022-32)

To the Department of Public Health:

My name is Julie Seguinot. I am the Director of Behavioral Health at Silver Springs Care Center in Meriden, Connecticut. Silver Springs has been providing nursing home care in our community for 49 years. We are a 158 bed nursing home, and we have 150 employees working at our facility.

There are major problems with how DPH has proposed increasing the direct care minimum staff from the outdated 1.9 hours to 3.0 hours of direct care staff per resident per day.

There are four main areas of concern:

THE PROPOSED REGULATION WRONGLY INCREASES THE CNA MINIMUMS FROM 1.26 TO 2.16 HOURS OF PER DAY.
This one-size fits all approach removes Silver Springs flexibility in assigning staff to address the care needs of our residents....

THE PROPOSED REGULATION REVERSES THE PUBLIC HEALTH CODE RULE THAT APPROPRIATELY COUNTED DIRECT CARE LICENSED STAFF AND CNA STAFF TOWARD MEETING THE MINIMUM STAFFING STANDARD.

THE PROPOSED RULE DOESN'T REFLECT MODERN NURSING HOME STAFFING BECAUSE IT DOESN'T COUNT ALL THE STAFF THAT ARE PROVIDING DIRECT CARE
In addition to the CNAs, and direct care provided by licensed nurses, many more positions should be included, such as Directors of Nursing, Asst Directors of nursing, Rehabilitation staff ,Recreation staff, Social Service staff, and Dietary staff as they all provide care in one way or the other.

THERE IS AN INSUFFICENT SUPPLY OF WORKERS
Our facility is facing the most significant staffing challenges we have ever experienced, We have worked tirelessly to recruit quality and sufficient staff to meet the needs of our residents. We have had to resort to use of Agency staff. There are simply not enough staff available to meet this new mandate.

THE AMOUNT OF MEDICAID RESOURCES THE STATE MADE AVAILABLE FOR COMPLIANCE WITH THE DPH INCREASED MINIMUM STAFFING RULE IS SIGNFICANTLY INADEQUATE
We thought that the state legislature was making sufficient Medicaid resources available to the Department of Social Services to assure nursing homes had the resources to comply with the anticipated DPH minimum staffing rule, but DPH put out a policy that requires significantly more

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resources. For example, just consider the unfunded costs just for additional CNAs that the proposed rule requires our facility to hire or contract for. Facilities in Connecticut have faced significantly increased labor costs due to competition from other industries. To implement this as an unfunded mandate will cause many nursing homes to simply close, leaving needy residents with no place to receive the care they deserve.

In conclusion, this is why we are requesting the proposed DPH regulation be substantially revised to address these concerns.

Sincerely,

Julie Seguinot, LMSW

Bethel Health Care Center

August 2, 2023

RE: Comments on DPH Proposed Regulation (PR2022-32)

To the Department of Public Health:

I am writing this testimonial in reference to the unfunded and unworkable DPH 3.0 Direct Care Minimum Staffing Regulations. Although we are not opposed to increased Connecticut's direct care staffing minimum from 1.9 to 3.0, we are opposed to how specifically DPH has interpreted this state legislative requirement in the proposed regulations and how DPH is currently implementing the requirement. Funding and the workforce are not available to meet such a mandate.

Bethel Health Care is a 161 bed skilled nursing facility located in Bethel, CT. I began my career in skilled nursing 13 years ago in the capacity of Admissions Director. My experience quickly solidified my passion and to advance in the healthcare field. The difference we make in the lives of our residents and families is invaluable. Since this time, I have worked in several management positions including Administrator for the past 5 and a half years.

I am confident in saying I speak for all Connecticut Nursing Homes when I tell you that our biggest daily challenge remains staffing. We navigate the days and weeks to creatively fill schedule gaps due to vacant positions and other staffing issues. In an effort to mitigate these challenges, we focus heavily on recruitment and retention efforts both at a regional and facility level. Bethel sponsors C.N.A certificate programs and we provide onsite clinical rotations for many LPN and RN schools. We provide robust employee incentives, such as scholarship programs, sign on bonuses, referral bonuses and employer funded retirement plan. In addition, the company has provided enhanced medical benefits, increased starting wages and provides wage increases to staff every 6 months.

Despite robust efforts, we continually struggle to find quality staff and fill the necessary positions. We have several C.N.A, LPN and RN positions open on all three shifts. We are forced to use agency nursing, which is far from ideal. Aside from the exorbitant costs, agency staffing disturbs the continuity of care for our residents. Agency staff are not invested in the facility, and therefore we experience excessive call outs, no shows and limited dependability. Such behaviors cause a low staff morale, high turnover rates and a decrease in quality of care. We continue to pay unsustainable bonuses to our dedicated staff to pick up additional shifts and lessen the unavoidable negative impact associated with agency nursing. This too causes high burnout and negatively impacts the residents and the facility.

The proposed regulation reverses the Public Health Code Rule that appropriately counted direct care licensed staff towards meeting the minimum staffing standard. Hospitals continue to send Nursing Homes increasingly complex patients with multiple comorbidities. The proposed regulations remove Bethel Health Care's flexibility in assigning staff to address the many complex and specialized needs of

our residents. Specified minimums by category simply do not reflect staffing that is needed to provide quality care to these residents, therefore the rule should include the additional licensed staff that provide direct care.

The amount of Medicaid resources the State made available for compliance with the DPH increased minimum staffing rule is significantly inadequate. We thought that the state legislature was making sufficient Medicaid resources available to the Department of Social Services to assure nursing homes had the resources to comply with the anticipated DPH minimum staffing rule, but DPH put out a policy that requires significantly more resources. The exorbitant costs of staffing with agency and employee shift bonuses, leave insufficient resources to hire increased levels of staff even if the workforce was available. Funding is needed in conjunction with a sustainable plan to add resources for Connecticut Nursing Homes.

In conclusion, this is why we are requesting the proposed DPH regulation be substantially revised to address these concerns.

Sincerely,

Erin Healy
Administrator

iCare HEALTH NETWORK | SILVER SPRINGS CARE CENTER

August 14, 2023

Comments on DPH Proposed Regulation (PR2022-32)

To the Department of Public Health:

My name is Raymond Hackling. I am the administrator at Silver Springs Care Center in Meriden, Connecticut. Silver Springs has been providing nursing home care in our community for 49 years. We are a 158 bed nursing home, and we have 150 employees working at our facility.

There are major problems with how DPH has proposed increasing the direct care minimum staff from the outdated 1.9 hours to 3.0 hours of direct care staff per resident per day.

There are four main areas of concern:

THE PROPOSED REGULATION WRONGLY INCREASES THE CNA MINIMUMS FROM 1.26 TO 2.16 HOURS OF PER DAY.
This one-size fits all approach removes Silver Springs flexibility in assigning staff to address the care needs of our residents....

THE PROPOSED REGULATION REVERSES THE PUBLIC HEALTH CODE RULE THAT APPROPRIATELY COUNTED DIRECT CARE LICENSED STAFF AND CNA STAFF TOWARD MEETING THE MINIMUM STAFFING STANDARD.

THE PROPOSED RULE DOESN'T REFLECT MODERN NURSING HOME STAFFING BECAUSE IT DOESN'T COUNT ALL THE STAFF THAT ARE PROVIDING DIRECT CARE
In addition to the CNAs, and direct care provided by licensed nurses, many more positions should be included, such as Directors of Nursing, Asst Directors of nursing, Rehabilitation staff ,Recreation staff, Social Service staff, and Dietary staff as they all provide care in one way or the other.

THERE IS AN INSUFFICENT SUPPLY OF WORKERS
Our facility is facing the most significant staffing challenges we have ever experienced, We have worked tirelessly to recruit quality and sufficient staff to meet the needs of our residents. We have had to resort to use of Agency staff. There are simply not enough staff available to meet this new mandate.

THE AMOUNT OF MEDICAID RESOURCES THE STATE MADE AVAILABLE FOR COMPLIANCE WITH THE DPH INCREASED MINIMUM STAFFING RULE IS SIGNFICANTLY INADEQUATE
We thought that the state legislature was making sufficient Medicaid resources available to the Department of Social Services to assure nursing homes had the resources to comply with the anticipated DPH minimum staffing rule, but DPH put out a policy that requires significantly more

33 Roy Street, Meriden, CT 06450
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www.SilverSpringsCare.com

resources. For example, just consider the unfunded costs just for additional CNAs that the proposed rule requires our facility to hire or contract for. Facilities in Connecticut have faced significantly increased labor costs due to competition from other industries. To implement this as an unfunded mandate will cause many nursing homes to simply close, leaving needy residents with no place to receive the care they deserve.

In conclusion, this is why we are requesting the proposed DPH regulation be substantially revised to address these concerns.

Sincerely,

Raymond E Hackling, LNHA

Touchpoints
Rehab at Manchester

August 7, 2023

To whom it may concern,

My name is Cassondra McKee and I am the nursing scheduler at Touchpoints at Manchester located in Manchester, CT. I am one of about 120 employees for the facility and have been working here for 2 and a half years. What I enjoy the most about my job is being able to have a sense of fulfillment and knowing that I can make a difference in the lives of our residents through connections with the staff. However, I do not feel that the new DPH 3.0 Direct Care Minimum Staffing Regulations proposal is feasible or appropriate for our facility at this time.

As scheduler, I have witnessed and experienced the staffing challenges and constant barriers to filling open shifts and positions. We currently have 224 open hours for CNAs and 24 hours vacant for LPNs. This is on top of vacation time being requested by staff experiencing burn-out post pandemic.

Many of our current staff have been with the company for years and know the specific needs of our long-term residents. To meet the new regulations, our facility would need to employ agency staff that our residents are not familiar with meaning they will not receive the standard of care that they are used to and deserve. This is not the type of care we strive to provide and it comes at an immense fee to the facility.

Implementing a direct care minimum staffing requirement is a good idea given it is implemented in the proper way with a solid plan. This needs to be well thought out including timeframes, recruitment efforts and a proper way to fund it. Please take the time to bring this into consideration.

Thank you,

Cassondra McKee
Scheduling Coordinator
Touchpoints at Manchester

ARK
HEALTHCARE &
REHABILITATION

Dear Legislature,

I , David Greenwald am the current Nursing Home Administrator at The Governor's House in Simsbury, CT. The Governor's House is a 70-bed skilled Nursing facility in which we have 97 employees. Governor's house has been providing nursing home care in our community for 45 years. I have been in Management for over 8 years. I decided I wanted to go into the health care industry as I worked as a health care volunteer during Covid. I have elderly grandparents and I always had respect for the elderly as they have life experience and are role models for the next generation.

I am testifying because I want the Human services and Aging Committees and the DPH to know how the new staffing mandates will have a negative effect on health care. I strongly feel that the committees should not pass the PR2022-32 Act concerning nursing homes.

In the health care industry, we require professional, knowledgeable and caring workers. During the past few years, we are limited in hiring health care workers as many have retired early, switched professions or work remotely at this time. In the Past quarter Governor's House used over 4000 hours of agency staff. Agencies of which of inflated their rates to take advantage of Skilled Nursing Facilities and/or other healthcare entities currently experiencing challenges.

We currently have a committed Human Resource team that is working very hard to staff our facility. They are strong and committed. We have posted job opportunities on Apploi and Indeed in which was not a great success. We have a bonus program in place in which we try to encourage our employees to refer health care professionals to apply for job postings. Again, we have had very little success.

This unfunded mandate will not solve the staffing problem. Our dedicated staff are already feeling burdened by the limited staff. We will be affected in a negative way if this Act is past. The proper care needed for our facility will only worsen our staffing issues. This mandate is something that we cannot achieve at this time.

The workers are not available to fill the open positions in our building. The CNA issue is our main issue. We are very discouraged because of the proposed regulation reverses the ability to meet the minimum staffing requirement in a way that best meets the specific needs of our facility residents, and instead requires specific minimums for CNAs vs. licensed direct care staff. The facility is in direct competition with hospitals, and even the state, in terms of hiring. but our nursing home lost more workers than anyone else.

My request as the Nursing Home Administrator is to please not pass PR2022-32.

Sincerely,

David Greenwald LNHA

Comments related to Proposed Regulation Concerning: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

August 14, 2023

I am Chief Clinical Officer at iCare Health Network representing 11 Connecticut nursing facilities. The purpose of this letter is to express concern for the State of Connecticut, Department of Public Health's (DPH) implementation of the nursing home minimum staffing. As a Registered Nurse for the past 40 years working in acute care, home health, hospice and now long term care I am seriously concerned about the ability of any facility to meet this unfunded mandate during a time of a critical nursing shortage. The Federal Bureau of Labor Statistics data indicates that over 210,000 jobs in the nursing home sector have been lost since the beginning of the pandemic. The staffing crisis facing nursing facilities is well documented by nursing home trade organizations[2], the media[3] and others. There have been parallel efforts by Federal officials to increase nursing home staffing levels that have received significant negative feedback from the industry, Congress and the media. Well intended efforts to increase staffing levels in nursing homes need to include a long-term multifaceted effort by the government, industry and stakeholders that includes but is not limited to staff training program development and tuition forgiveness programs or related tax credits.

Additionally, the statute indicated that the staffing level would be set at 3 hours per patient per day for direct care. In no way did the statute indicate that DPH was authorized to implement two mutually exclusive caps (2.16 for Certified Nurse Aides and 0.84 for nurses) that happen to add up to 3. There was no study performed by DPH at their own admission during industry calls in developing these caps. Having two caps does not reflect patient need. A patient or group of patients may need more nurse's aides than nurses, or vice versa. The regulation had been a combined cap for decades which provided flexibility to meet patient needs as appropriate. Additionally, on 7/1/2022 DSS implemented an acuity-based reimbursement system for nursing homes. It considers a nursing facility with an average acuity to be a 1.0 acuity and facilities with higher and lower acuity to be more or less than that benchmark. The lower the acuity, the lower the CT Medicaid reimbursement and vice versa. The underlying system used for this Connecticut's system used the CMS RUG-48 reimbursement methodology which itself was driven from of an exhaustive federal time study called Strive[1]. The Strive study connected time needed for patient care with acuity and the acuity with reimbursement. Since DSS implemented this acuity-based system, DPH should consider the underlying patient needs based on acuity. A facility with lower acuity should have a commensurate reduction in any minimum staffing requirement promulgated by DPH.

I encourage DPH to commission the State Labor Department to analyze nursing home worker employment data and develop a feasibility study to implement the proposed mandate.
Please consider the above, delay the implementation of the mandate and fully fund the impact to Connecticut nursing home providers.

[2] https://www.ahcancal.org/News-and-Communications/Fact-Sheets/Letters/AHCA%20Letter%20to%20President%20Biden%20-%20Staffing%20Mandate.pdf
[3] https://www.wsj.com/articles/green-card-backlog-fuels-shortage-of-nurses-at-hospitals-nursing-homes-4f0b0e44

Thank you

Allison Breault, RN, MS
Chief Clinical Officer
iCare Health Network

PRINTED: 06/22/2022
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075106	A. BUILDING _____ B. WING _____	C 12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDDLESEX HEALTH CARE CENTER	100 RANDOLPH RD MIDDLETOWN, CT 06457

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Unannounced visits were made to Middlesex Health Care Center on 11/1, 11/2, 11/3, 11/4, 11/5, 11/8, 11/9, 11/10, 11/23, 11/24, 12/1 and 12/2/21 by representatives of the Facility Licensing & Investigations Section for the purpose conducting a recertification survey, an extended survey, and multiple complaint investigations, ACTS Reference Number CT30940, CT30806, CT30254, CT30069, CT30187, CT30023, CT30058, CT30652, CT30101, CT30874, CT30766, CT30079, CT29721, CT29695, CT29641, CT29542, CT29511, CT29298, CT29259, CT28931, CT27033, CT30200, CT31213, CT31261 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. As a result of this survey, deficiencies were identified. During an onsite visit 11/23 and 11/24/21 it was identified that for Resident #54, the facility failed to conduct 15-minute safety checks in accordance with the plan of care and failed to initiate the Dr. Hunt policy when an egress door alarm was activated. As a result, the resident eloped from the facility which went unnoticed for approximately sixty (60) minutes until notified by the local authorities. As a result of this failure, Immediate Jeopardy was identified at F689 on 11/24/21. The IJ template was provided to the facility on 11/24/21. During an onsite visit on 12/2/21, the action plan was verified as implemented, therefore, the Immediate Jeopardy was abated.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/20/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1	F 000		

Abbreviations which may be used throughout this document include the following:

Capacity: 150 Census: 110

ADL ('s) - activities of daily living
ADNS/ADON - Assistant Director of Nursing
APRN - Advanced Practice Registered Nurse
BID - twice a day
BIMS- Brief Interview for Mental Status
BM - Bowel Movements
BUN - Blood Urea Nitrogen
C-Diff - Clostridium Difficile (Colitis)
COPD - chronic obstructive pulmonary disease
CVA - cerebrovascular accident (stroke)
DNS/DON - Director of Nursing
DTI - deep tissue injury (pressure related)
ED/ER - emergency department of acute care hospital
ESBL - Extended spectrum beta-lactamase
ESRD - End Stage Renal Disease
FSS/FSD - Food Service Director/ Food Service Supervisor
GI - gastrointestinal
HS - Bedtime
I&O - intake and output monitoring/measuring
IV - intravenous
LPN - Licensed Practical Nurse
MD - Medical Doctor
MDS - Minimum Data Set (interdisciplinary assessment tool)
MI - myocardial infarction (heart attack)
MRSA - Methicillin Resistant Staphylococcus Aureus
MDRO - Multi Drug Resistant Organisms
NA - Nurse Aide
OT - Occupational Therapist
PCV13 - Pneumococcal conjugate vaccine - Prevnar 13

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F 000	Continued From page 2 PPSV23 - Pneumococcal polysaccharide vaccine - Pneumovax 23 PT - Physical Therapist QD-every day RCP - resident care plan RN - Registered Nurse SW - Social Worker VRE - Vancomycin Resistant Enterococcus	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550		1/31/22

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F 550	Continued From page 3 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on review of the clinical record, facility documentation, facility policy and interviews for 2 of 3 residents (Resident #80 and 106) reviewed for an allegation of abuse, the facility failed ensure care was provided in a dignified and respectful manner. The findings include: 1. Resident #80 was admitted to the facility with diagnoses that included bipolar disorder, intellectual disability, and post-traumatic stress syndrome. A quarterly MDS dated 9/15/21 identified Resident #80 had mildly impaired cognition and was independent for bed mobility, transfers, locomotion on the unit and eating. A care plan dated 9/23/21 identified Resident #80 had episodes of anxiety with interventions that	F 550	1. Resident# 80 and Resident#106 continue to reside in the facility. 2. Any resident has the potential to be affected by this alleged practice. 3. The facility policy titled, Resident Bill of Rights was reviewed and remains current. 4. Staff were provided education on the Resident Bill of Rights to ensure all residents are treated and spoken to in a manner to promote their dignity. 5. Random weekly audits will be conducted to ensure residents are treated and spoken to in a manner to promote the resident□s dignity until substantial	

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F 550	Continued From page 4 included to offer support, reassurance and to provide a calm, quiet environment. A care plan dated 10/1/21 identified Resident #80 was a long term resident with interventions that included to encourage expression of feelings and to provide a safe, non- threatening environment. A care plan dated 10/18/21 identified that there was a report that a staff member was heard yelling at Resident #80. Interventions included for staff to listen and be supportive and to speak to the resident in a quiet calm and reassuring manner and to set limits as appropriate. A nurse's note dated 10/19/21 at 7:52 PM identified that the consulting psychology/psychiatric group social worker had reported that LPN #8 was heard yelling at Resident #80 in the hallway. Interview with the consulting psychology/psychiatric group social worker (Psychiatric SW) on 11/3/21 at 1:02 PM identified that LPN #8 was observed speaking loudly and throwing her hands up in the air when addressing Resident #80's request for ginger ale. The Psychiatric SW stated that LPN #8 had expressed to her that she was having a tough day and wasn't feeling well. Additionally, Psychiatric SW indicated that she provides counselling services to Resident #80 who does get fixated on things and on 10/19/21, Resident #80 was fixated on getting ginger ale. Resident #80 appeared to be following LPN #8 and repeatedly requesting the ginger ale. The Psychiatric SW continued by stating that LPN #8 seemed frustrated and responded to Resident #80 to leave her alone and that she did not have time for her/his	F 550	compliance is achieved. The results of the audits will be presented at the QAPI meeting as required. 6. The DNS and/or designee, and Social Service are responsible for the completion of this PoC.	

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F 550	Continued From page 5	F 550		

nonsense and that LPN #8 continued by telling Resident #80 that she knew her family member, and to (not start). Resident #80 then stopped asking for the ginger ale and moved away from LPN #8.

2. Resident #106 was admitted with diagnoses that included dementia without behavioral disturbance, anxiety disorder, major depressive disorder, and chronic pain.

A quarterly MDS dated 7/11/21 identified Resident #106 had severely impaired cognition and was independent for bed mobility, locomotion on the unit and eating, and needed 1 staff assistance with transfers.

A nurse's note dated 10/19/21 at 7:57 PM identified that the consulting psychology/psychiatric group social worker (Psychiatric SW) identified LPN #8 was heard yelling at Resident #80 in the hallway.

Interview with the Psychiatric SW on 11/3/21 at 1:02 PM identified she provides counselling services to Resident #106 and knows the resident well. The Psychiatric SW indicated that on 10/19/21, she observed Resident #106 ask LPN #8 for a cookie, and LPN #8 seemed frustrated and responded to Resident #106 that she didn't have time for this right now and later told Resident #106 here is some food so you'll leave me. Additionally, the Psychiatric SW identified that later in the day when Resident #106 was in front of both herself and LPN #8, and LPN #8 said (he/she's one of those lights on, nobody home type) referring to Resident #106. The Psychiatric SW further indicated Resident #106 responded to LPN #8 calling her crazy.

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F 550	Continued From page 6 Interview with the DNS on 11/4/21 at 8:00 AM identified that based on her investigation the allegation of abuse was unsubstantiated as LPN #8 was partially deaf and generally spoke loudly. The DNS continued by identifying that LPN #8 should not have stated the comments to Resident #80 or Resident #106 and that LPN #8 was re-educated on customer service after the allegations on 10/19/21. Interview with LPN #8 on 11/5/21 at 2:00 PM identified that she does speak loudly and that she does know Resident #80's family and likes to joke around with Resident #80 stating that the comment she made in regard to the lights on and nobody's home was referring to herself not Resident #80. LPN #8 could not recall that she had been accused of making that statement to Resident #106 and could not recall being told about that allegation. The DNS did talk to her after the incident and LPN #8 identified that the DNS told her that the comments, she made to Resident #80 was not consistent with good customer service. The facility's policy on Residents bill of rights directs the residents deserve to be treated with consideration, respect and in full recognition of their dignity and individuality.	F 550		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-	F 580		1/31/22

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F 580	Continued From page 7	F 580		

(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various

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F 580	Continued From page 8 locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on review of the clinical record, facility documentation, facility policy and interview for 1 of 3 residents (Resident #362) reviewed for accidents, the facility failed to ensure the resident's responsible party was notified timely after a fall and for 1 of 3 residents (Resident #601), reviewed for medication administration, the facility failed to ensure that the physician was notified when a medication was unavailable for administration, and for 2 of 6 residents (Resident #44 and #408) reviewed for wounds, the facility failed to ensure the APRN/MD was notified the treatments were not done per order and for 2 of 4 newly admitted residents (Resident #605 and #606), the facility failed to notify the physician when the residents did not receive medications as per physician's order. For one of three sampled residents (Resident #95) who exhibited signs and symptoms of an infection and required oxygen therapy, the facility failed to notify the resident's responsible party, and for 1 resident (Resident #700) reviewed for nutrition, the facility failed to notify the physician when bloodwork was not obtained as ordered and failed to notify the resident representative of a new order. The findings include:	F 580	1. Resident # 44, Resident #95, Resident #362, and Resident #408 continue to reside in the facility. Resident #601, Resident #605, Resident #606, and Resident #700 no longer reside in the facility. 2.Residents who exhibit a change in condition, need to alter treatment, and when physician orders are not implemented are potentially at risk for this alleged deficient practice. 3.The facility policy titled, Condition: Significant Change was reviewed and remains current. 4. Licensed staff will be educated on the facility policy for physician and responsible party notification when a resident experiences a significant change, wound treatment is not completed, bloodwork is not obtained, medication is not available for administration. 5.Random weekly audits will be conducted for compliance with physician/responsible party notification and results will be reviewed at the quarterly QA/QI Meetings until substantial compliance is met. 6.The DNS and/or designee is	

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F 580	Continued From page 9	F 580	responsible for compliance of this PoC	

1. Resident #362's diagnoses included dementia and status post left hip ORIF.

Review of an admission assessment dated 3/10/20 identified that the resident was confused and was dependent on staff for transfers and mobility.

A care plan dated 3/10/20 identified that that the resident was at risk for falls with interventions that included to orient to room, assess after awareness and observe frequently for compliance with safety plan.

Review of the resident's clinical record identified that on 3/10/20 at 9:00 PM the resident was found on the floor in his/her room. The resident was assessed with no apparent injuries and APRN #1 was notified with directive to obtain an X-ray of the left hip.

Review of the resident's record for the period of 3/10/20 at 9:00 PM to 3/11/20 at 10:30 AM failed to identify that the resident's responsible party was notified of his/her fall until 3/11/20 at 10:30 AM when the resident was transferred to the emergency department for a change in condition.

Interview with the Director of Nurses on 11/10/21 at 11:00 AM identified that although she was unable to speak to Resident #362's fall it was the expectation that a resident's family is notified when there is a fall. Additionally, the RN supervisor who assessed the resident after his/her fall was no longer employed at the facility and attempts to reach by telephone were unsuccessful.

The reportable event form dated 3/10/20

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identified that the resident had a fall and the family was notified however review of the resident's clinical failed to identify documentation that the resident's family/responsible party was notified when the resident fell on 3/1020 at 9:00 PM.

Review of the facility's condition change policy identified that the physician and resident or responsible party is notified timely in the event of a change in condition.

The Nursing Documentation Policy identified that notification of family must be documented with specific family member notified.

2. Resident #601 had diagnoses that included hepatic failure and alcoholic cirrhosis of the liver with ascites.

An admission assessment dated 2/15/21 identified Resident #601 as alert with confusion and required extensive assistance with activities of daily living.

Admission physician's orders dated 2/15/21 directed to administer Rifaximin (a medication that helps prevent liver problems) 550 milligrams (mg) two times a day, Ursodiol (a medication used to treat biliary cirrhosis) 300 mg two times a day, Bumetanide (a medication used for fluid retention) 2 mg every morning, and Pantoprazole 40 mg (a medication used to treat acid reflux) once a day at 6:00 AM.

Medication Administration Record (MAR) for February 2021 identified that the 9 AM administration time was initialed for the dose of

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Rifaximin but included parentheses around the signature and the 5 PM dose was not signed off as administered on 2/16/21. The Ursodiol 300 mg was initialed on 2/16/21 at 9 AM and 5 PM but the signatures were surrounded by parentheses. The Pantoprazole 40 mg was not signed off as administered at 6 AM on 2/16/21. The Bumetanide 2 mg was not signed off as administered at 9 AM on 2/16/21.

Interview with the Information Technology specialist on 11/9/21 at 12 PM identified that any signatures that have parentheses around them signified that the medication was either not available or refused by the resident.

Interview with the Pharmacy Representative on 11/10/21 at 2:01 PM in the presence of the interim Director of Nurses (IDON) identified that there are two (2) pharmacy deliveries to the facility, at 2:30 AM and 2:30 PM. The facility faxed Resident #601's medication orders to the pharmacy on 2/16/21 at 2 AM. The Ursodiol, Pantoprazole, and Bumetanide were delivered on the next delivery at 2:30 PM run on 2/16/21. The Rifaximin was delivered on 2/16/21 at 10:30 PM. The pharmacist identified that the medication orders came too late to be delivered on the 2:30 AM delivery, so they were delivered on the next delivery at 2:30 PM, and the Rifaximin was delivered at 10:30 PM on 2/16/21 because it needed to be authorized by the facility because of the cost of the medication.

Interview with the IDON on 11/10/21 at 2:32 PM identified that the Ursodiol, Bumetanide, Pantoprazole, and Rifaximin were not delivered to the facility until 2:30 PM apart from the Rifaximin which was delivered at 10:30 PM on 2/16/21 and

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it would be assumed that Resident #601 did not receive the medication as ordered. The IDON further identified that although there was no specific policy on direction of what to do when the medications is not arrive timely, the physician should have been notified that the medications were unavailable for administration, but she was unable to find the documentation in the clinical record.

Interview with the previous Advanced Practice Registered Nurse (APRN #4) on 11/10/21 at 2:22 PM identified that the facility did not notify her of the missed mediations, and she would have expected notification from the facility.

3. Resident #44 was admitted to the facility in November 2019 with diagnoses that included cancer.

The care plan dated 2/17/21 identified Resident #44 was at risk for skin breakdown related to decreased mobility and urine and bowel incontinence. Interventions included to do treatment as ordered. The care plan did not identify the non-pressure area to the left buttocks/coccyx area.

The quarterly MDS dated 2/19/21 identified Resident #44 had intact cognition, was frequently incontinent of bladder and always incontinent of bowel and required limited assistance for dressing and extensive assistance for toileting and transfers.

Review of nursing progress notes dated 2/20/21-2/28/21 failed to reflect the skin issues, did not

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reflect that the physician was called, or that there was a pressure, or a non-pressure area noted with measurements or description of the area.

A physician's order dated 2/26/21 directed to apply triad paste during the night, in the morning and evening for 14 days to affected area on buttocks stop date 3/11/21.

Review of the March TAR dated 3/1/21 - 3/11/21 identified to apply triad paste every shift three times a day with a stop date of 3/11/21. The TAR identified that out of 33 opportunities for Triad to be administered, 6 were not signed off as completed. Further, as of 3/11/21 there was no treatment for the buttock/coccyx area. The TAR indicated that on 3/16/21 the treatment to the coccyx wound directed to apply Triad followed by a foam dressing daily in the morning and as needed if soiled for 14 days end date 3/30/21. Treatment was not signed off as done on 3/16, 3/22, 3/24, and 3/30/21.

A wound physician note dated 3/2/21 indicated Resident #44 was seen for redness and excoriation to the left buttock. The wound on the left buttock was a full thickness, 2.0cm x 2.0 cm x 0.1 cm, with a scant amount of serous drainage, and wound bed was 76 - 100% granulation. The peri wound was excoriated, moist and red. Recommendations included to apply Triad cream followed by a dry clean dressing, change every 3 days and as necessary for soiling, saturation, or accidental removal.

A nurse ' s note dated 3/3/21 at 12:28 AM identified Resident #44 was seen by the wound doctor with no new orders at this time.

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The wound physician progress note dated 3/9/21 indicated Resident #44's left buttock measured 1.0 cm x 1.5 cm x 0.1 cm scant amount of serous drainage noted. Recommendations included to apply Triad and a dry clean dressing and change every 3 days and as needed for soiling, saturation, or accidental removal.

The wound physician note dated 3/16/21 indicated Resident #44's left buttock measured 2.0cm x 2.0cm x 0.1cm. Recommendations included to apply Triad followed by a dry clean dressing, change every 3 days and as necessary for soiling, saturation, or accidental removal.

A physician's order dated 3/16/21 directed to apply Triad paste to the coccyx wound followed by a foam dressing, change every shift for 14 days, and add foam dressing to triad paste on coccyx every shift and as needed if soiled last date 3/30/21.

Review of the TAR 3/16/21 - 3/30/21 identified a wound treatment to apply Triad followed by a foam dressing, change daily and as needed dated 3/16/21with a stop dated of 3/30/21. The treatment was not done 2 days, and the last treatment was done on 3/29/21, not 3/30/21.

The wound physician note dated 3/23/21 indicated Resident #44's left buttock measured 0.3cm x 1.0cm x 0.1 cm. Recommendations included to apply Triad followed by a dry clean dressing, change every 3 days and as necessary for soiling, saturation, or accidental removal.

The wound physician note dated 3/30/21 indicated Resident #44's left buttock measured 0.3cm x 1.0 cm x 0.1 cm. Orders directed to

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apply Triad hydrophilic wound dressing then apply dry clean dressing change every 3 days and as needed for soiling, saturation, or accidental removal.

The TAR dated 4/1/21 - 4/30/21 noted there was no treatment to the buttock/coccyx area from 4/1/21 - 4/7/21.

The nurse's note dated 4/1/21 at 7:48 AM identified that the non-pressure ulcer weekly assessment for 3/30/21, seen by wound doctor, area improved, measures 0.3 cm x 1.0 cm continue with Triad paste followed by foam dressing.

A grievance form dated 4/5/21 identified Resident #44 complained the dressing to the coccyx was not changed the morning of 4/5/21. The DNS was notified of concern, orders checked and ended on 3/30/21. Will have wound physician follow up.

The wound physician progress note dated 4/6/21 indicated the left buttock was resolved.

A physician ' s order dated 4/6/21 directed to discontinue the foam dressing and apply Triad every shift for 7 days.

A physician's order dated 4/7/21 directed to apply Triad paste followed by a foam dressing to the coccyx wound daily and as needed starting on 4/7/21.

The nurse's note dated 4/7/21 at 1:31 PM identified that weekly assessment seen by wound doctor for MASD to coccyx with treatment of Triad paste followed by a foam dressing much improved seen by wound doctor no new orders.

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F 580	Continued From page 16 Interview with the DNS on 11/4/21 at 9:15 AM noted the infection control nurse was responsible to make sure the weekly wound measurements and treatments were in place for Resident #44 and do weekly wound rounds with the wound physician. The DNS noted the facility had staffing issues so there were times no one would round with the wound doctor. The DNS indicated if the wound doctor saw a resident and put an order in place, she expected the nurses to transcribe and do the treatment until the next week when seen again by the wound doctor. The DNS indicated she thought the treatment from 2/26/21 - 3/11/21 and 3/30/21 - 4/6/21 dropped off because of the stop date on 3/11/21 and 3/30/21 and the nurses would assume it would just continue and not renew the treatment order. The DNS indicated she was not aware prior to surveyor inquiry and clinical record review that Resident #44 did not have a treatment for the wound in place from 3/11/21 - 3/16/21 and 3/30/21 and 4/6/21. The DNS indicated she was not aware of the grievance from Resident #44 regarding the treatment not being done but noted the prior DNS must have been aware. The DNS indicated her expectation was if someone knew or noticed the treatments were not done per the physician ' s orders, the physician should have been notified. Interview and review of the clinical record review with the DNS on 11/4/21 at 12:20 PM indicated she was not able to find any documentation of an RN assessment for a new non pressure area noted on Resident #44 around 2/26/21 when the first treatment was put into place, or that the physician was notified from 2/26/21 until 3/2/21.	F 580		

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The DNS indicated she did not see an RN assessment when the MASD on the coccyx or left buttock began until seen by wound physician on 3/2/21. The DNS could not definitely indicate when the MASD open area began based on the clinical record. The DNS indicated there was a treatment put into place on 2/26/21 but did not know why. The DNS indicated her expectation was when a nurse finds a new open area, he/she must have a registered nurse do an assessment first then call the APRN/MD for a treatment order and call the family. The DNS noted this was not in the clinical record per her expectation. The DNS noted there was so many agency nurses it was hard to keep track of what they do, but she tried.

Interview with RN #4 on 11/5/21 at 9:46 AM indicated when the treatment did not get done per the physician order, the wound doctor should have been notified in both cases.

Interview with APRN #1 indicated she was not notified when Resident #44 ' s treatments were not done during periods from 3/11/21 - 3/16/21 and 3/30/21 - 4/6/21 per the wound physician ' s orders.

Interview with MD #1 on 11/10/21 at 11:30 AM indicated Resident #44's area was on the buttocks across the coccyx. MD #1 indicated there were some weeks he would see residents at this facility and the dressing was dated with his initials and date from the week prior. MD #1 questioned if treatments were being done in the facility and would speak with the DNS on numerous occasions because areas were not getting better. MD #1 indicated he would write in the notes and verbally tell the nurses to utilize the

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treatment order or to follow the recommendations for treatments. MD #1 indicated the wound got bigger from 3/9/21 to 3/16/21 and that would have happened if the treatments were not being done and there was not a barrier for protection. MD #1 indicated Resident #44's area was healed on 4/6/21 and he had put an order for Triad on 4/6/21 to the area for 7 days preventatively. MD #1 indicated no one at the facility informed him that Resident #44 had missed any treatments that he had ordered during March or April 2021.

Although attempted, an interview with prior DNS was not obtained.

Review of Significant Change of Condition identified professional staff will communicate with the physician, resident, and family regarding changes in condition to provide timely communication of resident status change which is essential to quality care management. The physician, resident or responsible party will be notified by the nurse in the event of a change in condition. The notification will be documented in the clinical record.

Review of Nursing Documentation Policy identified licensed nursing personnel documents information related to the residents' condition and care provided in the resident's medical record. A narrative note is written for any change in condition and frequency of this documentation is dependent on individual residents' condition and every shift nurse is required to write a note until situation is resolved. Request for physician services must be documented with time the call was placed and contact made, specific physician nurse spoke with, what physician was notified, and action taken by the physician. Notification of

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family must be documented with specific family member notified, recording of action taken by the nurse and residents' response to, the date and time the call was placed, and specifically what the was notified of.

4. Resident #408 was admitted to the facility in October 2019 with diagnoses that included dementia, heart failure, acute embolism and thrombosis of unspecified deep vein of right lower extremity (on admission), idiopathic peripheral autonomic neuropathy, bilateral pulmonary embolisms, and edema.

The annual MDS dated 6/4/21 identified Resident #408 had severely impaired cognition, was always incontinent of bowel and bladder and required extensive assistance for dressing, eating, toileting, and personal hygiene with one staff.

The care plan dated 6/18/21 identified Resident was at risk for skin breakdown related to decreased mobility. Interventions included treatment as ordered, provide with pressure reducing mattress, turn and reposition frequently, monitor for signs and symptoms of redness or skin breakdown. Perform a weekly body audit.

An APRN order, written by APRN #1 dated 8/4/21 at 1:55 PM directed to apply skin prep to the right heel twice a day, off load right heel when in and out of bed, monitor area for infection, and a wound consult.

The agency nurse's note dated 8/4/21 at 2:55 PM identified a nurse aide found the area on the resident ' s right heel during morning care, and

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the LPN did an assessment and notified the APRN. The APRN wrote a new order to apply skin prep, off load heels while in bed, and to be seen by wound doctor. Responsible party aware.

Review of an APRN note, written by APRN #1 dated 8/4/21 at 11:58 PM identified that Resident #408 was seen for a closed right heel blister measuring 3.0 cm x 4.0 cm. New order for skin prep, off load heels in and out of bed, monitor for signs of infection, and a wound consult.

Physician ' s order dated 8/4/21 at 3:11 PM directed to apply skin prep to the right heel blister every day and evening.

Review of the August TAR dated 8/1/21 - 8/31/21 failed to reflect Resident #408 received the skin prep to the right heel blister 8/4/21 through 8/31/21.

An APRN note, written by APRN #1 dated 9/7/21 at 9:35 PM identified that Resident #408 ' s right heel blister had opened and measured 4.0 cm x 4.0 cm with no drainage. New order directed to cleanse with normal saline, apply xeroform followed by kerlix, continue to off load heels and consult wound team.

An APRN note, written by APRN #1 dated 9/17/21 at 4:27 PM indicated Resident #408 currently was being treated for a right heel wound, and a stage 1 to the coccyx. Resident followed by the house wound physician.

The wound physician note dated 9/21/21 identified a right heel pressure wound resolved, no treatment needed (this was the only wound physician note in the clinical record).

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Review of the TAR dated 9/1/21 - 9/30/21 indicated Resident #408 did not receive the skin prep to right heel twice a day from 9/1/21 -9/7/21 and had a new order starting 9/8/21 with a stop date 9/22/21 to cleanse the right heel pressure ulcer with normal saline apply xeroform followed by kerlix once a day. Resident #408 only received the treatment 4 days out of 14 days.

Interview with RN #4 on 11/5/21 at 9:46 AM indicated if treatments were not done per physician or APRN orders the physician and responsible party should be notified and documented in the clinical record. RN #4 indicated she did not see documentation in the clinical record that the physician or responsible party were notified of the missed treatments, or the responsible party was notified when the right heel opened and was larger in size with a new treatment order.

Interview with the DNS on 11/5/21 at 11:30 AM identified the agency nurse that placed the treatment order into the computer put the order in wrong which resulted in Resident #408 not getting the treatment ordered from 8/4/21 - 9/7/21. The DNS noted because the agency nurse did not put the order in the computer correctly, the order never came up on the TAR for the nurses to do the treatment twice a day. The DNS indicated she did not see a progress note in the medical record indicating the APRN, wound physician, or responsible party were notified that the treatment wasn't done. The DNS was not able to explain why the wound consult took over a month, between 8/4/21 until 9/21/21 to be done. The DNS indicated her expectation was when the APRN ordered a wound consult on 8/4/21 that

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Resident #408 would have been seen the next Tuesday on 8/10/21 when the wound physician comes in. The DNS indicated the wound physician comes in every Tuesday. The DNS could not explain why it took 7 weeks for Resident #408 to be seen by the wound physician until 9/21/21.

Interview with the DNS on 11/5/21 at 12:20 PM noted she was not aware that Resident #408 did not receive the treatment to the right heel pressure area from 9/7 - 9/16/21, and 9/18/21. The DNS noted if she was aware or a nurse her expectation was the APRN or physician and responsible party would be notified and documented in the clinical record.

Interview with APRN #1 indicated she was not notified that Resident #408's treatment was not done from 8/4/21 until 9/7/21. APRN #1 indicated she expected the nurses to initiate the treatment right away to the right heel when she ordered it on 8/4/21. APRN #1 noted if the treatment wasn't done, she would expect to be notified. APRN #1 indicated she ordered skin prep and ordered a wound consult. APRN #1 indicated she was aware the wound doctor comes in every week on Tuesdays and expected Resident #408 to be seen within a week of her recommendation. APRN #1 indicated she was asked on 9/7/21 to evaluate the right heel because the blister had opened. APRN #1 indicated had seen Resident #408 and gave orders for the right heel at the beginning of August, and she was asked again to evaluate the right heel because it was open. It did not look infected and she did not realize she had put in for the wound consult on 8/4/21 so she again asked for a wound consult on 9/7/21. APRN #1 noted no one had notified her or

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informed her that Resident #408 had not been seen by the wound physician from when she ordered it on 8/4/21, and her expectation was when the order was put in the nurses would follow through with the order and if not for some reason would inform her. APRN #1 indicated she prefers for the wound physician to see and follow all wounds because he is the expert for wounds. APRN #1 indicated she does not follow any wounds weekly. APRN #1 indicated she was not notified Resident #408 did not receive his/her treatment from 9/7/21 - 9/16/21 and 9/18/21 per her treatment order.

Interview with MD #1 on 11/10/21 at 11:30 AM indicated most times he did the wound rounds by himself without the assistance of a facility staff person. MD #1 indicated there was no infection control nurse to do rounds with him, and occasionally the ADNS would start the rounds with him and go off to do something else and not come back, or the ADNS would be on a floor passing medications. MD #1 indicated it was the responsibility of the ADNS and the DNS to keep a list each week for him so he would know whom he needed to see each week whether new or a follow up. MD #1 indicated if a resident was not on the list they would not be seen because he was not able to remember week to week everyone that needed to be seen. MD #1 indicated he only saw Resident #408 once on 9/21/21. MD #1 indicated that no one at the facility had informed him the treatment ordered by the APRN had not been done for August or September 2021. MD #1 indicated no one at the facility prior to 9/21/21 informed him that Resident #408 had a pressure area on the right heel or that the APRN had requested a wound consult on 8/4/21. MD #1 indicated he was upset because

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he was at the facility every week on Tuesdays and no one asked him to see Resident #408's heel and he questions the nurse's on each unit, every week asking if there are any new residents that need to be seen and there was a book at the nurses station he looks in every week that the nurses could add in a new resident to be seen. Resident #408 was not in his book.

Interview and review of the clinical record with the DNS on 11/5/21 at 12:20 PM failed to provide documentation that the physician or APRN or the responsible party were notified the treatments were not done per physician orders, or that the wound consult was not done as per the recommendation on 8/4/21. Further, the responsible party was not updated when Resident #408's right heel wound opened and was larger in size and needed a new treatment.

Review of the Physicians Orders - Transcription policy indicated all written or telephone physicians' orders must be duly noted and accurately transcribed by a licensed nursing staff. Check physicians order for physicians' signature, date and time. Carefully transcribe orders as written to the Treatment Record. The nurse will write noted, sign first initial and last name, title, time with am or pm and complete date.

Review of the Significant Change of Condition policy indicated professional staff will communicate with the physician, resident, and family regarding changes in condition to provide timely communication of resident status change which is essential to quality care management. The physician, resident or responsible party will be notified by the nurse in the event of a change in condition. The notification will be documented

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in the clinical record.

Review of the Nursing Documentation Policy identified licensed nursing personnel documents information related to the residents' condition and care provided in the resident's medical record. A narrative note is written for any change in condition and frequency of this documentation is dependent on individual residents' condition and every shift nurse is required to write a note until situation is resolved. Request for physician services must be documented with time the call was placed and contact made, specific physician nurse spoke with, what physician was notified, and action taken by the physician. Notification of family must be documented with specific family member notified, recording of action taken by the nurse and residents' response to, the date and time the call was placed, and specifically what the was notified of.

5. Resident #605 was admitted to the facility on 12/4/20 with diagnoses that included hypertension, hyperlipidemia, COVID-19, and gastroesophageal reflux disease (GERD).

Physician orders dated 12/5/21 directed Escitalopram Oxalate (a medication to treat depression) 20 milligrams (mg) by mouth daily, Flonase (a medication to prevent asthma attacks) 50 micrograms/activated clotting time (mcg/act) suspension spray daily, Clozapine (an antipsychotic medication) 12.6 mg by mouth twice a day, Lipitor (a medication to treat hyperlipidemia) 20 mg by mouth daily, Artificial Tears (a medication to treat dry eyes) solution to both eyes twice a day, Memantine (a medication to slow the progression of dementia) 14 mg by

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mouth daily, Pantoprazole (a medication to treat GERD) 40 mg by mouth daily, Prednisone (a steroidal medication to treat inflammation) 20 mg by mouth daily and Xarelto (a medication to treat and prevent blood clots) 20 mg by mouth daily.

The Medication Administration Record (MAR) for 12/4/20, 12/5/20 and 12/6/20 identified Escitalopram Oxalate was to be administered at 9:00 AM first dose on 12/5/20, Flonase was to be administered at 9:00 AM first dose on 12/5/20, Clozapine was to be administered at 9:00 AM and 5:00 PM first dose on 12/5/20, Lipitor was to be administered at 9:00 PM first dose on 12/5/20, Artificial Tears solution was to be administered at 9:00 AM and 5:00 PM first dose on 12/5/20. The MAR further identified Memantine was to be administered at 9:00 AM first dose on 12/5/20, Pantoprazole was to be administered at 9:00 AM on first dose 12/5/20, Prednisone was to be administered at 9:00 AM first dose on 12/5/20, and Xarelto was to be administered at 5:00 PM first dose on 12/5/20.

The MAR identified on 12/5/20, 9:00 AM medications consisting of Escitalopram Oxalate 20 mg, Flonase 50 mcg/act suspension, Clozapine 12.6 mg, Artificial Tears, Memantine 14 mg, and Pantoprazole 40 mg were not administered as directed by the physician.

The MAR identified on 12/5/20, 5:00 PM medications consisting of Clozapine 12.6 mg, Xeralto 20 mg, and Artificial tears were not administered. Additionally, Lipitor 20 mg was not administered at 9:00 PM on 12/5/20 per physician's order.

The MAR also identified on 12/6/20, 9:00 AM

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medications consisting of Escitalopram Oxalate 20 mg, Flonase 50 mcg/act suspension spray, Clozapine 12.6 mg, Memantine 14 mg, and Pantoprazole 40 mg were not administered per physician's order.

The MAR also identified on 12/6/20, 5:00 PM medications consisting of Clozapine 12.6 mg, Artificial tears and Xeralto 20 mg were not administered. Additionally, Lipitor 20 mg was not administered at 9:00 PM on 12/6/21 per physician's order.

Interview with Pharmacist #1 on 11/10/21 at 11:30 AM identified Resident #605's medication order was received by the pharmacy on 12/5/20 at 3:30 AM and Resident #605 medications left the pharmacy for delivery to the facility on 12/6/20 at 6:00 AM.

6. Resident #606 was admitted to the facility on 12/4/20 with diagnoses that included hypertension, COVID-19, and gastroesophageal reflux disease (GERD).

Physician orders dated 12/5/21 directed Amlodipine (a medication to treat hypertension)10 mg by mouth daily, Eliquis (a medication to treat and prevent blood clots and stroke) 5 mg by mouth twice a day, Pantoprazole (a medication to treat GERD) 40 mg by mouth daily.

The Medication Administration Record (MAR) for 12/4/20 and 12/5/20 identified Amlodipine was to be administered at 9:00 AM first dose on 12/5/20, Eliquis was to be administered at 9:00 AM and 9:00 PM first dose 12/5/20 and Pantoprazole was to be administered at 9:00 PM first dose on

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The MAR identified Amlodipine 10 mg at 9:00 AM on 12/5/20, Eliquis 5 mg at 9:00 AM on 12/5/20 and Pantoprazole 40 mg at 9:00 PM on 12/5/20 were not administered as per physician's order.

Interview with Pharmacist #1 on 11/10/21 at 11:30 AM identified Resident #606's medication order was received by the pharmacy on 12/5/20 at 2:18 AM and the medications left the pharmacy for delivery to the facility on 12/6/20 between 2:00 AM to 3:00 AM. Pharmacist #1 indicated medication was being delivered to the facility twice a day, at 2:00 PM and 2:00 AM during the week, Saturdays at 1:00 PM and 9:00 PM and Sundays at 12:00 PM and 9:00 PM. Pharmacist #1 identified STAT drivers were available for delivery of medications if necessary with a 4 hour turnaround time.

Interview and clinical record review with Acting Director of Nursing (ADON) on 11/10/20 at 11:30 AM identified the medical provider was to be notified when medications were not available, or medications were not administered as per the physician's order. The ADON indicated the medical provider was not notified Resident #605 and Resident #606 did not receive medications.

Interview with MD #3 on 11/10/21 at 12:01 PM identified he was not notified Resident #605 and Resident #606 did not receive medications on 12/4/20, 12/5/20 and 12/6/20. MD #3 indicated he and the APRN wouldn't find out that medications were not available until days later.

The Admission/Readmission checklist directed to order medications, please make physician/APRN

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aware of any medications not available and obtain order to start medications when available and document.

7. Resident #95's diagnoses included dementia with behavioral symptoms, dysphagia (difficulty swallowing), cerebrovascular accident, and metabolic encephalopathy.

The quarterly Minimum Data Set assessment dated 9/11/20 identified Resident #95 rarely or never made decisions regarding task of daily life and had a history of pneumonia and septicemia.

The resident care plan dated 9/24/20 identified Resident #95 was at risk for upper airway complications and had a history of ineffective airway. Interventions directed to observe for signs and symptoms of respiratory complications, obtain vital signs and update the physician as needed. The care plan evaluation identified the goal was met on 9/17/20 and the problem was discontinued.

The nurse's note dated 11/6/20 at 1:29 PM identified the Advanced Practice Registered Nurse (APRN) ordered urine specimens secondary to lethargy, to continue to monitor Resident #95's vital signs for three (3) days, and bloodwork to be obtained on 11/9/20. The note failed to reflect documentation Resident #95's responsible party was notified of the orders and change in Resident #95's condition.

The nurse's note dated 11/7/20 at 2:04 PM identified Resident #95 had no congestion, cough, the lungs were clear to auscultation and the oxygen saturation level was 94% on room air.

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The nurse's note dated 11/8/20 at 7:57 AM identified lung sounds were clear and Resident #95's oxygen saturation level was 98% on two (2) liters of oxygen. The note failed to reflect documentation Resident #95's responsible party was notified of the application of the oxygen therapy.

Upon further review, the nurse's notes from 11/8/20 through 11/9/20 identified Resident #95's responsible party was notified on 11/9/20 at 10:51 PM of the chest x-ray results, mild congestive heart failure.

The grievance sheet dated 1/10/20 identified Resident #95's responsible party reported he/she had not been notified Resident #95 had a change in condition when oxygen therapy was administered.

In an interview with Resident #95's responsible party (Person #4) on 11/8/21 at 1:45 PM identified the facility did not notify him/her on 11/8/20 when the oxygen was administered.

In an interview with the Director of Nursing (DON) on 11/10/21 at 9:30 AM identified when the oxygen was initiated for a change in Resident #95's condition, the responsible party should have been informed.
The facility policy Condition: Significant Change directs staff to communicate with the physician, resident and family regarding changes in condition to provide timely communication of the resident status change which is essential to quality care management. The policy indicates the physician, resident, and/or responsible party will be notified by the nurse in an event of a

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change in condition.

8. Resident #700 was admitted to the facility on 11/13/21 with diagnoses that included Covid 19, dysphagia, schizophrenia, weakness, gastro-esophageal reflux disease, and stage IV malignant neoplasm of colon.

The care plan dated 11/13/21 identified Resident #700 required extensive assistance due to a recent hospitalization for Covid 19. Interventions included allow resident to make choices, ask and encourage resident to participate to the full extent that he/she is able.

The admission MDS dated 11/19/21 identified Resident #700 had intact cognition, required supervision with eating and one-person physical assist.

A physician's order dated 11/20/21 directed to obtain bloodwork - complete blood count, and basic metabolic panel.

Review of the nurse's note dated 11/20/21 failed to reflect documentation of the APRN new order for blood work or notification to the resident representative of the new order for bloodwork.

The nutrition assessment dated 11/21/21 at 4:11 PM identified Resident #700 ' s diet was regular mechanical soft (dental) ground texture, thin liquids. Recommendations included to initiate magic cup with lunch and dinner and house supplement 120 ml twice a day. Resident #700 eats in his/her room with assistance. Weight

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136.5 lbs. on (11/14/21) with mechanical lift. Hospital weight was 145.3 lbs. Resident #700 is alert and oriented and has their own teeth. Resident consumed 51% - 75% of meals. Mechanical altered diet in place currently secondary to diagnosis. Albumin decreased indicating moderate depletion of visceral protein stores. Recommend Magic cup twice a day and house supplement for optimal nutritional intakes. Resident #700 is at high nutritional risk secondary to diagnosis and low albumin. Swallowing difficulty secondary to diagnosis. Planning: Goals as per care plan. Continue with diet as ordered, monitor for need to adjust as needed.

A physician's order dated 11/21/21 directed to provide regular diet mechanical soft (dental) ground texture, thin liquids consistency.

Review of the physician's orders dated 11/21/21 through 11/24/21 failed to reflect documentation for an order for magic cup twice a day with lunch and dinner or house supplement 120 ml.

The care plan dated 11/22/21 identified Resident #700 is at risk for weight loss due to symptoms of dysphagia, diagnosis of colon cancer, and variable appetite. Interventions included determine and offer food preferences. Monitor food intake with every meal. Offer snacks between meals and meal substitutions as appropriate. Offer bedtime snacks. Likes ice cream, and milkshakes. Provide magic cup with lunch, dinner, and house milkshake 120 ml twice a day.

Review of the nurse's note dated 11/22 and 11/23/21 failed to reflect documentation that the responsible party was notify of the new diet order

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and failed to reflect bloodwork was obtained or the physician was notified the bloodwork was not obtained.

The nurse's note dated 11/24/21 at 1:17 PM identified Resident #700 was seen by the APRN on rounds for lethargy, and new order for STAT bloodwork, Intravenous Fluids D5 ½ Normal Saline at 100 ML an hour times 2000 Liters to start when peripheral line is placed. Fluids encouraged and bloodwork obtained. Awaiting results.

The APRN progress note dated 11/24/21 at 2:38 PM identified Resident #700 was being seen for a fall. Nursing reported Resident #700 was found sitting on the floor. Resident #700 denied dizziness, headache, chest pain, and shortness of breath. Denies hitting his/her head. Resident #700 appears fatigued and dry this visit. Person #2 at bedside who reported Resident #700 is much slower to respond than baseline. APRN indicated she discussed the plan for intravenous hydration and blood work with Person #2. Muscle skeletal strength 5/5 in upper and lower extremities. Resident #700 was awake, alert, with no aggression or agitation identify. Fall likely due to dehydration and weakness. New order for Intravenous Fluid D5 ½ Normal Saline at 100 ML an hour times 2 Liters and blood works. Continue to monitor neurological status per fall protocol and notify with any acute changes.

The nurse's note dated 11/24/21 at 10:58 PM identified Resident #700 was sent to the hospital for evaluation due to abnormal bloodwork per the APRN new order. The nurse's note failed to reflect documentation what time the resident had left the facility.

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Interview with RN #1 identified he was not aware of the issue. RN #1 identified the nurses should have contacted supervisor when the bloodwork was not obtained.

Interview with the DNS on 12/12/21 at 1:34 PM identified she was not aware and indicated the bloodwork should have been obtained the day the APRN ordered it. She also indicated the nurses should have notified the APRN, the RN supervisor and the DNS that the bloodwork was not obtained in a timely manner. The DNS also indicated the nurses should have notified the responsible party with new orders.

Interview with APRN #1 on 12/2/21 at 1:39 PM identified LPN #8 notified her that Resident #700 was on the floor in the room. APRN #1 indicated when she arrived at Resident #700 room the resident was in the bed. APRN #1 indicated she assessed Resident #700 in the bed, and he/she complained of feeling weak. APRN #1 indicated Person #2 was at the bedside and she discussed the plan of care with Person #2. APRN #1 indicated she ordered intravenous hydration and blood work STAT. APRN #1 indicated she had ordered bloodwork on 11/20/21 and it was not collected that is why she ordered bloodwork again on 11/24/21 STAT. APRN #1 indicated the facility did not notify her that the bloodwork for (11/20/21) was not obtained or collected as ordered. The APRN indicated Resident #700 was transferred to the hospital sometime after 5:30 PM.

Review of the facility condition: significant change policy identified professional staff will communicate with the physician, resident/patient, and family regarding changes in condition to

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F 580	Continued From page 35 provide timely communication of resident/patient status change which is essential to qualify care management. The physician, resident/patient and/or responsible party will be notified by the nurse in the event of a change in condition. Order changes given by the physician will carried out, including emergency transport if necessary. This notification shall be documented in the clinical record. The facility failed to notify the physician or APRN timely when bloodwork that was ordered was not obtained and failed to notify the resident representative of the new orders.	F 580		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.	F 585		1/31/22

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F 585	Continued From page 36 §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being	F 585		

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F 585	Continued From page 37 investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 resident (Resident #15) reviewed for grievances, the facility failed to ensure the grievances were investigated, including a resolution, in a timely	F 585	1. Resident# 15 continues to reside in the facility. 2. Any resident has the potential to be affected by this alleged deficient practice. 3. The facility policy titled, Grievance	

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F 585	Continued From page 38 manner. The findings include: Resident #15 was admitted to the facility in September 2018 with diagnoses that included cancer and diabetes. Review of the grievance log dated 4/5/21 - 7/1/21 identified several grievances filed by Resident #173. The log failed to reflect 5 grievances that were submitted by Resident #15 via other means and were not in the grievance log. The quarterly MDS dated 4/16/21 identified Resident #15 had intact cognition, was independent with personal hygiene, dressing, toileting, and transfers. A social service note dated 4/22/21 at 8:46 AM identified Resident #15 prefers to email his/her concerns to proper staff. A grievance form dated 4/30/21 identified a concern with the number of nursing staff on the unit during the 3:00 PM - 11:00 PM shift, and there was no coverage in case of emergency. A grievance dated 4/30/21 at 6:45 PM identified fire doors slammed by DNS because a resident that wanders was trying to leave, and now other residents were restrained with only 1 staff member on unit. A grievance filed via email dated 5/3/21 identified concerned that the grievance book had been moved since 4/30/21 and no one even left blank grievance forms available if a resident wanted to file a grievance. A grievance dated 5/1/21 identified during the 3:00 PM - 11:00 PM shift the facility had only 1 staff member on unit, dinner was served late, cold, and missing items. Spoke with the ADNS	F 585	Policy was reviewed and remains current. 3. Licensed staff were provided education on the facility□s Grievance Policy to ensure that each resident has a grievance investigated in a timely manner and receives the resolution of the grievance timely. 4.Random audits will be conducted weekly to ensure the facility Grievance Policy is implemented to ensure every grievance is investigated and the resolution provided to the resident timely until substantial compliance is achieved. The results of the audits will be presented at the QAPI as required. 5. The Grievance Officer and/or designee is responsible for the completion of this PoC.	

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about needing assistance to get his/her medications. ADNS told Resident #15 to go to another unit to ask nurse to give his/her medications.
A grievance dated 5/6/21 at 6:00 PM identified Resident #15 had ordered chicken pot pie, 2 diet cokes, and an apple. Resident #15 received 2 pieces of baked chicken, mashed potatoes, a pear, and 2 cokes. Chicken was dry, potatoes watery. No one answered phone in dietary. The grievance form has area for follow up response or plan of action which was blank and date of response/plan of action reported to resident was blank.

Email dated 4/30/21 at 8:12 PM (grievance dated 4/30/21 at 6:45 PM) regarding fire doors closed was forwarded via email from Resident #15 to the social worker at the facility and the Ombudsman.

Email dated 4/30/21 at 8:13 PM (grievance dated 4/30/21 3:00 PM - 11:00 PM) about staffing and the grievance book being removed was sent from Resident #15 to the social worker at the facility.

Email dated 5/1/21 at 7:39 PM (grievance dated 5/1/21) problems with dinner served late, cold food, and meal ticket and tray did not match. Emailed from Resident #15 to the Administrator and the social worker at the facility.

Email dated 5/6/21 at 6:58 PM (grievance dated 5/6/21) noted regarding concerns with dinner. Sent from Resident #15 to the social worker and dining services at facility.

Observation and interview with Resident #15 on 11/2/21 at 2:50 PM identified he/she had filed grievances and was not informed of the

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resolutions to the grievances verbally or in writing. Resident #15 indicated she would fill out grievance and would not hear anything, so he/she started to fill out the grievance forms on the computer and email the grievance to the social worker, administrator, and dietary department heads to keep track of the grievances filed. Resident #15 indicated there were still grievances she thinks the management threw away and did not respond to. Resident #15 indicated she had asked the nurse's, social worker and administrator who was the grievance officer, and no one could tell him/her. Resident #15 indicated the new administrator who had been at the facility about 6 weeks was very responsive to the grievances but the prior administrator he/she believed threw the grievances out.

Interview with Administrator on 11/4/21 at 11:45 AM noted after review of the grievance log and records he was not able to locate the grievances dated 4/30/21 at 6:45 PM, 4/30/21 at 3:00 PM, 5/3/21 not timed, 5/1/21 at 3:00 PM, and 5/6/21 at 6:00 PM. The Administrator indicated the prior administrator and social worker must have received the emailed grievances from Resident #15 because he receives them currently. The Administrator noted when he receives an email/grievance from Resident #15 he will go to discuss the grievance and the steps he will take to follow up on the grievance with resident. The Administrator indicated the social worker was responsible to complete the grievances but has not worked at the facility for the last 3 weeks and he was currently interviewing for a new social worker. The Administrator noted the regional social worker had been coming to the facility a few days a week to help. The Administrator indicated his expectation was that every

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F 585	Continued From page 41 grievance should be logged in the grievance book and have a resolution whether it was verbally told to a staff member, filed out by a resident, or emailed from a resident. The Administrator indicated the resident or who files out the grievance should be informed verbally or in writing the resolution to the grievance. The Administrator noted these 5-grievances filed by Resident #15 were not addressed at that time. Review of Resident Bill of Rights identified the resident has the right to voice grievances without discrimination or reprisal. Additionally, have the right to have prompt efforts made by the facility to resolve any grievances you may have. Review of Grievance Policy identified the grievance officer was responsible to oversee the grievance process including receiving and tracking grievances to conclusion, conducting necessary investigations, issuing written grievance decisions to residents as requested. Residents will be notified individually the right to file a grievance and a reasonable time frame for completing the review of the grievance. Review of any grievances filed should be completed within 7 days.	F 585		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 602		1/18/22

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This REQUIREMENT is not met as evidenced by:
Based on review of the clinical record, facility documentation, facility policy and interviews for 1 resident (Resident #359) reviewed for misappropriation of resident property, the facility failed to ensure the resident was free from misappropriation. The findings include:

Resident #359 was admitted to the facility on 7/17/19 with diagnoses that included diabetes and COPD.

The 5-Day PPS MDS dated 4/1/21 identified Resident #359 had intact cognition, required total 2-person assistance with bed mobility, dressing and toilet use and required oxygen.

The care plan dated 4/8/21 identified Resident #359 was at risk for changes in mood/behavior. Interventions included all staff to minimize/ameliorate psychosocial stressors, validate feelings, build trust and rapport and refer for psychiatric services as needed.

A reportable event form dated 4/20/21 identified Resident #359 reported that he/she let a staff member, LPN #5, borrow $1500.00 and has not

Past noncompliance: no plan of correction required.

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received the money back yet.

A written statement dated 4/15/21 indicated LPN #5 did not borrow any money from any resident in the facility.

A statement dated 4/15/21 identified the SW and ADNS met with Resident #359 who stated he/she lent $1500.00 to an LPN at the facility under the pretense that this would be paid back. Resident #359 indicated he/she spoke to the LPN on Monday 4/12/21 and requested the money be returned in 48 hours but he/she has not yet received the money back.

Facility documentation included in the investigation was printed text messages from Resident #35' s phone between LPN #5 and Resident #359. In an interview with the former DNS on 11/3/21 at 1:15 PM, the former DNS verified the authenticity of the copies of the text messages as having come from Resident #359's phone.

A text message dated 4/9/21 from Resident #359 to LPN #5 read "sooner. No more bs. 2 day!!!?? $$?? "

A text from LPN #5 to Resident #359 read "Can I give you $500.00 now and the rest when I get back? Text me your account number."

In response, Resident #359 texted "you have deposit slips."

Text message dated 4/10/21 from Resident #359 to LPN #5 read "yeah, that's why I have been waiting this long for my money. Suppose there are other steps to take to get it back. NEVER

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again will I trust anyone."

A text from LPN #5 to Resident #359 dated 4/13/21 read "thanks for keeping your word, expected nothing less ". Resident #359 responded "bull crap, 48 hours to take care of this or I will take other action. Shouldn ' t have to come to this."

A text message from LPN #5 to Resident #359, undated, read "There are no Webster banks down hear so calm down momma. I'll deposit it on Monday when I get back."

A text message from Resident #359 to LPN #5 , undated, read "Don't smart mouth me. This should have been resolved."

A text message from LPN #5 to Resident #359, undated, read "Can I put the money in the bank next week definitely only because I have to go somewhere this weekend and I won't have any money if I deposit it. Not messing with you I swear, I'm paying you next week. "

Resident #359 is no longer a resident at the facility and is unable to be interviewed.

The DNS provided surveyor with LPN #5's phone number that she retrieved from her own personal contacts. The phone number provided matched the phone number associated with the text messages Resident #359 received from LPN #5.

Attempts to interview LPN #5 were unsuccessful.

Interview with the DNS on 11/3/21 at 1:15 PM identified she was in the room when the former DNS interviewed LPN #5. The DNS recalled that

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F 602	Continued From page 45 LPN #5 stated she knew that she should not borrow money from residents. Review of the facility's Abuse Prohibition Policy identified every facility has the responsibility to ensure that each resident has the right to be free from abuse, mistreatment, neglect, exploitation and misappropriation of his or her personal property. Review of a Quality Improvement plan document identified that on 4/16/21 entitled: (to ensure that residents are free from misappropriation of funds/property) identified a completion date of 4/22/21. Action steps included to educate staff on the facility ' s abuse policy which prohibits borrowing/accepting money or property from residents with random audits conducted to ensure residents are free from misappropriation of funds and property. Documentation of completion of the action steps included in-service attendance sheets on the in-service topic of misappropriation and abuse and audits that reviewed Resident's grievances dated 5/3/21 to 10/19/21 with no issues identified.	F 602		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations	F 644		1/31/22

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F 644	Continued From page 46 from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on review of the clinical record, facility documentation, facility policy and interviews for 1 of 7 residents (Resident #91) reviewed for PASRR, the facility failed ensure a PASRR level II was completed when the resident had a diagnosed with major depression and bipolar disorder. The findings include: Resident #91 was admitted with diagnoses that include a stroke with right sided hemiplegia and hemiparesis and major depressive disorder. A PASRR level 1 dated 11/10/16 identified Resident #91 had a negative Level 1 PASRR screen. The PASRR lacked documentation that Resident #91 had a diagnosis of major depression. Resident #91's face sheet identified that on 5/3/18 the diagnosis of bipolar disorder was added. A quarterly MDS dated 6/28/19 identified Resident #91 had active psychiatric/mood disorder that included depression and bipolar	F 644	1. Resident# 91 continues to reside in the facility. 2. Any resident has the potential to be affected by this alleged deficient practice. 3. The Ascend Manual which is utilized by the facility was reviewed and remains current. 3. Social Service staff were provided education on the Ascend Manual to ensure that a resident identified with a new diagnosis that requires a Level 2 assessment, will have the Level 2 assessment completed. 4.Random audits will be conducted weekly to ensure the Ascend Manual is implemented to ensure a resident identified with a new diagnosis that requires a Level 2 assessment, has the Level 2 assessment completed until substantial compliance is achieved. The results of the audits will be presented at the QAPI as required. 5. Social Service or designee are	

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F 644	Continued From page 47 disease. A review and interview with Social Worker #2 on 11/3/21 at 11:00 AM identified Resident #91's medical record lacked a completed PASARR level II assessment since admission. SW #2 identified that a PASRR level II should have been completed due to Resident #91's diagnoses of major depression and bipolar disorder as it would meet the definition of a mental health disability. Subsequent to surveyor's observation, SW #2 submitted a PASRR level II on 11/4/21.	F 644	responsible for the completion of this PoC.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs	F 657		1/31/22

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F 657	Continued From page 48 or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, review of the clinical record, facility documentation and interview for 3 of 6 residents reviewed for pressure ulcers (Resident #44, 97 and 408) the facility failed develop a comprehensive care plan related to pressure ulcer care. The findings include: 1. Resident #97's diagnoses included dementia and diabetes. The quarterly MDS dated 7/2/21 identified Resident #97 had severely impaired cognition, required total 2-person assistance with transfers between surfaces and bed mobility including turning from side to side, was always incontinent of bladder and bowel and had no skin impairment but was at risk for developing pressure ulcers. The care plan dated 7/16/21 identified Resident #97 was at risk of developing skin breakdown related to decreased mobility and occasionally incontinent of bowels. Interventions included the provision of a pressure reducing mattress, reposition every 2 hours, inspect skin daily for signs and symptoms of redness or breakdown and perform weekly skin checks.	F 657	1. Resident #44, Resident #97, and Resident #408 continue to reside in the facility. 2. Any resident has the potential to be affected by this alleged deficient practice. 3. The facility policy titled, Comprehensive Care Plan was reviewed and remains current. 3. Licensed Staff were provided education on the facility Comprehensive Care Plan Policy to ensure that any resident that develops a pressure ulcer has the care plan revised to include the wound. 4.Random audits will be conducted weekly to ensure the facility Comprehensive Care Plan Policy is implemented to ensure any resident with a pressure ulcer has the care plan revised to include the wound until substantial compliance is achieved. The results of the audits will be presented at the QAPI as required. 5. The DNS or designee is responsible for the completion of this PoC.	

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A physician's order dated 8/23/21 directed to apply barrier spray followed by form dressing to the coccyx wound.

Review of an APRN note, written by APRN #1, dated 8/26/21 identified Resident #97 was being seen at the request of nursing for a stage II pressure ulcer to the coccyx. The note indicated Resident #97 was mainly bedbound and at risk for skin breakdown and indicated that the plan for the stage II pressure ulcer was to start utilizing a form dressing and refer the resident for a wound consult. The note failed to reflect measurements and or any other description of the identified stage II pressure ulcer on the coccyx.

Review of the August 2021 TAR failed to reflect the barrier spray followed by form dressing to the coccyx wound, ordered on 8/23/21 was being completed.

The annual MDS dated 10/2/21 identified Resident #97 had severely impaired cognition, no behaviors, required total 2-person assistance with transfers between surfaces and bed mobility including turning from side to side, was always incontinent of bladder and bowel and had no skin impairment but was at risk for developing pressure ulcers.

A nurse's noted dated 10/10/21 at 3:43 PM identified that Resident #97 had a sacral wound that was assessed by the wound doctor and that a new treatment was ordered.

A Wound Care Specialist note, written by the wound doctor, (MD #1) dated 10/12/21 identified that Resident #97's family member noted a

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wound on the resident ' s sacral area and is worried that staff is not changing his/her undergarment frequently. The sacral wound was identified as a stage three III pressure injury that measured 0.2 cm x 0.2 cm x 0.3 cm. The assessment included additional orders that included pressure relief/offloading, pressure redistribution mattress per facility protocol and to offload/ reposition the resident every 2 hours.

A physician's order dated 10/12/21 directed to apply Calcium Alginate with foam daily to coccyx stage three III ulcer.

An APRN note, written by APRN #1 dated 10/12/21 identified Resident #97 has a sacral pressure ulcer and does not currently have an air mattress.

The care plan dated 10/18/21 (first written on 10/8/21) identified Resident #97 is at risk of developing skin breakdown related to decreased mobility and incontinent of bladder and bowel. Interventions included provision of a low air loss mattress and provide turning and repositioning approximately every 2 hours and as needed.

An APRN note, written by APRN #1 dated 10/21/2021 identified that Resident #97 had a stage III pressure ulcer on the coccyx and (we will order an air mattress for the patient).

A Wound Care Specialist note, by MD #1, dated 10/19/2021 identified that the sacral stage III ulcer increased in size and now measured 0.5 cm x 0.3 cm x 0.3 cm in depth. Recommendations included to apply Alginate and a dry clean dressing change as needed.

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A Wound Care Specialist note, by MD #1, dated 10/26/21 identified that that the sacral stage three III increased in size, and now measured 2.0 cm x 0.5 cm x 0.3 cm in depth. Recommendations included to apply Alginate and a dry clean dressing change as needed.

A physician's order dated 10/26/21 directed to provide an air mattress, no thick mattress pads and to apply Calcium Alginate with foam daily to coccyx stage three III ulcer.

Interview with RN #5 on 11/4/21 at 6:55 AM and at 10:38 AM and review of the care plan failed to reflect new interventions were implemented after Resident #97 developed a stage II pressure ulcer on 8/26/21, and again the care plan failed to reflect new interventions when the pressure ulcer worsened to a stage III on 10/12/21, and increased in size on 10/19/21 and 10/26/21 according to the measurements by MD #1. Further, the clinical record failed to reflect consistent documentation of the wound (including measurements, descriptions and treatment) from 08/23/2021 through 10/12/21. Further, RN #5 was unable to provide documentation when the low air loss mattress was implemented.

Interview with APRN #1 and review of the clinical record on 11/4/21 at 1:26 PM identified she observed Resident #97 had a stage II pressure ulcer in August 2021. APRN #1 indicated that she directed LPN #2 to enter Resident #97 in the wound consult log for a wound consult to be obtained for the stage II pressure ulcer. APRN #1 indicated that it was the facility process to have the charge nurse enter the wound consult request.

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Facility Prevention and management of pressure injuries policy procedure identified that residents with pressure ulcers injuries and those at risk for skin breakdown are identified, assessed and provided appropriate treatment to encourage healing and/or maintenance of skin integrity. It further identified that ongoing monitoring and evaluation are provided to ensure optimal resident outcomes.

2. Resident #44 was admitted to the facility in November 2019 with diagnoses that included malignant neoplasm of the duodenum, malignancy of the bone, and below the knee left amputation.

The care plan dated 2/17/21 identified at risk for skin breakdown related to decreased mobility and urine and bowel incontinence. Interventions directed to do treatment as ordered. The care plan did not identify the non-pressure area to the left buttocks/coccyx area or that Resident #44 was being followed by the wound physician.

The quarterly MDS dated 2/19/21 identified Resident #44 had intact cognition, was frequently incontinent of bladder and always incontinent of bowel and required limited assist for dressing and extensive assistance for toileting and transfers.

A physician's order dated 2/26/21 directed to apply triad paste during the night, in the morning and evening for14 days to affected area on buttocks stop date 3/11/21.

Review of nursing progress notes dated 2/20/21-2/28/21 did not mention any skin concerns or issues, did not reflect that an APRN or Physician

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was called, or that there was a pressure, or a non-pressure area noted with measurements or description of the area.

The nurses note dated 3/3/21 at 12:28 AM noted Resident #44 was seen by the wound doctor, no new orders at this time.

The nurse's note dated 4/7/21 at 1:31 PM identified that weekly assessment seen by wound doctor for MASD to coccyx with treatment of Triad paste followed by a foam dressing much improved seen by wound doctor no new orders.

An interview with DNS on 11/4/21 at 9:15 AM noted the infection control nurse was responsible to make sure the weekly wound measurements, treatments were in place, and care planned for Resident #44 and do weekly wound rounds with the wound physician.

Interview and clinical record review with the DNS on 11/4/21 at 12:20 PM indicated she was not able to find any documentation of an RN assessment for a new non pressure area noted on Resident #44 around 2/26/21 when the first treatment was put into place.

Interview with the DNS on 11/4/21 at 12:20 PM indicated she did not see an RN assessment in Resident #44's clinical record of when the MASD on the coccyx or left buttock began in the nursing notes or assessments. The DNS could not definitely indicate when the MASD open area began based on the clinical record. The DNS indicated there was a treatment put into place on 2/26/21 but did not know why. The DNS indicated her expectation was when a nurse finds a new open area, he/she must get an RN

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assessment first then call the APRN/MD for a treatment order and call the family. The DNS noted her expectation was that all non-pressure and pressure areas were care planned when they start. The DNS did not indicate why the care plan was not updated with the MSAD non pressure open area, but it should have been.

Interview and clinical record review with RN #4 on 11/4/21 at 1:45 PM indicated the non-pressure area for Resident #44 was not care planned but RN #4 would have expected the nurses to have care planned the area to the left buttock/coccyx area when it started. RN #4 indicated she had reviewed the clinical record for Resident #44 and was not able to find an RN assessment to indicated when the MASD to the coccyx or left buttock began around 2/26/21.

Interview and clinical record review with RN #4 on 11/5/21 at 9:46 AM indicated there was not a care plan done for the MASD to the coccyx or for Resident #44 and that he/she was being followed by the wound physician.

Interview with MD #1 on 11/10/21 at 11:30 AM indicated Resident #44's area was on the buttocks across the coccyx area. MD #1 indicated he would expect the nurses to follow his treatment orders week to week for Resident #44's plan of care.

Although attempted, an interview with prior DNS was not obtained.

Although requested a care planning policy it was not provided.

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3. Resident #408 was admitted to the facility in October 2019 with diagnoses that included dementia, heart failure, acute embolism, and thrombosis of unspecified deep vein of right lower extremity (on admission), idiopathic peripheral autonomic neuropathy, bilateral pulmonary embolisms, and edema.

The annual MDS dated 6/4/21 identified Resident #408 had severely impaired cognition, was always incontinent of bowel and bladder and required extensive assistance for dressing, eating, toileting, and personal hygiene with one staff.

The care plan dated 6/18/21 identified at risk for skin breakdown related to decreased mobility. Interventions directed to treatment as ordered, provide with pressure reducing mattress, turn and reposition frequently, monitor for signs and symptoms of redness or skin breakdown. Perform a weekly body audit. The care plan did not address the right heel facility acquired pressure area.

APRN#1 interim order dated 8/4/21 at 1:55 PM directed to apply skin prep to right heel twice a day, off load right heel when in and out of bed, monitor area for infection, and a wound consult.

The agency nurse's note dated 8/4/21 at 2:55 PM noted the nursing assistant during morning care noted the area on the right heel and LPN did an assessment and notified the APRN. The APRN wrote a new order to apply skin prep, off load heels while in bed, and to be seen by wound doctor. Responsible party aware.

The Electronic Medical Record Physician Order

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dated 8/4/21 at 3:11 PM indicated to apply skin prep to right heel blister every day and evening. (Other type noted: standard other).

The APRN #1 progress note dated 8/4/21 at 11:58 PM identified that Resident #408 was seen for a right heel blister measuring 3.0 cm x 4.0 cm closed blister. New order for skin prep, off load heels in and out of bed, monitor for signs of infection, and a wound consult.

The Wound Physician progress note dated 9/21/21 noted right heel pressure wound resolved no treatment needed. This was the only Wound Physician progress note in the clinical record.

Interview and clinical record review with RN #4 on 11/5/21 at 9:46 AM indicated there was not a care plan for the right heel pressure area on Resident #408's heel or that Resident #408 had an order for a wound consult. RN #4 indicated her expectation was the pressure area would have been documented in the care plan when first identified.

Interview and clinical record review with the DNS on 11/4/21 at 12:20 PM indicated The DNS indicated her expectation was when a nurse finds a new open area, he/she must get an RN assessment first then call the APRN/MD for a treatment order, call the family, and care plan the new area. The DNS noted there was so much agency nurses it was hard to keep track to what they do, but she tried. The DNS indicated her expectation was there would be a care plan in place for the right heel pressure area, but she did not see it in the clinical record.

Interview with RN #4 on 11/5/21 at 9:46 AM

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F 657	Continued From page 57 indicated there was not a care plan for the right heel facility acquired pressure area for Resident #408. RN #4 indicated her expectation was for the right heel to be care planned when area started by nursing. Review of facility Pressure and non-pressure injury wound risk management identified residents who have actual skin impairment are provided with care to address their individual risk factors and goals of treatment. Heels are extremely vulnerable and must be elevated completely off the bed and or chair surface. Use pillows, positioning devices, and or suspension boot devices. Although requested a policy for care planning was not provided.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	F 684		1/31/22

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This REQUIREMENT is not met as evidenced by:
Based on observation, review of the clinical record, facility documentation and interviews for 2 of 3 residents (Resident #2 and 54) who were reviewed for accident and required frequent checks, the facility failed to ensure that frequent checks were conducted per the plan of care, and for 4 of 4 newly admitted residents (Resident #605, #606, #607, and #608), the facility failed to ensure Resident #607 was administered the correct number of IV antibiotic doses per physician's order and failed to ensure a Registered Nurse (RN) conducted an admission assessment including a body audit within 24 hours of admission for Resident #605, #606 and #608. Additionally, for 1 of 3 residents reviewed for a change in condition, (Resident #601), the facility failed to ensure that the resident had the adequate amount of bowel movements to ensure control of ammonia levels, and for 1 resident (Resident #108), reviewed for death, the facility failed to ensure an RN assessment was documented at time of death. For 1 of 6 residents (Resident #44) reviewed for wounds, the facility failed to ensure an RN assessment

1. Resident # 2, Resident #44, Resident #54 continue to reside in the facility. Resident #75, Resident #108, Resident #408, Resident #605, Resident #606, Resident #607, Resident #608, and Resident #700 no longer reside in the facility.
2. Any resident has the potential to be affected by this alleged deficient practice.
3. The facility policies titled, Weekly Skin Audits, Wound Assessment, Nursing Documentation, RN Assessment, Frequent Monitoring, and Bladder and Bowel Management were reviewed and remain current.
3. Licensed staff were provided education on the facility□s Weekly Skin Audits, Wound Assessment, Nursing Documentation, RN Assessment, Frequent Monitoring, and Bladder and Bowel Management Policies to ensure physician orders are followed, wounds are assessed, RN assessments conducted and documented, care plan interventions

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F 684	Continued From page 59 was documented when the non-pressure area was first identified. For 1 of 6 residents (Resident #408) the facility failed to complete weekly wound measurements of a pressure area and ensure the wound consult was obtained in a timely manner. For one of seven sampled residents (Resident #75) who had a skin growth and required cryotherapy, the facility failed to conduct weekly skin audits. For 1 residents (Resident #700) reviewed for accidents, the facility failed to ensure an RN assessment and neurological assessment was completed in accordance with professional standard after an unwitnessed fall, failed to obtain bloodwork according to physician's order, and failed to obtain a physician order following a dietician recommendation. The findings include: 1. Resident #54 diagnoses included Dementia and Parkinson disease. The admission Minimum Data set assessment dated 9/13/21 identified Resident #54 with cognitive impairment and required supervision and one person assistance for ambulation. The Resident Care Plan (RCP) dated 9/10/21 indicated that the resident wanders in facility aimlessly due to cognitive deficit. Intervention directed to assist the resident to find his/her own room/bathroom and unit as needed, conduct fifteen-minute safety checks for location due to wandering and apply wander guard to right arm. Additional care plan dated 9/30/21 identified the resident at risk for trying to leave facility and roaming in and out other rooms. Interventions directed to provide picture identification or description of the resident to office staff located near the exits. A physician's order dated 9/30/21 directed	F 684	for checking a resident are implemented, skin audits completed, and bowel management monitored per the facility□s policies. 4.Random audits will be conducted weekly to ensure the facility Weekly Skin Audits, Wound Assessment, Nursing Documentation, RN Assessment, Frequent monitoring of a resident when indicated, and Bladder and Bowel Management Policies are implemented to ensure residents receive necessary care until substantial compliance is achieved. The results of the audits will be presented at the QAPI as required. 5. The DNS or designee is responsible for the completion of this PoC.	

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wander guard to right arm and check function every shift.

The nurse's note dated 11/19/21 at 11:14 PM identified that the nursing supervisor was notified by the local authorities that Resident #54 was found walking on the streets and was transported to the local hospital emergency department for evaluation.
Additional nursing notes dated 11/19/21 at 11:36 PM indicated that the employee entrance alarm went off late in the evening and charge nurse input code to stop alarm went outside check and did not see anyone, the charge nurse then return to the unit.

Review of Resident #54 clinical record indicated that although the RCP indicated every fifteen minutes check the facility failed to provide documentation that frequent checks were performed between 9/12/21 and 11/19/21.

In an interview with LPN#4 (7-3 charge nurse) on 11/23/21 at 11:53 AM, she indicated that Resident #54 wanders around facility and into other residents' room and although she monitor Resident 54# on her shift and tries to keep a close eye on the resident she was not aware that every fifteen minutes check should be completed and documented for the resident.

In an interview with RN#11(3-11charge nurse) on 11/23/21 at 1:12 PM he indicated that sometime during the 3-11 shift on 11/19/21 the alarm at the employee entrance sounded and he went to the door turn off the alarm and return to his unit. RN#11 also indicated that resident #54 was not on frequent checks and was not aware that the resident had left the facility unattended.

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2. Resident # 2 diagnoses included hemiplegia and hemiparesis.

The nursing admission assessment dated 9/30/21 was noted to be incomplete and failed to identify the resident cognitive status.

A physician's order dated 10/1/21 directed assist of two for bed mobility and all functional transfers using mechanical lift.

The Resident Care Plan dated 10/7/21 identified resident at risk for fall and interventions directed floor mats to floor on both sides of bed and fifteen minutes check every shift.

The nurse's note dated 10/25/21 at 10:56 PM indicated that the resident had an unwitnessed fall at the beginning of the shift and appears to have no injuries and the resident will be monitored every fifteen minutes.

Review of the resident close observation sheet dated 10/19/21 to 11/21/21 failed to indicated that frequent checks were conducted every shift as per the resident plan of care.

In an interview Licensed Practical Nurse (LPN #4) 11/23/21 at 11:53 AM she indicated that residents on close observation are monitored by charge nurse and aide every shift and documentations are kept at the nursing station.

In an interview with Registered Nurse (RN#11) on 11/23/21 at 1:12 PM he indicated that he was not familiar with the residents on unit and was not aware that Residents #2 and #54 were on fifteen

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minutes checks and frequent checks were not conducted for the residents.

In an interview with the Assistant Director of Nursing on 11/24/21 at 10:10 AM, she indicated that it is the charge nurse responsibility to ensure that frequent checks are done for residents per their plan of care and the nursing staff did not conduct frequent checks.

In an interview an 11/24/21 at 11:50AM the Regional nurse indicated that facility does not have a policy for frequent checks however residents on close observation should be monitored every fifteen minutes and documentation kept in clinical record.

NA#8 (agency staff) was assigned to care for Residents #2 and Resident #54 on 11/19/21 during the 3 PM-11 PM shift. Review of the assignment included to conduct fifteen minutes checks and document resident's whereabouts. The documentation failed to identify that fifteen-minute checks were conducted. Several attempts to contact the Nursing Agency to conduct an interview with NA#8 were unsuccessful.

The facility did not provide a policy for residents on close observation/frequent checks.

3. Resident #605 was admitted to the facility on 12/4/20 with diagnoses that included hypertension, history of falling, difficulty in walking, and COVID-19.

Although a bladder and bowel evaluation, oral evaluation, skin audit and restraint/siderail

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evaluation were completed on 12/5/20, the clinical record failed to reflect documentation of a RN admission/readmission evaluation, pain assessment, Norton plus scale pressure risk assessment, hydration assessment, fall risk assessment, smoking safety assessment, substance abuse assessment, elopement/wandering risk assessment, and resident/family education were completed within 24 hours of admission.

4. Resident #606 was admitted to the facility on 12/4/20 with diagnoses that included hypertension, diabetes, COVID-19, difficulty walking, and abnormalities in gait and mobility.

Although a bladder and bowel evaluation, oral evaluation and restraint/siderail evaluation were completed on 12/5/20, the clinical record failed to reflect documentation of a RN admission/readmission evaluation, pain assessment, Norton plus scale pressure risk assessment, hydration assessment, fall risk assessment, smoking safety assessment, substance abuse assessment, elopement/wandering risk assessment, resident/family education and skin audit were completed within 24 hours of admission.

5. Resident #607's diagnoses included a coronary artery bypass graft (CABG) infection.

The Inter-Agency Patient Referral Report (W-10) from the hospital and dated 12/3/20 directed Cefazolin (a Cephalosporin antibiotic used to treat infection) 2 gm/20 ml into a venous catheter 3 times daily (every 8 hours).

A physician order dated 12/3/20 directed

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Cefazolin 2gm/20 ml into a venous catheter 3 times daily (every 8 hours).

The Medication Administration Record (MAR) reviewed for December 2020 directed to administer Cefazolin three times a day at 10:00 AM, 6:00 PM and 2:00 AM. The MAR failed to identify Resident #607 received Cefazolin at 10:00 AM on 12/5/20, 12/7/20, 12/8/20 and 12/9/20. The MAR further identified Resident #607 did not receive the IV antibiotic at 6:00 PM on 12/7/20, 12/8/20 and 12/9/20.

The 5-day Minimum Data Set assessment dated 12/9/20 identified Resident #607 had no cognitive impairment, had surgical wounds, received surgical wound care and received IV medications while not a resident at the facility and while a resident.

The Resident Care Plan dated 12/10/20 identified Resident #607 had surgical incision status post CABG with infection and received intravenous antibiotic every 8 hours. Interventions directed licensed nurse to administer antibiotic as ordered.

Interview and clinical record review with the Acting Director of Nursing (ADON) on 11/10/21 at 11:54 AM identified although the Cefazolin order was transcribed in the computer to be administered every 8 hours, the "task" section was input as twice daily, therefore not alerting the medication nurse to administer Cefazolin three times daily as physician ordered.

The ADON indicated as a result of the transcription error Resident #607 missed 7 doses of antibiotic in 2 days.

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The Administering an Intermittent Infusion Policy directed to verify physician order with medication bag/bottle. A physician order was required for an intermittent infusion.

6. Resident #608 was admitted to the facility on 12/4/20 with diagnoses that included hypotension, COVID-19, weakness, difficulty in walking, schizoaffective disorder bipolar type, and irritable bowel syndrome.

Although a substance abuse assessment was completed on 12/4/20, a bladder and bowel evaluation was completed on 12/5/20, an oral evaluation and restraint/siderail evaluation was completed on 12/6/20, the clinical record failed to reflect documentation of a RN admission/readmission evaluation, pain assessment, Norton plus scale pressure risk assessment, hydration assessment, fall risk assessment, smoking safety assessment, elopement/wandering risk assessment, resident/family education and skin audit were completed within 24 hours of admission.

Interview and clinical record review with the Acting Director of Nursing (ADON) on 11/10/21 at 11:30 AM identified a RN admission assessment inclusive of skin audit, cardiac assessment, respiratory assessment, bowel and bladder, pain, elopement, fall risk, Norton plus scale, medication self-administration, oral assessment was to be completed within 24 hours of admission. The ADON indicated the Agency nurses had computer access before the start of their shift and if a nurse did not complete an admission assessment, the nurse would be called back to document admission assessments. The ADON indicated she was not sure as to the reason an admission

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assessment was not completed by a RN within 24 hours of admission for Resident #605, Resident #606 and Resident #608.

The Policy and Procedure related to Evaluations and Schedules of Nursing Policy directed the facility will utilize evaluations and/or other tools to collect and analyze data in order to aid facilities in the development of resident-centered care plans. Utilize the following evaluations and other tools per the schedule below: AIMS- conduct on admission for residents on antipsychotic medications, Bowel and Bladder, Resident/Family education, Elopement Risk, Fall Risk, Medication Reconciliation, Norton Plus scale, Oral Health, Pain, Restraint, Self-Administration of Medications, Side Rail, Smoking Safety, Substance and/or Alcohol Abuse conduct on admission.

7 Resident #601 had diagnoses that included hepatic failure and alcoholic cirrhosis of the liver with ascites.
An admission assessment dated 2/15/21 identified that the resident was alert with confusion and required extensive assistance with activities of daily living.
Physician's orders dated 2/15/21 directed to administer lactulose 45 milliliters three times a day.
Hospital discharge paperwork dated 2/15/21 identified that the resident was admitted to the hospital on 2/12/21 after a fall at home with an increased ammonia level. The discharge summary identified that the resident had a diagnosis of hepatic encephalopathy and upon discharge ensure the resident have three (3) to four (4) bowel movements per day with the use of

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the lactulose. The increased ammonia levels were related to the resident's underlying cirrhosis and the only treatment for those symptoms was ensuring that the resident had frequent bowel movements. The discharge summary further identified that the resident's ammonia level was 87 (normal 15-45) upon admission to the hospital.
Review of the medication administration record for 2/16/21 and 2/17/21 identified that the resident received the lactulose as ordered.
Review of the clinical record failed to identify that the there was any information regarding the need for the resident to have three to four bowel movements a day.
A nurse's note dated 2/18/21 at 4:48 PM identified that the resident was noted to be slumped over in the wheelchair, with right arm swelling and a change in mental status. The physician was called, and the resident was transferred to the hospital due to a change of condition.
The acute care hospital discharge summary dated 2/27/21 identified that the resident was admitted on 2/18/21 with a diagnosis of hepatic encephalopathy and Urinary Tract Infection (UTI), the ammonia level was 169. The resident was admitted for management of recurrent hepatic encephalopathy.
Review of Nurse Aide documentation with the interim Director of Nurses (IDON) on 11/10/21 at 12:45 PM dated 2/16/21 through 2/18/21 identified that on 2/16/21 the resident had one small bowel movement and one large bowel movement for a total of two bowel movements in that 24-hour period. On 2/17/21 the resident had one bowel movement for that 24-hour period.
The clinical record failed to identify that the resident had three to four bowel movements a day.
Interview with the IDON on 11/10/21 at 12:45 PM

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F 684	Continued From page 68 identified that the clinical record failed to identify that the resident needed to have three to four bowel movements a day. The IDON further identified that the information should have been included on the admission physician orders, so it could have been tracked on the medication or treatment administration records, and the physician be notified if the resident did not have the necessary number of bowel movements per day. Interview with the Previous Medical Director (PMD) on 11/10/21 at 12:34 PM identified that he would expect the facility to ensure that the resident was having three to four bowel movements a day if that was the direction given on the discharge summary. The PMD identified that he did not believe that the increased ammonia level was solely due to not having 3-4 bowel movements a day but could have been due to having the UTI as well. 8. Resident #108 was admitted with diagnoses that included dementia with behavioral disturbance, stroke and major depressive disorder. A facility advanced directives declaration form dated 6/24/18 identified that Resident #108 did not wish to have resuscitative efforts. A quarterly MDS dated 9/23/21 identified that	F 684		

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Resident #108 was severely cognitively impaired and extensive assistance of 2 staff for bed mobility and extensive assistance of 1 staff for toilet use and personal hygiene.

A care plan dated 9/28/21 identified that Resident #108 wishes to be a Do Not Resuscitate /Do Not Intubate and Registered Nurse Pronouncement.

A death certificate dated 10/4/21 at 9:05AM identified that Resident #108 was pronounced deceased by RN.

Resident #108's record lacked documentation of an RN assessment at the time of Resident #108's death.

Interview with the DNS on 11/4/21 at 8 AM identified that the RN who pronounces a Resident would be required to complete a comprehensive note as per the facility policy and she was unclear as to why it was not done.

The facility policy RN pronouncement of Death directed to inform the physician of the circumstances surrounding the death, the exact location to which the descendant will be moved and to document a comprehensive nurse's detailing the interchange with the physician.

9. Resident #44 was admitted to the facility in November 2019 with diagnoses that included malignant neoplasm of the duodenum, malignancy of the bone, and below the knee left amputation.

The care plan dated 2/17/21 identified at risk for

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skin breakdown related to decreased mobility and urine and bowel incontinence. Interventions directed to do treatment as ordered. The care plan did not identify the non-pressure area to the left buttocks/coccyx area.

The quarterly MDS dated 2/19/21 identified Resident #44 had intact cognition, was frequently incontinent of bladder and always incontinent of bowel and required limited assist for dressing and extensive assistance for toileting and transfers.

Review of nursing progress notes dated 2/20/21-3/2/21 did not mention any skin concerns or issues, did not reflect that an APRN or Physician was called, or that there was a pressure, or a non-pressure area noted with measurements or description of the area.

A physician's order dated 2/26/21 directed to apply triad paste during the night, in the morning and evening for14 days to affected area on buttocks stop date 3/11/21.

The Wound Physician progress note dated 3/2/21 indicated Resident #44 was seen for redness and excoriation to the left buttock. Wound left buttock was a full thickness, 2.0cm x 2.0 cm x 0.1 cm, with a scant amount of serous drainage, and wound bed was 76-100% granulation. The peri wound was excoriated, moist and red. Plan was to apply triad cream followed by a dry clean dressing and change every 3 days and as necessary for soiling, saturation, or accidental removal.

The nurses note dated 3/3/21 at 12:28 AM noted Resident #44 was seen by the wound doctor no new orders at this time.

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F 684	Continued From page 71 Interview with the DNS on 11/4/21 at 12:20 PM indicated she did not see an RN assessment in Resident #44's clinical record of when the MASD on the coccyx or left buttock began in the nursing notes or assessments. The DNS could not definitely indicate when the MASD open area began based on the clinical record. The DNS indicate there was a treatment put into place on 2/26/21 but did not know why. The DNS indicated her expectation was when a nurse finds a new open area, he/she must get an RN assessment first then call the APRN/MD for a treatment order and call the family. The DNS noted there was so much agency nurses it was hard to keep track to what they do, but she tried. The DNS indicated the first assessment and measurement were done by the wound physician on 3/2/21 but expected there should have been a nursing note prior to the wound physician seeing Resident #44. Interview and clinical record review with RN #4 on 11/4/21 at 1:45 PM indicated she had reviewed the clinical record for Resident #44 and was not able to find an RN assessment to indicated when the MASD to the coccyx or left buttock began around 2/26/21. Review of Nursing Documentation Policy dated 2/2016 licensed nursing personnel documents information related to the residents' condition and care provided in the resident's medical record. A narrative note is written for any change in condition and frequency of this documentation is dependent on individual residents' condition and every shift nurse is required to write a note until situation is resolved. Request for physician services must be documented with time the call	F 684		

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was placed and contact made, specific physician nurse spoke with, what physician was notified, and action taken by the physician. Notification of family must be documented with specific family member notified, recording of action taken by the nurse and residents' response to, the ate and time the call was placed, and specifically what the was notified of.

10. Resident #408 was admitted to the facility in October 2019 with diagnoses that included dementia, heart failure, acute embolism and thrombosis of unspecified deep vein of right lower extremity (on admission), idiopathic peripheral autonomic neuropathy, bilateral pulmonary embolisms, and edema.

The annual MDS dated 6/4/21 identified Resident #408 had severely impaired cognition, was always incontinent of bowel and bladder and required extensive assistance for dressing, eating, toileting, and personal hygiene with one staff.

The care plan dated 6/18/21 identified at risk for skin breakdown related to decreased mobility. Interventions directed to treatment as ordered, provide with pressure reducing mattress, turn and reposition frequently, monitor for signs and symptoms of redness or skin breakdown. Performa weekly body audit.

APRN#1 interim order dated 8/4/21 at 1:55 PM directed to apply skin prep to right heel twice a day, off load right heel when in and out of bed, monitor area for infection, and a wound consult.

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The agency nurse's note dated 8/4/21 at 2:55 PM noted the nursing assistant during morning care noted the area on the right heel and LPN did an assessment and notified the APRN. The APRN wrote a new order to apply skin prep, off load heels while in bed, and to be seen by wound doctor. Responsible party aware.

The APRN #1 progress note dated 8/4/21 at 11:58 PM identified that Resident #408 was seen for a right heel blister measuring 3.0 cm x 4.0 cm closed blister. New order for skin prep, off load heels in and out of bed, monitor for signs of infection, and a wound consult.

The Physician Order dated 8/4/21 at 3:11 PM indicated to apply skin prep to right heel blister every day and evening.

Treatment Administration Record dated 8/1/21-8/31/21 indicated Resident #408 did not receive the treatment ordered on 8/4/21 through 8/31/21.

APRN #1 progress note dated 9/7/21 at 9:35 PM identified that Resident #408 right heel blister had opened measuring 4.0 cm x 4.0 cm with no drainage. New order cleanse with normal saline apply xeroform followed by kerlix. Continue to off load heels and consult wound team.

APRN #1 progress note dated 9/17/21 at 4:27 PM indicated Resident #408 currently was being treated for right heel wound and a stage 1 to the coccyx and followed by the house wound Physician.

The Wound Physician progress note dated 9/21/21 noted right heel pressure wound resolved

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no treatment needed. This was the only Wound Physician progress note in the clinical record.

Treatment Administration Record dated 9/1/21-9/30/21 indicated Resident #408 did not receive the skin prep to right heel twice a day from 9/1/21 -9/7/21 and had a new order starting 9/8/21 and a stop date 9/22/21 to cleanse the right heel pressure ulcer with normal saline apply xeroform followed by kerlix once a day. Resident #408 only received the treatment 4 days out of 14 days.

Interview and clinical record review with the DNS on 11/4/21 at 12:20 PM indicated The DNS indicated her expectation was when a nurse finds a new open area, he/she must get an RN assessment first then call the APRN/MD for a treatment order, call the family and care plan area. The DNS noted there was so much agency nurses it was hard to keep track to what they do, but she tried. The DNS indicated her expectation was there would be a care plan in place for the left heel pressure area but there was not in the clinical record. The DNS noted that the wound doctor does the weekly measurements for the facility for the residents being seen. The DNS indicated there was no one assigned as an RN consistently to do wound measurements and initially it would be done by the RN on and after the initial wound measurement, they only wanted one person to measure and that was the wound doctor. The DNS noted her expectation was there would be a would measurement every week for the right heel. The DNS noted with clinical record review there was a wound measurement for the right heel by the APRN on 8/4/21 and 9/7/21 and the wound doctor on 9/21/21. The DNS noted the wound measurements and

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assessments were not done on week of 8/8, 8/15, 8/22, 8/29, and 9/12/21.

Interview with RN #4 on 11/5/21 at 9:46 AM indicated the treatment order did not get done per the APRN/physician order, then the wound doctor or APRN should have been notified but did not see any notification in the clinical record. RN #4 indicated her expectation was there was wound assessments and measurement done every week on Resident #408 from first noted on 8/4/21 until resolved 9/21/21 but did not find any weekly wound measurement documentation except for the APRN 8/4, 9/7, and wound physician on 9/21/21.

An interview with DNS on 11/5/21 at 11:30 AM noted the agency nurse that placed the order into the computer put the order in wrong which resulted in Resident #408 not getting the treatment ordered from 8/4/21-9/7/21. The DNS indicated the agency nurse did not put in the designation where it said standard other the agency nurse needed to put in as TAR the treatment record. The DNS noted because the agency nurse did not put the order in the computer correctly the order never came up on the treatment record for the nurses to do the treatment twice a day. The DNS indicated she did not see a progress note in the medical record indicating the APRN or wound physician were notified that the treatment wasn't done. The DNS was not able to explain why the wound consult took from 8/4/21 until 9/21/21 to be done. The DNS indicated her expectation was when the APRN ordered a wound consult on 8/4/21 that Resident #408 would have been seen the next Tuesday on 8/10/21 when the wound physician comes in. The DNS indicated the wound

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physician comes in every Tuesday. The DNS could not explain why it took 7 weeks for Resident #408 to be seen by the wound physician until 9/21/21.

Interview with APRN #1 indicated she was not notified that Resident #408's treatment she had ordered were not done during periods from 8/4/21 until 9/7/21. APRN #1 indicated she expected the nurses to initiate the treatment right away to the right heel when she ordered it on 8/4/21. APRN #1 noted if the treatment wasn't done, she would expect to be notified. APRN #1 indicated the right heel blister did not look infected and had clear fluid in the blister, so she ordered skin prep and ordered a wound consult. APRN #1 indicated she was aware the wound doctor comes in every week on Tuesdays and expected Resident #408 to be seen within a week. APRN #1 indicated she was asked on 9/7/21 to evaluate the right heel because the blister had opened. APRN #1 indicated she forgot she had already seen and gave orders for the right heel at the beginning of August she was asked to evaluate the right heel because the right heel was open and it did not look infected an did not realize she had put in for the wound consult on 8/4/21 so she put in again for a wound consult on 9/7/21. APRN #1 indicated she prefers for the wound physician to see and follow all wounds because he is the expert for wounds. APRN #1 indicated she does not follow any wounds weekly. APRN #1 indicated she was not notified Resident #408 did not receive his/her treatment from 9/7-9/16/21 and 9/18/21 per her treatment order.

Interview with MD #1 on 11/10/21 at 11:30 AM indicated he most times did the wound rounds by himself without the assistance of a facility staff

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person. MD #1 indicated there was no infection control nurse to do rounds with him and occasionally the ADNS would start the rounds with him and go off to do something else and not come back or the ADNS would be on a floor passing medications. MD #1 indicated it was the responsibility of the ADNS and the DNS to keep a list each week for him so he would know whom he needed to see each week whether new or a follow up. MD #1 indicated if a resident was not on the list they would not be seen because he was not able to remember week to week everyone that needed to be seen. MD #1 indicated he only saw Resident #408 once on 9/21/21. MD #1 indicated that no one at the facility had informed him the treatment ordered by the APRN had not been followed through with for August or September 2021. MD #1 indicated no one at the facility prior to 9/21/21 informed him that Resident #408 had a pressure area on the right heel and had a wound consult ordered since 8/4/21. MD #1 indicated he was upset because he was at the facility every week on Tuesdays and no one asked him to see Resident #408's heel and he questions the nurse's on each unit every week asking if there are any new residents that need to be seen and there was a book at the nurses station he looks in every week that the nurses could add in a new resident to be seen and Resident #408 was not in his book.

Interview and clinical record review with the DNS on 11/5/21 at 12:20 PM failed to provide documentation that the treatments per physician orders were followed from 8/4/21 until 9/7/21 to prevent the facility acquired right heel pressure area from getting larger in size, and did weekly wound measurements/assessments, and had the wound physician see Resident #408 in a timely

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manner. Additionally, did not provide the treatment per the physician order for a daily treatment to the right heel except for 4 days out of 14 days from 9/8/21 - 9/21/21.

Review of facility Pressure and non-pressure injury wound risk management identified residents who have actual skin impairment are provided with care to address their individual risk factors and goals of treatment. Heels are extremely vulnerable and must be elevated completely off the bed and or chair surface. Use pillows, positioning devices, and or suspension boot devices.

Review of Physicians Orders-Transcription dated 4/2015 indicated all written or telephone physicians' orders must be duly noted and accurately transcribed by a licensed nursing staff. Check physicians order for physicians' signature, date and time. Carefully transcribe orders as written to the Treatment Record. The nurse will write noted, sign first initial and last name. title, time with am or pm and complete date.

Review of Significant Change of Condition policy indicated professional staff will communicate with the physician, resident, and family regarding changes in condition to provide timely communication of resident status change which is essential to quality care management. The physician, resident or responsible party will be notified by the nurse in the event of a change in condition. The notification will be documented in the clinical record.

Review of Nursing Documentation Policy identified licensed nursing personnel documents information related to the residents' condition and

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care provided in the resident's medical record. A narrative note is written for any change in condition and frequency of this documentation is dependent on individual residents' condition and every shift nurse is required to write a note until situation is resolved. Request for physician services must be documented with time the call was placed and contact made, specific physician nurse spoke with, what physician was notified, and action taken by the physician. Notification of family must be documented with specific family member notified, recording of action taken by the nurse and residents' response to, the date and time the call was placed, and specifically what the was notified of.
11. Resident #75's diagnoses included chronic kidney disease, diabetes mellitus, and dementia with Lowy Bodies.

The quarterly Minimum Data Set assessment dated 9/12/21 identified Resident #75 had some difficulty with decision making skills regarding tasks of daily life and had no skin problems.

The physician's progress note dated 10/13/20 identified Resident #75 was seen due to a skin horn on theleft ear that was approximately eight (8) millimeters long extending from the pinna of left ear and had slight erythema. The note indicated the area was frozen with cryotherapy with three (3) cycles, would reevaluate in two (2) weeks, and may need retreatment.

The physician's progress note dated 11/7/20 (twenty-five days later) identified
Resident #75 was seen for follow-up routine exam and reevaluate the left ear lesion. The note indicated ulceration might represent early squamous cell, lesion was treated with three (3)

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cycles of cryotherapy, will observe as to healing, and may need biopsy in the next couple of weeks.

The physician's progress note dated 1/5/21 identified Resident #75 was seen regarding the left ear lesion as the lesion was much bigger in size and had a small nodule at the base consistent with probable squamous cell cancer. The note indicated Resident #75 would be referred to an ear, nose and throat specialist and the appointment would not be for a couple of weeks.

Review of the weekly body audits from 9/21/20 through 1/20/21 failed to reflect documentation the left ear skin horn was monitored on a weekly basis to determine if the area was deteriorating or healing.

Interview with the attending physician on 11/10/21 at 12:10 PM identified he would expect some degree of monitoring by the wound nurse.

The weekly body audit policy directs all residents will have a body audit to address any skin issues on a weekly basis. If an alteration in the skin integrity is discovered, it will be documented on the weekly skin audit form and monitoring of the area will continue until the area is resolved.

12a. Resident #700 was admitted to the facility on 11/13/21 with diagnoses that included difficulty in walking, weakness, hypertension, and malignant neoplasm of colon.

The care plan dated 11/13/21 identified Resident #700 was at risk for falls secondary to being

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newly admitted, generalized weakness, and previous history of falls. Interventions included to provide the assistance of 2 staff with the gait belt device with transfers, instruct to ask for assistance prior to attempting to transfer or ambulation, place call light within reach.

Review of the nurse's aide care card dated 11/14/21 identified Resident #700 required assistance of 1 with transfer status, able to make needs known, high risk for falls.

The admission MDS dated 11/19/21 identified Resident #700 had intact cognition, activity occurred only once or twice with transfer, walking in the room and corridor.

A reportable event form dated 11/24/21 at 11:30 AM identified Resident #700 was observed sitting on the floor mat by bedside in the room. No injury noted. Resident #700 denies hitting head. Resident #700 was alert with confusion.

The APRN progress note dated 11/24/21 at 2:38 PM identified Resident #700 was being seen for a fall. Nursing reported Resident #700 was found sitting on the floor. Resident #700 denied dizziness, headache, chest pain, and shortness of breath. Denies hitting his/her head. Resident #700 appears fatigue and dry this visit. Person #2 was at bedside who reported Resident #700 is much slower to respond than baseline. Continue to monitor neurological status per fall protocol and notify with any acute changes.

Interview with RN #1 on 12/2/21 at 8:30 AM identified he had not seen the resident prior to the fall. RN #1 identified he was not paged STAT to the unit that day. RN #1 identified he was not

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aware Resident #700 fell until that afternoon. RN #1 identified he did not conduct an RN assessment after the fall because LPN #8 never called or informed him of the fall. RN #1 indicated that LPN #8 should not have moved Resident #700 onto the bed prior to the arrival of the APRN or before the RN assessment per the facility policy. RN #1 indicated the facility expectation is that the licensed nurse is to call the supervisor when a resident fall.

Interview with NA #10 on 12/2/21 at 11:00 AM identified NA #10 she provided AM care to Resident #700 and left him/her in bed because he/she was agitated and kept on speaking about going home. NA #10 indicated she notified LPN #8 regarding Resident #700 was agitated. NA #10 identified at 11:30 AM she checked on Resident #700 and Person #2 was at the bedside and the resident was on the floor sitting with both legs crossed. NA #10 identified she went to notified LPN #8 and she and the nurse went to the room. NA #10 identified LPN #8 went to get the APRN #1 while she stayed with the resident. NA #10 indicated when LPN #8 returned she left the room and APRN #1 was not with LPN #8.

Interview with LPN #8 on 12/2/21 at 1:01 PM identified NA #10 notified her Resident #700 was on the floor. LPN #8 indicated when she arrived Person #2 was in the room and Resident #700 was on the floor with his/her legs crossed by the bed. LPN #8 indicated she directed NA #10 to stay with Resident #700 while she went to notified APRN #1. LPN #8 indicated APRN #1 assessed Resident #700 and then she and NA #10 moved Resident #700 to the bed. (This is in conflict with the interview with APRN #1 on 12/2/21 at 1:39 PM who indicated that Resident #700 was in bed

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prior to APRN #1 's assessment after the fall).

Interview with the DNS on 12/2/21 at 1:34 PM identified she was not aware of Resident #700 ' s unwitnessed fall, or that the resident was moved prior to an RN assessment, or that neurological assessment had not been completed. The DNS indicated the expectation of the facility is after unwitnessed fall, an RN assessment need to be conducted prior to moving the resident. Neurological assessment is to be completed and documented on the form. The DNS indicated that the fall should have been documented in the nurse's notes.

Interview with APRN #1 on 12/2/21 at 1:39 PM identified LPN #8 notified her that Resident #700 was on the floor in the room. APRN #1 indicated she told LPN #8 she was with a resident at that moment and when she finished, she will be right there. APRN #1 indicated when she arrived at Resident #700 ' s room, the resident was already in the bed. APRN #1 indicated she assessed Resident #700 in the bed, and he/she complained of feeling weak. APRN #1 indicated Person #2 was at the bedside and she discussed the plan of care with Person #2. APRN #1 indicated she ordered intravenous hydration and bloodwork. APRN #1 indicated she had ordered blood work on 11/20/21 and it was not collected, that is why she ordered blood work STAT on 11/24/21. APRN #1 indicated the facility did not notify her that the blood work for (11/20/21) was not collected as ordered. The APRN indicated Resident #700 was transferred to the hospital approximately after at 5:30 PM.

Although attempted, an interview with LPN #8 for clarification was not obtained.

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F 684	Continued From page 84 Review of the falls management policy identified the facility will utilize all resident/patient related information made available upon admission and ongoing to determine resident/patient at-risk for fall status. A fall is defined as any incident in which a resident/patient unintentionally has a change in elevation/plane, an occasion where the resident would have lost their balance without staff intervention, or an incidence where resident rolls off a bed or mattress close to the floor. Unless there is evidence suggesting otherwise, anytime a resident is found on the floor, a fall is considered to have occurred. A fall risk evaluation will be conducted by the "nurse on duty/supervisor" on any resident/patient sustaining a fall with or without injury. Once the resident/patient is clinically evaluated as being stable, vital signs, neurological signs, range of motion, and evaluation of cognitive status will be documented. Neurological checks, to be documented on the neurological flow sheet for 72 hours in the following circumstances, resident/patient states that he/she hit head, physical evidence resident hit head, and unwitnessed fall if the resident an unreliable historian. In addition, documentation for 72 hours to assess for latent injury. b. A physician's order dated 11/20/21 directed to obtain bloodwork - complete blood count, and basic metabolic panel. The nutrition assessment dated 11/21/21 at 4:11 PM identified Resident #700 ' s diet was regular mechanical soft (dental) ground texture, thin liquids. Recommendations included to initiate magic cup with lunch and dinner and house	F 684		

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supplement 120 ml twice a day.

The care plan dated 11/22/21 identified Resident #700 was at risk for weight loss due to symptoms of dysphagia, diagnosis of colon cancer, and variable appetite. Interventions included to determine and offer food preferences, monitor food intake with every meal, offer snacks between meals and meal substitutions as appropriate including bedtime snacks. Provide magic cup with lunch, dinner, and house milkshake 120 ml twice a day.

Review of the clinical record failed to reflect orders were obtained for the magic cup or house supplement after dietitian recommendation.

Interview with the DNS on 12/2/21 at 1:34 PM identified she was not aware of the dietitian recommendations and indicated it is the responsibility of the license nurses to contact the physicians or the APRN and update them with the dietitian recommendations and obtain a new order. The DNS indicated it is very difficult for any follow ups and consistency because the facility is short of staff and currently utilizing agency license nurses and supervisors.

Interview with APRN #1 on 12/2/21 at 1:39 PM identified she was not aware of the dietitian ' s recommendations. The APRN indicated it is the responsibility of the nurses to notify her of any recommendation for her to verbalize a new order over the phone or transcribe a new order in resident chart.

The facility failed to ensure an RN assessment was completed after the resident fell and before moving the resident, failed to complete neurologic

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F 684	Continued From page 86 vital signs after an unwitnessed fall, failed to complete bloodwork as ordered, and failed to implement dietitian recommendations for magic cup and supplements.	F 684		
F 686 SS=H	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, review of the clinical record, facility documentation and interview for 4 of 6 residents reviewed for pressure ulcers (Resident #97, 27, 44 and 408), the facility failed provide care and services according to professional standards to prevent the development, further decline and promote healing of pressure ulcers. This failure led to the identification of substandard quality of care. The findings include: 1. Resident #97's diagnoses included dementia and diabetes.	F 686	1. Resident # 27, Resident #44, and Resident #97 continue to reside in the facility. Resident #408 no longer resides in the facility. 2. Any resident has the potential to be affected by this alleged deficient practice. 3. The facility policies titled, Weekly Skin Audits, Wound Assessment, Nursing Documentation, and RN Assessment were reviewed and remain current. 3. Licensed staff were provided education on the facility□s Weekly Skin Audits, Wound Assessment, Nursing Documentation, and RN Assessment	1/31/22

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F 686	Continued From page 87 The quarterly MDS dated 7/2/21 identified Resident #97 had severely impaired cognition, required total 2-person assistance with transfers between surfaces and bed mobility including turning from side to side, was always incontinent of bladder and bowel and had no skin impairment but was at risk for developing pressure ulcers. The care plan dated 7/16/21 identified Resident #97 was at risk of developing skin breakdown related to decreased mobility and occasionally incontinent of bowels. Interventions included the provision of a pressure reducing mattress, reposition every 2 hours, inspect skin daily for signs and symptoms of redness or breakdown and perform weekly skin checks. Review of the clinical record during the period of 7/16/21 through 8/23/21 to reflect that weekly skin checks were completed. On 8/23/21, a physician's order directed to apply barrier spray followed by form dressing to the coccyx wound. Review of the clinical record failed to identify that this order was implemented. Review of the clinical record failed to reflect that an assessment of the coccyx was done or documented. Review of APRN #1's note dated 8/26/21 identified Resident #97 was being seen at the request of nursing for a stage II pressure ulcer to the coccyx. The note indicated the resident was mainly bedbound, at risk for skin breakdown and identified that the plan for the stage II pressure ulcer was to start utilizing a form dressing and refer the resident for a wound consult. The note failed to reflect measurements and or any other	F 686	Policies to ensure new pressure ulcers are assessed by the Registered Nurse, weekly wound assessments are completed, treatments are provided per the facility□s policies, and that wounds are evaluated by the wound physician. 4.Random audits will be conducted weekly to ensure the facility Weekly Skin Audits, Wound Assessments, Nursing Documentation, and RN Assessment Policies are implemented to ensure residents receive necessary care for pressure ulcers until substantial compliance is achieved. The results of the audits will be presented at the QAPI as required. 5. The DNS or designee is responsible for the completion of this PoC.	

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description of the identified stage II pressure ulcer on the coccyx.

Review of the August 2021 TAR failed to reflect the barrier spray followed by form dressing to the coccyx wound, ordered on 8/23/21 was being completed.

Review of the September 2021 TAR failed to reflect that a treatment was being done on the coccyx pressure ulcer.

The annual MDS dated 10/2/21 identified Resident #97 had severely impaired cognition, no behaviors, required total 2-person assistance with transfers between surfaces and bed mobility including turning from side to side, was always incontinent of bladder and bowel and had no skin impairment but was at risk for developing pressure ulcers.

A Wound Care Specialist note, written by the wound doctor, (MD #1) dated 10/12/21 identified that Resident #97's family member noted a wound on the resident's sacral area and was worried that staff was not changing his/her undergarment frequently. The sacral wound was identified as a stage three III pressure injury that measured 0.2 centimeters (cm) x 0.2 cm x 0.3 cm. The plan further included pressure relief/offloading, pressure redistribution mattress per facility protocol and to offload/ reposition the resident every 2 hours.

A physician's order dated 10/12/21 directed to apply Calcium Alginate with foam daily to coccyx stage three III ulcer.

Review of APRN #1's note dated 10/12/21

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identified Resident #97 has a sacral pressure ulcer and currently did not have an air mattress.

The care plan dated 10/18/21 identified Resident #97 was at risk of developing skin breakdown related to decreased mobility and incontinence of bladder and bowel. Interventions included provision of a low air loss mattress and provide turning and repositioning approximately every 2 hours and as needed.

APRN #1's note dated 10/21/21 identified that Resident #97 had a stage III pressure ulcer on the coccyx and "we will order an air mattress for the patient".

Review of MD #1's note dated 10/19/21 identified that the sacral stage III ulcer increased in size and now measured 0.5 cm x 0.3 cm x 0.3 cm in depth. Recommendations included to apply Alginate and a dry clean dressing change as needed.

Review of MD #1's note dated 10/26/21 identified that the sacral stage three III increased in size, and now measured 2.0 cm x 0.5 cm x 0.3 cm in depth. Recommendations included to apply Alginate and a dry clean dressing change as needed.

A physician's order dated 10/26/21 directed to provide an air mattress, no thick mattress pads and to apply Calcium Alginate with foam daily to coccyx stage three III ulcer.

Interview with RN #5 on 11/4/21 at 6:55 AM and at 10:38 AM and review of the care plan failed to reflect that new interventions were implemented after Resident #97 developed a stage II pressure

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ulcer on 8/26/21, and again the care plan failed to reflect new interventions when the pressure ulcer worsened to a stage III on 10/12/21, and increased in size on 10/19/21 and 10/26/21 according to the measurements by MD #1. Further, the clinical record failed to reflect consistent weekly documentation of the wound (including measurements, descriptions and treatment) from 8/23/21 through 10/12/21. Further, RN #5 was unable to provide documentation when the low air loss mattress was implemented, and she was unable to explain why the residents care plan was not revised after the development of a stage II pressure ulcer or when the pressure ulcer worsened to a stage III.

Interview with APRN #1 and review of the clinical record on 11/4/21 at 1:26 PM identified she observed Resident #97 had a stage II pressure ulcer in August 2021. APRN #1 indicated that she directed LPN #2 to enter Resident #97 in the wound consult log for a wound consult to be obtained for the stage II pressure ulcer and directed a treatment to the wound. APRN #1 indicated that it was the facility process to have the charge nurse enter the wound consult request and indicated that it was her understanding that the wound consultants did the wound assessments and measurements, as well as ordered the treatments. APRN #1 indicated she was not aware that the wound consult was not requested and that she has asked for a nurse to accompany the wound doctor during his rounds and that communication was difficult due to not enough consistent staff.

Interview with LPN #2 on 11/04/21 at 12:58 PM she was unable to recall or explain whether she had seen an open pressure ulcer on Resident

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#97 or if the APRN had requested a wound consult in August 2021.

Interview with the wound doctor, (MD #1) on 11/5/21 at 1:38 PM indicated that when he conducts his wound rounds/treatments, he frequently does so by himself without the benefit of a facility nurse present to observe and assist. MD #1 identified that he first became aware of Resident #97's stage III coccyx pressure ulcer on 10/12/21 via Resident #97's representative and had not been informed by facility staff. MD #1 indicated he recommended a low air loss mattress on 10/12/21, and after seeing Resident #97 two additional times, he had to write an order for the air mattress because staff had still not provided Resident #97 with the air mattress and the resident needed one. MD #1 further indicated that he did not change the treatment modalities because it was his belief that the treatments he had ordered were not being consistently done. MD #1 indicated he was always encouraging staff to do the treatments and to provide turning and repositioning. The facility did not have a consistent wound nurse, or consistent staff.

Intermittent observations of Resident #97 on 11/3/21 and on 11/4/21 from 6:01 AM to 12:05 PM identified the resident was positioned on his/her back without the benefit of turning/offloading to his/her sides.

Observation on 11/4/21 at 12:16 PM identified Resident #97 was incontinent of urine and did not have a dressing on the pressure ulcer. LPN #2 measured the coccyx pressure ulcer at that time and noted 2.5 cm x 0.5 cm and failed to measure the depth of the wound.

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F 686	Continued From page 92 Interview with NA #25 on 11/4/21 at 12:06 PM and at 12:29 PM identified she had provided care to Resident #97 at 10:00 AM, and the resident wasn't provided positioning off his/her back because NA #25 felt Resident #97 was more comfortable that way. NA #25 identified she had not seen a dressing on the resident's sacral area, and she applied additional Triad cream. Interview with LPN #2 on 11/4/21 at 12:32 PM indicated that she was unaware that the resident was missing the sacral area dressing. Subsequent observation of Resident #97 on 11/5/21 at 8:45 AM and at 10:04 AM noted the resident offloaded with a pillow behind his/her back positioned to left side. The facility failed to conduct weekly skin checks according to the care plan between 7/16/21 -10/12/21, failed to provide an air mattress between 7/16/21 to sometime in November 2021 (staff were not able to provide that date), failed to ensure a registered nurse assessed the pressure ulcer, failed to do weekly wound assessments and document that assessment between the time the resident developed a stage II pressure ulcer on 8/26/21 to 10/12/21, over 6 weeks, when the wound doctor, MD #1, assessed the wound at a stage III pressure ulcer. Additionally, the facility failed to provide a treatment to the stage II pressure ulcer between 8/26/21 to 10/12/21, over 6 weeks at which time the wound had deteriorated to a stage III. Further, upon observations during the survey, the resident was not provided adequate offloading of the pressure ulcer according to the care plan and physician recommendations.	F 686		

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As a result of these failures, substandard quality of care was identified.

Facility Prevention and management of pressure injuries policy procedure identified that residents with pressure ulcers injuries and those at risk for skin breakdown are identified, assessed and provided appropriate treatment to encourage healing and/or maintenance of skin integrity. It further identified that ongoing monitoring and evaluation are provided to ensure optimal resident outcomes.

2. Resident #27 was admitted to the facility on 7/28/21 with diagnoses that include diabetes, chronic kidney disease and dementia.

A weekly skin audit dated 7/28/21 identified Resident #27 had no new skin impairments since last review.

The care plan dated 7/29/21 identified Resident #27 is at risk for skin breakdown due to decreased motility, and incontinence. Interventions included to inspect skin for redness, irritation or breakdown during care, offload heels, turning and repositioning every 2 hours, pressure reduction cushion/mattress prn, toileting or incontinent care a needed, treatments as ordered and weekly skin inspections.

The admission MDS dated 8/3/21 identified Resident #27 had severely impaired cognition, required limited assistance with bed mobility, transfers and walking, extensive assistance with dressing and toilet use, and total assistance with bathing. Additionally, the MDS identified Resident #27 was frequently incontinent of bowel and

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bladder and was at risk for the development of pressure ulcers and did not have any open areas.

Physician ' s order dated 8/17/21 directed weekly skin checks on bath/shower day (Tuesdays).

A Norton plus assessment (used to assess the risk for pressure ulcer in adults) dated 8/23/21 identified a score of 15. No other information was provided on the assessment.

A weekly skin audit dated 9/2/21 identified Resident #27 had no new skin impairments since last review.

A weekly skin audit dated 9/7/21 identified Resident #27 had no new skin impairments since last review.

The clinical record lacked a weekly skin audit dated 9/14/21.

A weekly skin audit dated 9/20/21 was incomplete.

A pressure injury evaluation dated 9/20/21 identified reason for evaluation; initial evaluation, date of origin 9/20/21, facility acquired DTI, physician and responsible representative notified, current stage; unstageable, left lateral heel, measurement 3.0cm by 2.5cm by 0cm, 0% healthy tissue, 50% unhealthy tissue, 0% eschar, comments; skin prep to site every shift. Resident #27 was educated to elevate heels while in bed.

A wound consultation dated 10/17/21 identified the left heel was a DTI. Resident #27 is in a wheelchair for most of the day, suspect due to not wearing protection while her heel rests on metal

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foot pad. Left heel is a DTI, persistent non blanchable deep red, maroon, or purple discoloration. Initial wound encounter, wound measurements are 2.0cm by 3.5cm by 0cm with an area of 7sq cm and a volume of 0cc. Pressure induced deep tissue damage of left heel. Important to offload the heel as best as possible, with her dementia the resident may not keep the offloading boots on. Apply skin prep twice daily, facility pressure ulcer prevention protocol, pressure redistribution mattress per protocol, offload heels per protocol - heel boots, offload pressure, reposition every two hours. Consider referral to dietitian.

A wound consultation dated 10/19/21 identified slow improvement, continue skin prep twice daily, continue offloading, boots and consider referral to dietitian.

A weekly skin audit dated 10/26/21 identified Resident #27 had no new skin impairments since last review.

A weekly skin audit dated 10/27/21 identified the type of audit was interim and Resident #27 had no new skin impairments since last review.

A weekly skin audit dated 11/2/21 identified Resident #27 had no new skin impairments since last review.

A wound consultation dated 11/2/21 identified continue skin prep twice daily, continue offloading, boots and consider referral to dietitian.

Interview with RN #4 and RN #5 on 11/4/21 at 1:40 PM identified that pressure ulcers should be assessed by an RN weekly including

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measurements, however, for Resident #27, other than the first pressure injury evaluation done on 9/20/21, no other pressure injury evaluations were done. RN #4 and RN #5 indicated there has been inconsistent staffing, increased use of pool nurses and not a steady infection control nurse. Due to the staffing issues, weekly pressure ulcer assessments had not been done.

Interview with the Dietitian on 11/4/21 at 3:00 PM identified that if a resident has a pressure ulcer, the dietitian should review the resident monthly until the wound it healed.

The prevention and management of pressure injuries identified residents with pressure injuries and those at risk for skin breakdown are identified, assessed and provided appropriate treatment to encourage healing and/or maintenance of skin integrity. Are plans are developed based on individual residents ' goals and decisions for treatment. Ongoing monitoring and evaluation are provided to ensure optimal resident outcomes. The facility follows the NPUAP guidelines when staging wounds. The resident ' s skin is observed daily with care and residents will have a weekly body audit completed by the licensed staff. Pressure injuries are assessed and documented on at least weekly and with a significant change in the wound until it is resolved. The pressure injury assessment includes location, measurement in centimeters (length, width, depth, undermining and tunneling), stage, drainage, color, odor, appearance of wound bed and edges and peri wound, pain and effectiveness of treatment. In Connecticut, an RN assessment is required weekly for all wounds, (pressure and non-pressure) and upon identification of any new wounds.

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The facility failed to ensure weekly skin checks were completed between admission - 11/4/21, failed to ensure weekly pressure ulcer assessments were completed after a DTI was identified on 9/20/21, failed to have the wound doctor evaluation the residents new pressure ulcer for over 3 weeks, and failed to ensure that the dietitian was consulted to ensure adequate nutrition for wound healing when Resident #27 developed a DTI on 9/20/21.

3. Resident #44 was admitted to the facility in November 2019 with diagnoses that included malignant neoplasm of the duodenum, malignancy of the bone, and below the knee left amputation.

The care plan dated 2/17/21 identified at risk for skin breakdown related to decreased mobility and urine and bowel incontinence. Interventions directed to do treatment as ordered. The care plan did not identify the non-pressure area to the left buttocks/coccyx area or that Resident #44 was being followed by the wound physician.

The quarterly MDS dated 2/19/21 identified Resident #44 had intact cognition, was frequently incontinent of bladder and always incontinent of bowel and required limited assist for dressing and extensive assistance for toileting and transfers.

A physician's order dated 2/26/21 directed to apply triad paste during the night, in the morning and evening for14 days to affected area on buttocks stop date 3/11/21.

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Review of nursing progress notes dated 2/20/21-2/28/21 did not mention any skin concerns or issues, did not reflect that an APRN or Physician was called, or that there was a pressure, or a non-pressure area noted with measurements or description of the area.

The nurses note dated 3/3/21 at 12:28 AM noted Resident #44 was seen by the wound doctor, no new orders at this time.

The nurse's note dated 4/7/21 at 1:31 PM identified that weekly assessment seen by wound doctor for MASD to coccyx with treatment of Triad paste followed by a foam dressing much improved seen by wound doctor no new orders.

An interview with DNS on 11/4/21 at 9:15 AM noted the infection control nurse was responsible to make sure the weekly wound measurements, treatments were in place, and care planned for Resident #44 and do weekly wound rounds with the wound physician.

Interview and clinical record review with the DNS on 11/4/21 at 12:20 PM indicated she was not able to find any documentation of an RN assessment for a new non pressure area noted on Resident #44 around 2/26/21 when the first treatment was put into place.

Interview with the DNS on 11/4/21 at 12:20 PM indicated she did not see an RN assessment in Resident #44's clinical record of when the MASD on the coccyx or left buttock began in the nursing notes or assessments. The DNS could not definitely indicate when the MASD open area began based on the clinical record. The DNS indicated there was a treatment put into place on

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2/26/21 but did not know why. The DNS indicated her expectation was when a nurse finds a new open area, he/she must get an RN assessment first then call the APRN/MD for a treatment order and call the family. The DNS noted her expectation was that all non-pressure and pressure areas were care planned when they start. The DNS did not indicate why the care plan was not updated with the MSAD non pressure open area, but it should have been.

Interview and clinical record review with RN #4 on 11/4/21 at 1:45 PM indicated the non-pressure area for Resident #44 was not care planned but RN #4 would have expected the nurses to have care planned the area to the left buttock/coccyx area when it started. RN #4 indicated she had reviewed the clinical record for Resident #44 and was not able to find an RN assessment to indicated when the MASD to the coccyx or left buttock began around 2/26/21.

Interview and clinical record review with RN #4 on 11/5/21 at 9:46 AM indicated there was not a care plan done for the MASD to the coccyx or for Resident #44 and that he/she was being followed by the wound physician.

Interview with MD #1 on 11/10/21 at 11:30 AM indicated Resident #44's area was on the buttocks across the coccyx area. MD #1 indicated he would expect the nurses to follow his treatment orders week to week for Resident #44's plan of care.

Although attempted, an interview with prior DNS was not obtained.

Although requested a care planning policy it was

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F 686	Continued From page 100 not provided. 4. Resident #408 was admitted to the facility in October 2019 with diagnoses that included dementia, heart failure, acute embolism, and thrombosis of unspecified deep vein of right lower extremity (on admission), idiopathic peripheral autonomic neuropathy, bilateral pulmonary embolisms, and edema. The annual MDS dated 6/4/21 identified Resident #408 had severely impaired cognition, was always incontinent of bowel and bladder and required extensive assistance for dressing, eating, toileting, and personal hygiene with one staff. The care plan dated 6/18/21 identified at risk for skin breakdown related to decreased mobility. Interventions directed to treatment as ordered, provide with pressure reducing mattress, turn and reposition frequently, monitor for signs and symptoms of redness or skin breakdown. Perform a weekly body audit. The care plan did not address the right heel facility acquired pressure area. APRN #1 interim order dated 8/4/21 at 1:55 PM directed to apply skin prep to right heel twice a day, off load right heel when in and out of bed, monitor area for infection, and a wound consult. The agency nurse's note dated 8/4/21 at 2:55 PM noted the nursing assistant during morning care noted the area on the right heel and LPN did an assessment and notified the APRN. The APRN wrote a new order to apply skin prep, off load heels while in bed, and to be seen by wound doctor. Responsible party aware.	F 686		

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F 686	Continued From page 101 The Electronic Medical Record Physician Order dated 8/4/21 at 3:11 PM indicated to apply skin prep to right heel blister every day and evening. (Other type noted: standard other). The APRN #1 progress note dated 8/4/21 at 11:58 PM identified that Resident #408 was seen for a right heel blister measuring 3.0 cm x 4.0 cm closed blister. New order for skin prep, off load heels in and out of bed, monitor for signs of infection, and a wound consult. The Wound Physician progress note dated 9/21/21 noted right heel pressure wound resolved no treatment needed. This was the only Wound Physician progress note in the clinical record. Interview and clinical record review with RN #4 on 11/5/21 at 9:46 AM indicated there was not a care plan for the right heel pressure area on Resident #408's heel or that Resident #408 had an order for a wound consult. RN #4 indicated her expectation was the pressure area would have been documented in the care plan when first identified. Interview and clinical record review with the DNS on 11/4/21 at 12:20 PM indicated The DNS indicated her expectation was when a nurse finds a new open area, he/she must get an RN assessment first then call the APRN/MD for a treatment order, call the family, and care plan the new area. The DNS noted there was so much agency nurses it was hard to keep track to what they do, but she tried. The DNS indicated her expectation was there would be a care plan in place for the right heel pressure area, but she did not see it in the clinical record.	F 686		

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F 686	Continued From page 102 Interview with RN #4 on 11/5/21 at 9:46 AM indicated there was not a care plan for the right heel facility acquired pressure area for Resident #408. RN #4 indicated her expectation was for the right heel to be care planned when area started by nursing. Review of facility Pressure and non-pressure injury wound risk management identified residents who have actual skin impairment are provided with care to address their individual risk factors and goals of treatment. Heels are extremely vulnerable and must be elevated completely off the bed and or chair surface. Use pillows, positioning devices, and or suspension boot devices. Although requested a policy for care planning was not provided.	F 686		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		1/31/22

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F 689	Continued From page 103 This REQUIREMENT is not met as evidenced by: Based on a review of clinical records, review of facility documentation, interviews, and policy review, for one of three residents at risk for elopement (Resident #54), the facility failed to conduct 15-minute safety checks in accordance with the plan of care and failed to initiate the Dr. Hunt policy when an egress door alarm was activated. As a result, the resident eloped from the facility which went unnoticed for approximately sixty (60) minutes until notified by the local authorities resulting in Immediate Jeopardy. The finding includes: Immediate Jeopardy was cited on 8/18/21, F 689 CFR(s): 483.25(d)(1)(2), for the facility's failure to implement their Dr. Hunt policy when an egress door alarm was activated following the elopement of a resident. An action plan was provided at that time and identified that staff including agency staff would be educated to the Wandering and Elopement policies, educated to the procedure when and exit door alarms, and random exit alarm drills would be conducted. The facility failed to sustain compliance. Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 resident (Resident #46), reviewed	F 689	Immediate Jeopardy Removal Plan Middlesex Health Care is submitting the following Removal Plan related to notification of an Immediate Jeopardy on 11/24/21 at 1:10 PM. Any resident has the potential to be affected by this alleged deficient practice. The facility policies titled, “Wandering Management System” and “Elopement” were reviewed and remain current. Facility staff, including agency staff were provided education on the facility policies “Wandering Management System” and “Elopement” to ensure all residents, specifically residents assessed to be an elopement risk do not elope from the building and are kept safe. Education on the procedure to follow when an exit door alarm sounds was provided to staff. Education was provided on the procedure to follow when an exit door alarm sounds which includes not turning the alarm off, searching the perimeter of the building and conducting a head count of all residents. Education on the “Resident Monitoring Tool” when a resident is placed on every 15 minute checks to ensure residents are checked on every 15 minutes.	

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F 689	Continued From page 104 for smoking, the facility failed to assure a smoking assessment was completed prior to Resident # 46 smoking to maintain safety. The findings include: 1. Resident #54 diagnoses included Dementia and Parkinson disease. The admission elopement and wandering assessment dated 9/10/21 identified the resident was at risk for elopement and wandering. The Resident Care Plan (RCP) dated 9/10/21 indicated that the resident wandered in facility aimlessly due to cognitive deficit. Interventions included to assist the resident to find his/her own room/bathroom and unit as needed and conduct fifteen-minute safety checks for location due to wandering. The admission Minimum Data Set assessment dated 9/13/21 identified Resident #54 had cognitive impairment, required supervision and one-person assistance for ambulation. A physician's order dated 9/30/21 directed to apply a wander guard to the resident's right arm and check function every shift. On 9/30/21 the care plan was updated and identified the resident was at risk for trying to leave facility and roaming in and out other rooms. Interventions included to provide a picture identification or description of the resident to office staff located near the exit doors and use of wander guard to the right arm. Review of the clinical record identified that fifteen minutes checks were conducted from 9/7/21-9/10/21, however, stopped after 9/10/21 absent an assessment that warranted the	F 689	Elopement assessments were conducted on all residents in the facility. The elopement books were reviewed and are current to include all residents assessed to be an elopement risk. The facility conducted an inspection of door alarms to ensure proper functioning. The facility conducted unannounced Dr. Hunt drills. Audits of residents identified to be an elopement risk will be conducted to ensure the Wander Guard bracelet is intact and functional and the residents are included in the facility elopement books. Random drills will be conducted to ensure staff, including agency staff respond when the Wander Guard alarm or exit door alarm sounds per the facility policy. Audits of residents on every 15 minute checks will be conducted to ensure when resident is on 15 minute checks the checks are being completed and documented on the flow sheet. The results of the audits will be presented at the QAPI as required. The DNS and/or designee is responsible for the completion of this PoC. The facility alleges the removal of the Immediate Jeopardy was on 11/24/21 at 1:11 PM. Part 2 1.Resident #46 no longer resides in the facility. 2.Any resident has the potential to be affected by this alleged deficient practice.	

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F 689	Continued From page 105 discontinuation of this monitoring although the resident was identified as an elopement risk. Review of the resident's record during the period of 9/30/21 through 11/19/21 identified that the wander guard was on the resident's right arm and checked for function. The nurse's note dated 11/19/21 at 11:14 PM identified that the nursing supervisor was notified by the local authorities that Resident #54 was found walking around the streets and was transported to the hospital emergency department for evaluation. An additional nurse's note dated 11/19/21 at 11:36 PM indicated that the employee entrance alarm went off late in the evening, the charge nurse entered the access code to deactivate the alarm, went outside to check and did not see anyone, then returned to the unit. Review of the facility incident report dated 11/19/21 indicated the resident eloped from facility at 9:30 PM and the facility was notified by the local authorities at 10:30 PM that the resident was taken to a local hospital for evaluation. Review of the hospital record indicated that on arrival to the hospital on 11/19/21, the resident was dressed in pants and a t-shirt and complained of feeling cold. The temperature outside was 36 degrees. The resident sustained some mild abrasions to both hands. Review of Resident #54's clinical record indicated that although the RCP directed every fifteen minutes checks would be completed to monitor the resident, the facility failed to provide documentation that frequent checks were	F 689	3.The facility policy titled, Smoking was reviewed and remains current. 4.Licensed staff were provided education on the Smoking policy to ensure a resident who expresses the desire to smoke will be evaluated using the smoking assessment completed prior to the resident smoking. 5.Audits will be conducted weekly to ensure when a resident desires to smoke a smoking assessment will be completed prior to the resident smoking until substantial compliance is achieved. The results of the audits will be presented at the QAPI as required. 6. The DNS and/or designee is responsible for the completion this PoC. Immediate Jeopardy Removal Plan Middlesex Health Care is submitting the following Removal Plan related to notification of an Immediate Jeopardy on 11/24/21 at 1:10 PM. Any resident has the potential to be affected by this alleged deficient practice. The facility policies titled, “Wandering Management System” and “Elopement” were reviewed and remain current. Facility staff, including agency staff were provided education on the facility policies “Wandering Management System” and “Elopement” to ensure all residents, specifically residents assessed to be an elopement risk do not elope from the building and are kept safe. Education on the procedure to follow when an exit door alarm sounds was provided to staff.	

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F 689	Continued From page 106 performed from 9/12/21 through 11/19/21. NA#8 (agency staff) was assigned to care for Resident #54 on 11/19/21 during the 3 PM-11 PM shift. Review of the assignment included to conduct fifteen minutes checks and document resident's whereabouts. The documentation failed to identify that fifteen-minute checks were conducted. Several attempts to contact the Nursing Agency to conduct an interview with NA#8 were unsuccessful. Interview with Licensed Practical Nurse (LPN) #4, on 11/23/21 at 11:53 AM, who was the assigned charge nurse during the 7AM-3PM shift on the unit where the resident resided, indicated that Resident #54 wandered around the facility and into other residents' rooms, however, she was not aware that every fifteen-minute monitoring checks should be completed every shift. LPN#4 indicated that fifteen-minutes checks are usually written as a physician order and Resident #54 did not have a written order for fifteen minutes checks. Interview with Registered Nurse (RN#11), on 11/23/21 at 1:12 PM indicated that he was the charge nurse during the 3-11PM shift on 11/18/21. RN#11 stated sometime during the 3-11 shift (unable to identify the specific time), the alarm at the employee entrance sounded. RN#11 stated he turned the alarm off, looked briefly outside while standing at the exit door then returned to his unit. RN#11 further indicated that he did not check the premises, do a head count on the unit, or call a Dr. Hunt according to facility policy. RN#11 indicated that he thought it was an employee or a visitor who activated the alarm therefore he did not go outside to check. RN#11	F 689	Education was provided on the procedure to follow when an exit door alarm sounds which includes not turning the alarm off, searching the perimeter of the building and conducting a head count of all residents. Education on the “Resident Monitoring Tool” when a resident is placed on every 15 minute checks to ensure residents are checked on every 15 minutes. Elopement assessments were conducted on all residents in the facility. The elopement books were reviewed and are current to include all residents assessed to be an elopement risk. The facility conducted an inspection of door alarms to ensure proper functioning. The facility conducted unannounced Dr. Hunt drills. Audits of residents identified to be an elopement risk will be conducted to ensure the Wander Guard bracelet is intact and functional and the residents are included in the facility elopement books. Random drills will be conducted to ensure staff, including agency staff respond when the Wander Guard alarm or exit door alarm sounds per the facility policy. Audits of residents on every 15 minute checks will be conducted to ensure when resident is on 15 minute checks the checks are being completed and documented on the flow sheet. The results of the audits will be presented at the QAPI as required. The DNS and/or designee is responsible for the completion of this PoC. The facility alleges the removal of the Immediate Jeopardy was on 11/24/21 at	

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F 689	Continued From page 107 also indicated that Resident #54 was not on frequent checks, he could not recall the last time he saw the resident, and was not aware that the resident was missing prior to facility receiving a call from the police. In an interview with the Assistant Director of Nursing (ADON) on 11/23/21 at 2 PM she indicated that it was the responsibility of the charge nurse (assigned to the resident) and the MDS coordinator to ensure care plans are updated and interventions are implemented, such as the fifteen-minute checks for Resident #54. The ADON further indicated that RN#11 did not follow facility policy and procedure when the alarm sounded. The ADON stated that if a wander guard alarm sounds, staff should check the door, go outside to check the surroundings, overhead page Dr. Hunt (missing person) three times, and initiate a head count prior to deactivating the alarm. Review of the facility in-service attendance record dated 10/14/21 identified that RN#11 attended the ongoing education regarding responding to alarms/wander guards. The education directed that staff would respond immediately to door alarms to see who exited and check the lobby outside of the door activated to ensure a resident did not leave. Staff were also instructed to conduct a head count to verify residents are accounted for in facility. Although RN #11 was educated on 10/14/21, he failed to implement the facility policy when an egress door alarmed including implementing the Dr. Hunt policy and as a result Immediate Jeopardy was identified. Review of the facility elopement policy indicated	F 689	1:11 PM.	

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that the licensed nurse will conduct an elopement risk on admission, re-admission, annually and upon change of condition. The Licensed nurse will have visual contact with each resident at the beginning of the shift and/or know where each resident is. When it is determined that a resident may be missing, the licensed nurse or designee will page three times and a systematic search will be conducted.

On 11/24/21 the facility provided the Department with an immediate action plan that included; on-going education of facility staff including agency staff on the facility policies, "Wandering Management System and "Elopement" to ensure all residents, specially the residents assessed to be an elopement risk do not elope from the building and were kept safe; education on the procedure to follow when an exit door alarm sounds was provided to staff; and the facility conducted an exit alarm drill.

During the onsite visit on 12/2/21, Immediate Jeopardy was verified as abated when the facility implemented their immediate action plan to mitigate further risk to all residents.

Subsequent to the incident the facility implemented an immediate action plan that included:
Education on the "Resident Monitoring Tool" when a resident is placed on every fifteen (15) minute checks to ensure residents are checked every 15 minutes
Random drills will be conducted to ensure staff, including agency staff respond when the wander Guard alarm or exit door alarm sounds per the facility policy.
Audits on every fifteen minute checks will be

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conducted to ensure when resident is on 15 minute check the checks are being completed and documented on the flow sheet.

2. Resident #46 was admitted to the facility with diagnoses that included heart failure peripheral vascular disease, lower limb amputation and hypertension.

An interdisciplinary care plan meeting dated 5/26/21 identified that Resident #46 participates in smoke breaks.

The quarterly MDS dated 8/22/21 identified that Resident #46 had mildly impaired cognition and is totally dependent for transfers and is independent for locomotion of unit.

The care plan dated 9/7/21 identified that Resident #46 enjoyed time spent outside during smoke breaks with peers with a goal that Resident #46 would spend time outside with peers during smoke breaks 4 - 5 times weekly.

The care plan dated 11/1/21 identified Resident #46 had a history of smoking with a goal for Resident #46 to comply with the smoking policy. Interventions included to instruct the resident about the facilities policy on smoking and to ascertain resident's wishes about smoking and to respect resident's decision.

An APRN progress note dated 10/25/21 at 2:35 PM identified that Resident #46 is awake alert reports chronic cough and a current smoker, not interested in quitting. The progress note continued by identifying that Resident #46 transferred to smoking facility to resume smoking

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privileges 5/2021 and smokes 6 cigarettes a day.

Interview with Resident #46 on 11/1/21 at 1:00 PM identified that Resident #46 enjoyed smoking and would try to get out for smoke breaks as often as he/she could but was limited based on when staff got her/him up in the chair stating that he/she got out to smoke at least twice a day.

Interview and review of Resident #46 ' s medical record on 11/2/21 at 9 AM with RN #4 identified that Resident #46's medical record lacked a smoking evaluation and safety screening form and education in regard to smoking.

Interview with NA #9 on 11/3/21 at 11:30 AM identified that Resident #46 enjoys her/his smoke breaks, and that Resident #46 gets out there at least twice on her shift.

Interview with the DNS on 11/4/21 at 8 AM identified that a smoking evaluation and safety screening should be completed prior to a resident being able to smoke and that residents need to sign a form. She was not sure why one this had not been done for Resident #46.

The facility policy on smoking identified that residents who have a desire to smoke will be asked to review and sign the smoking policy, attesting they will adhere to the facility guidelines and residents who smoke will be evaluated for their ability to smoke safely upon admission, quarterly and with a significant change in condition to ensure they are capable of smoking and can use smoking material without presenting a danger to themselves or others.

Subsequent to surveyor's observation, a smoking

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F 689	Continued From page 111 evaluation and safety screening was completed on 11/3/21 at 4:32 PM.	F 689		
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on clinical record review, interview and review of facility policy for one of three residents with weight loss (Resident #361) the facility failed to ensure that weights were obtained in accordance with the resident's plan of care and facility policy and for one of three sampled	F 692	1. Resident #95 continues to reside in the facility. Resident #361 and Resident #700 no longer resides in the facility. 2. Any resident has the potential to be affected by this alleged deficient practice. 3. The facility policies titled, Weight and	1/31/22

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F 692	Continued From page 112 residents (Resident #95) who exhibited signs and symptoms of an infection and had a decline in oral intake, the facility failed to monitor the resident's fluid intake to ensure the resident consumed a sufficient amount of fluids, and for 1 resident (Resident #700) reviewed for nutrition, the facility failed to consistently monitor and document intake and ensure the resident was meeting their food and fluid intake needs and failed to follow dietician recommendation and conduct an assessment for dehydration. The findings include: 1. Resident #361's diagnoses included dementia. A care plan dated 10/14/19 identified that the resident weighed 147.2 pounds and was at risk for weight loss related to dementia. Interventions included to weigh the resident monthly, assist with meals as needed and provide a regular diet. Review of the resident's clinical record identified that the resident's weight on 2/20/2020 was 147 pounds. Review of an annual nutrition assessment dated 4/14/20 identified that the resident dines independently with supervision while eating and the resident's meal intake was 75% to 100% . The assessment identified that the resident's weight on 3/19/2020 was 138.2 pounds (6% loss in 30 days) and was questionable. The assessment failed to identify that a reweight was obtained when the resident had a 6 % loss in 30 days. Additionally the assessment failed to identify a weight for April 2020 and directed to 'obtain April weight'.	F 692	Hydration were reviewed and remain current. 3. Licensed staff were provided education on the facility□s Weight and Hydration policy to ensure weights are obtained, intake monitored, recommendations from the dietitian followed, and hydration assessment conducted. 4.Random audits will be conducted weekly to ensure the facility Weight and Hydration Policies are implemented to ensure resident weights are obtained, intake monitored, dietitian recommendations followed, and hydration assessments conducted until substantial compliance is achieved. The results of the audits will be presented at the QAPI as required. 5. The DNS or designee is responsible for the completion of this PoC.	

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Review of the resident's clinical record for the period of 4/14/2020 to 4/23/2020 failed to identify that the resident's weight obtained.

Review of a practitioner's progress note date 4/24/2020 identified that the resident was seen for a decline in condition. The progress note identified that the resident was not eating well. The note identified that the resident was treated with tamiflu in early March 2020 for suspected flu and had not rebounded since. The resident's diet was downgraded to puree and the resident was placed on supplement of fortified shakes. The evaluation identified that the resident's dementia was progressive and decline was expected.

Review of the resident's clinical record for the period of 4/24/2020 to 5/8/2020 failed to identify that the resident's weight was obtained since 3/19/2020.

Review of progress note dated 5/8/2020 identified that the resident had a 9 pound weight loss over the past two months and was consuming 100% of meals and supplement. The note identified that the resident's functional decline was likely contributing to the resident's weight loss.

Although a review of the resident's clinical record for the period of 5/8/2020 through 6/29/2020 with the DON on 11/9/21 at 11:00 AM failed to identify documentation of the resident's monthly weights, a review of a change of condition nutritional assessment dated 7/3/2020 identified that the resident's weights were 124.5 pounds on 5/10/2020 and 121.2 pounds on 6/4/2020. The nutritional assessment identified that the resident was admitted to Hospice care on 7/1/2020 and the nutritional plan of care would continue with

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liberalized diet and supplements.

The DIeitician was no longer employed at the facilty and attempts to interview were unsuccessful.

Interview and review of the facility's weight policy, with the DON on 11/9/21 at 11:00 AM, identified that the resident's monthly weights should have been documented in the clinical record when they were obtained and based on the facility policy all weight losses or gains of 5 pounds or more on a resident weighing 100 pounds or more requires a reweigh for verification. A reweigh is done on the same scale with a licensed nurse present.

2. Resident #95's diagnoses included dementia with behavioral symptoms, dysphagia (difficulty swallowing), cerebrovascular accident, and metabolic encephalopathy.

The quarterly Minimum Data Set assessment dated 9/11/20 identified Resident #95 rarely or never made decisions regarding task of daily life, was independent with eating, was always incontinent of bladder, and had a history of pneumonia and septicemia.

The resident care plan dated 9/24/20 identified Resident #95 was at risk for alteration in nutrition related to dementia. Interventions directed to provide a regular diet and document meal intakes. The resident care plan did not address if Resident #95 was at risk for dehydration.

The laboratory results dated 11/4/20 identified Resident #95's Sodium level was 148 (normal

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range 133-145), Blood Urea Nitrogen 26 (normal range 1-24), and creatinine was 0.7 (normal range 0.7-1.5). The urinalysis dated 11/7/20 identified white blood cells level 47 (normal range 0-5) and the presence of gram negative rods.

A physician's order dated 11/9/20 directed to administer the antibiotic Rocephin one gram immediately and a chest x-ray for oxygen decomposition.

Review of the nurse's notes from 11/6/20 through 11/11/20 identified Resident #95 was lethargic, ate with encouragement, and meal consumption varied.

Review of the clinical record failed to reflect documentation Resident #95 was assessed for dehydration and monitoring the resident's intake and output was initiated when Resident #95 had a change in condition

The laboratory results dated 11/10/20 identified Resident #95's Sodium level was 158 (normal range 133-145), Blood Urea Nitrogen 43 (normal range 1-24), and creatinine was 1.1 (normal range 0.7-1.5).

The nurse's note dated 1/11/20 at 10:45 AM identified Resident #95 was seen by the Advanced Practice Registered Nurse (APRN) and physician who directed to transfer Resident #95 to the hospital for an evaluation.

The hospital discharge summary dated 11/15/20 identified the principal diagnoses was acute metabolic encephalopathy, hypernatremia, dehydration, and urinary tract infection. The report indicated Resident #95's status improved

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with intravenous fluids.
In an interview with the Director of Nursing (DON) on 11/10/21 at 9:30 AM identified under the Urinary Tract Infection protocol a resident would be put on intake and output, documentation would be found on paper. Although requested the intake and output documentation was not available.

3. Resident #700 was admitted to the facility on 11/13/21 with diagnoses that included Covid 19, dysphagia, gastro-esophageal reflux disease, and stage IV malignant neoplasm of colon.

The care plan dated 11/13/21 identified Resident #700 required extensive assistance due to a recent hospitalization for Covid 19. Interventions included allow resident to make choices, ask and encourage resident to participate to the full extent that he/she is able.

Review of the nurse's note dated 11/14/21 through 11/24/21 failed to reflect the physician/APRN was notified that the resident was not meeting the estimated fluid intake and meal intake.

The admission MDS dated 11/19/21 identified Resident #700 had intact cognition and required supervision with eating with one-person physical assist.

A physician's order dated 11/20/21 directed to obtain blood work - complete blood count, and basic metabolic panel.

A nutrition assessment dated 11/21/21 at 4:11 PM

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identified Resident #700 was receiving a regular mechanical soft ground texture, thin liquids diet and required an estimated 1551ml - 1860ml of fluids daily. recommendations included to initiate magic cup with lunch and dinner meals and house supplement 120ml twice a day. Albumin decreased indicating moderate depletion of visceral protein stores. Resident #700 is at high nutritional risk due to diagnosis and low albumin. Swallowing difficulty secondary to diagnosis.

A physician's order dated 11/21/21 directed to provide Regular diet Mechanical Soft Ground texture, thin liquids consistency.

Review of the NA documentation survey report dated 11/21/21 through 11/24/21 failed to reflect documentation for snacks 3 days out 4.

The care plan dated 11/22/21 identified Resident #700 is at risk for weight loss due to symptoms of dysphagia, diagnosis of colon cancer, and variable appetite. Interventions included determine and offer food preferences. Monitor food intake with every meal. Offer snacks between meals and meal substitutions as appropriate. Offer bedtime snacks. Likes ice cream, and milkshakes. Provide Magic cup with lunch, dinner, and house milkshake 120 ML twice a day.

Review of the intake and output flow sheets dated 11/14/21 through 11/23/21 identified the resident did not meet the fluid goal and had a reduction in fluid intake less than estimated needs (10 of 11 days) until transferred to hospital on 11/24/21.

Review of the NA documentation survey report dated 11/14/21 through 11/24/21 failed to reflect

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documentation for amount eaten/eating at 9:00 AM breakfast (7 days out 11 days), at 1:00 PM lunch (7 days out of 11 days), and 6:00 PM dinner (5 days out of 11 days).

Review of the nurse's note dated 11/14/21 through 11/24/21 failed to reflect documentation regarding meals and fluid intake.

The nurse's note dated 11/24/21 at 1:17 PM identified Resident #700 was seen by the APRN on rounds for lethargy, and new order STAT blood work, Intravenous Fluid D5 ½ Normal Saline at 100 ML an hour times 2000 Liters to start when peripheral line is placed. Fluids encouraged and blood work obtained. Awaiting results.

The APRN progress note dated 11/24/21 at 2:38 PM identified Resident #700 was being seen for a fall. Resident #700 denied dizziness, headache, chest pain, and shortness of breath. Denies hitting his/her head. Resident #700 appears fatigue and dry this visit. Person #2 at bedside who reported Resident #700 is much slower to respond than baseline. APRN indicated she discussed the plan for intravenous hydration and blood work with Person #2. Fall likely due to dehydration and weakness. New order for intravenous fluid D5 ½ Normal Saline at 100 ML an hour times 2 Liters and blood works STAT. Continue to monitor neurological status per fall protocol and notify with any acute changes.

Review of the lab results report dated 11/24/21 at 6:23 PM identified collected on 11/24/21 included BUN 141 high (reference range 10-24), Creatinine 4.6 high (reference range 0.7-1.5), sodium 129 low (reference range 133-145), potassium 6.7 high (reference range 3.3-5.1), and

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Carbon Dioxide CO2 low (reference range 22-33).

The nurse's note dated 11/24/21 at 10:58 PM identified Resident #700 was transferred to the hospital for evaluation due to abnormal lab work per the APRN new order.

Interview with RN #1 on 12/2/21 at 8:30 AM identified he was not aware of the issue.

Interview with NA #10 on 12/2/21 at 11:30 AM identified she was assigned to Resident #700 on 11/24/21 that was her first time assigned to the resident. NA #10 indicated Resident #700 consumed 0-25 % of breakfast and lunch. Although she noticed that Resident #700 drank his/her fluids. NA #10 indicated she attempted to feed the resident, but resident refused to eat breakfast and lunch. She indicated she was aware of the resident poor meal intake. NA #10 indicated she failed to notify the nurse that the resident did not eat breakfast and lunch.

Review of the clinical record failed to reflect an assessment for dehydration.

Interview with the DNS on 12/12/21 at 1:34 PM identified she was not aware of the issues identified. The DNS identified that the facility has been having issues with staffing. She identified that there had been a problem with documenting and monitoring fluids, and meals intake at the facility. The DNS indicated it is the responsibility of the nurse's aide to document meal intake. She indicated the nurse on the second shift is responsible to total the fluid intake at the end of the shift. She indicated a hydration assessment was to be initiated and the physician/APRN

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should have been notified. The DNS indicated the nurse's aide are responsible to notify the nurse when the resident does not meet their meal and fluid intake. The DNS indicated the facility did not have a dietician. She indicated the facility just hired a new dietician couple of weeks ago.

Interview with APRN #1 on 12/2/21 at 1:39 PM identified LPN #8 notified her that Resident #700 was on the floor in the room. APRN #1 indicated she assessed Resident #700 in the bed, and he/she complained of feeling weak. APRN #1 indicated Person #2 was at the bedside and the plan of care was discussed. APRN #1 indicated she ordered intravenous hydration and blood work. APRN #1 indicated she had ordered blood work on 11/20/21 and it was not collected that is why she ordered blood work again on 11/24/21 STAT. APRN #1 indicated the facility did not notify her that the blood work for (11/20/21) was not collected as ordered. APRN indicated she was not notified of resident poor fluid and meal intakes. The APRN indicated Resident #700 was transferred to the hospital sometime after 5:30 PM.

Review of the facility intake and output monitoring policy dated identified intake and output will be monitored, as indicated by the resident's hydration status, risk for dehydration, and/or per physician's order. Intake and output will be monitored initially for 72 hours after a resident is admitted or readmitted. Continued monitoring may be required based on the resident's risk factors for dehydration, as outlined in the Hydration policy, or based on results of dehydration evaluation, if conducted. Intake and output is totaled daily by the 3:00 PM to 11:00 PM shift nurse and the 24 hour totals are transcribed

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F 692	Continued From page 121 to the medication administration record. Review of the facility hydration policy identified at risk residents will be reviewed and will be provided with interventions to promote hydration based on the resident's physical and mental abilities, resident/responsible party's wishes pertaining to hydration and quality of life. The goal is to maintain the resident's hydration to the extent possible. Residents identified for a potential at risk for dehydration will be placed on intake and output monitoring until adequate hydration status is achieved or until intake and output monitoring is no longer clinically indicated. Registered Dietician/MD/Licensed Nurse will determine minimum fluid needs range. If the resident has consumed less than their estimated needs for 3 consecutive days, complete a dehydration evaluation. The facility failed to consistently monitor and document intake and ensure a resident was meeting their food and fluid intake needs and notify the physician and APRN timely of a blood work that was ordered and was not obtained and failed to follow dietician recommendation and conduct an assessment for dehydration.	F 692		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced	F 697		1/31/22

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F 697	Continued From page 122 by: Based on observation, review of the clinical record, facility documentation, and interview for 1 resident (Resident #71) reviewed for pain management, the facility failed to ensure an as needed (prn) pain medication was administered when requested. The findings include: Resident #71's diagnoses included chronic pain, dorsalgia, and peripheral vascular disease. The quarterly MDS dated 9/10/21 identified Resident #71 had intact cognition, was independent with all activities of daily living and used a walker for mobility. Pain assessment identified resident had almost constant, severe pain which limited day to day activities and made it hard to sleep at night. The care plan dated 9/22/21 identified pain related to chronic lower back pain. Interventions directed to administer pain medications as ordered, assess characteristics of pain including location, severity and discuss with resident the need to request pain medications before pain becomes severe. Monthly Physician's orders for October 2021 directed to monitor pain every shift using 0-10 scale; Oxycodone 20 milligrams (mg) (short act) give 1 tablet every 4 hours for back pain; Oxycodone 10mg give 1 tablet every 6 hours as needed for pain. Review of the Medication Administration Record October 2021 identified Oxycodone 10mg every 6 hours as needed (prn) for pain. Further review identified Resident #51 received Oxycodone 10mg (prn) on 10/4/21 at 4:05PM and not again	F 697	1. Resident#71 no longer resides in the facility. 2. Any resident has the potential to be affected by this alleged practice. 3. The facility policy titled, Pain Management was reviewed and remains current. 4. Licensed staff were provided education on the Pain Management policy to ensure residents pain medication is administered when requested by the resident per the physician order. 5. Random weekly audits will be conducted to ensure residents pain medications are being administered when requested per the physician order until substantial compliance is achieved. The results of the audits will be presented at the QAPI meeting as required. 6. The DNS and/or designee are responsible for the completion of this PoC.	

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until 10/5/21 at 8:33AM.

Interview with Resident #71 on 11/2/21 at 9:50 AM identified that on 10/5/21 he/she had requested Oxycodone 10mg around 12:15AM-12:30AM from LPN #1. Resident #71 identified that LPN #1 indicated his/her supply of Oxycodone had run out and he/she could not borrow medication from another resident. LPN #1 summoned RN #1 who, per resident, explained he/she would have to wait until his/her scheduled 2:00 AM dose of Oxycodone 20mg because she could not access the facility's emergency medications. Resident #71 identified that RN #1 needed another RN to access the medications. Resident #71 identified being upset because he/she was always in constant pain (9 out of 10 on the pains scale) and needed his/her medication when he/she asked for it. Resident #71 identified being in constant severe pain for 27 years secondary to motor vehicle accidents and other injuries he/she had sustained in the past. Resident #71 indicated becoming very frustrated and left to wait until his/her 2:00 AM scheduled dose was due.

Interview with RN #1 on 11/2/21 at 2:55 PM identified on 10/5/21 around 12:30 AM she was summoned by LPN #1 indicating Resident #71 requested Oxycodone 10mg prn but had none available. RN #1 identified she explained to the resident they could not borrow from another resident and she did not have access to the facility's emergency supply. RN #1 identified the resident was very upset but indicated because she had no access to the Pyxis emergency medication supply, she asked resident to wait until he/she was due for the scheduled Oxycodone 20mg at 2:00 AM. RN #1 identified an

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RN plus another licensed nurse were required to access and retrieve narcotic medications from the Pyxis. Although RN #1 indicated she had requested to be provided access with pass code multiple times, from the DNS, she did not have access at the time Resident #71 requested the medication. RN #1 identified she did receive access subsequent to this incident.

Interview with LPN #1 on 11/2/21 at 3:25 PM identified that on 10/5/21 at around midnight, Resident #71 requested Oxycodone 10mg but because his/her supply had run out, she summoned RN #1 to see if she could obtain medication form their emergency supply as the resident was becoming upset. RN #1 explained to Resident #71 that she did not have access to the emergency supply and asked if he/she could wait until the scheduled dose of Oxycodone 20mg was due. LPN #1 identified Resident #71 walked away and did wait to receive the scheduled 2:00 AM medication without further incident.

Interview with former DNS on 11/4/21 at 10:10AM identified that she and the DNS (who was the former ADNS), were both able to provide access and pass codes to nurses using the Pyxis. Former DNS identified she would provide access if/when she was made aware that a nurse required access however was not aware RN#1 did not have Pyxis access on 10/5/21, and had not been asked by RN #1 to provide her access prior to that time. Former DNS identified if an RN needed to access the Pyxis when she (former DNS) was not in the building to provide them access, the RN should call the DNS, who could contact the emergency pharmacy person who could provide Pyxis access. Former DNS identified at the time, she was performing so

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F 697	Continued From page 125 many other functions, she was not able to also keep track of nurses who did or did not have Pyxis access. Additionally, she identified that ideally, all the nurses, especially the RN's, should have access to the Pyxis so when a medication is newly ordered or when a resident runs out of a medication, a delay in the resident receiving the prescribed medication can be avoided. Review of the facility's Pain Management policy identified facilities are committed to assisting each resident/patient to attain or maintain his/her highest practicable mental and psychosocial wellbeing. This done by evaluating pain and using interventions to prevent pain from interfering with eating, mobility and overall quality of life. In the evaluation process, the resident's/patient's perception of pain is always considered reality and the resident's/patient's goals for pain management will be honored. The resident's/patient's acceptable level of pain will be determined by resident interview and evaluation.	F 697		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, review of the clinical record, facility documentation, facility policy and	F 698	1. Resident # 61 continues to reside in the facility.	1/31/22

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F 698	Continued From page 126 interviews for 1 resident (Resident #61) reviewed for a specialized treatment, the facility failed to ensure a fluid restriction order was in place and that intake and output was monitored according to the specialized provider recommendations and facility policy. The findings include: Resident #61 was admitted to the facility on 11/29/20 with diagnoses that included end stage renal disease and type II diabetes mellitus. Physician's order dated 6/23/21 directed to provide a liberal renal diet, regular consistency texture, 2-4 Grams sodium. The physician's order failed to reflect a fluid restriction. Review of the nutrition progress notes from 6/2021 through 7/2021 failed to reflect Resident #61 was on fluid restriction. The quarterly MDS dated 8/24/21 identified Resident #61 had severely impaired cognition and required supervision with one-person physical assist with eating. Review of the Nutrition Therapy Assessment (Quarterly) dated 9/6/21 identified Resident #61's diet order is liberal renal, low sodium (2-4gm Na), controlled carb, regular consistency, thin liquids (no nuts, no fish, no chicken, no black pepper). Built up utensils with all meals. The assessment failed to reflect that Resident #61 was on fluid restriction. The care plan dated 9/9/21 identified Resident #61 needs dialysis related to end stage renal disease. Interventions directed to monitor intake and output.	F 698	2. Any resident has the potential to be affected by this alleged deficient practice. 3. The facility policies titled, Physician Orders and Intake and Output were reviewed and remain current. 3. Licensed staff were provided education on the facility□s Physician Orders and Intake and Output policies to ensure residents who require dialysis have fluid restrictions implemented and intake and output monitored per physician orders. 4.Random audits will be conducted weekly to ensure the facility Physician Orders and Intake and Output policies are implemented to ensure resident who require dialysis have fluid restrictions maintained and intake and output completed until substantial compliance is achieved. The results of the audits will be presented at the QAPI as required. 5. The DNS or designee is responsible for the completion of this PoC.	

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Review of the nurse's note dated 10/1/21 through 11/4/21 failed to reflect documentation Resident #61 was on fluid restriction.

Review of the specialized treatment provider nutrition notes dated 10/26/21 identified Resident #61 is on 1200 ML fluid restriction.

Review of the intake and output logs dated 9/2021 through 11/2021 failed to reflect documentation that Resident #61's fluid intake/output was being monitored.

Interview with Person #3 on 11/4/21 at 12:38 PM identified Resident #61 has been on a 1200 ML/day fluid restriction per specialized treatment provider recommendations.

Interview with LPN #10 on 11/4/21 at 11:45 AM identified she is from the staffing agency and this is her first time on the unit. LPN #10 indicated she was not aware, nor was she given report that Resident #61 was on a fluid restriction.

Interview and review of facility documentation with the DNS on 11/4/21 at 3:16 PM identified that Resident #61 was not on a fluid restriction and fluid intake and output were not being monitored. The DNS indicated she was not aware Resident #61's fluid intake and output were not being monitor during 9/2021, 10/2021 and 11/2021. The DNS indicated that the staff should have been monitoring fluid intake and output because the resident was receiving a specialized treatment and she could not explain why intake and output were not being monitored per facility policy. The DNS indicated the computer system was changed in August 2021.

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Interview with Person #1 on 11/5/21 at 10:16 AM identified she was not aware Resident #61 was not on a fluid restriction at the facility. Person #1 indicated Resident #61 has an order at the treatment center for Fluid Restriction 1200 ML every day. Person #1 indicated that the facility was aware of the fluid restriction when the order was first placed. Person #1 indicated she has not spoken to the facility dietitian in some months now. She indicated the facility did not notify the center that Resident #61 was not on a fluid restriction. Person #1 indicated the center had communicated with the facility at the beginning of the year regarding the fluid restriction recommendation.

Interview with APRN #2 on 11/5/21 at 11:25 AM identified she was not aware that the staff were not monitoring Resident #61's fluid intake and output. She indicated the expectation is that all shift are to monitor and document Resident #61's intake and output at the end of each shift.

Although attempted, an interview with Person #2 was not obtained.

Review of the facility hemodialysis policy directed to provide comprehensive care to residents/patients that receive hemodialysis treatments. If resident/patient is placed on fluid restriction, monitor intake. Allocate fluids to be given by nursing and dietary with amounts per shift. Communication between the facility and the hemodialysis center will occur using a communication book/sheet.

Review of the facility fluid restriction policy directed restricted fluid intake will be maintained for an individual resident, as ordered by the

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F 698	Continued From page 129 physician, as part of a treatment protocol for certain medical conditions. There must be a physician's order specifying the amount of the restriction per 24 hours. The dietary department staff must be notified. The Registered Dietitian should calculate the fluid restriction breakdown to include the amount of fluids to be provided during the meal service and the rest of the fluids to be provided by the nursing staff during medication passes and hydration passes. The fluid restriction breakdown should be documented on the medication administration record, as well as dietary or tray card. Maintain accurate intake and output. Review of the facility intake and output monitoring policy directed intake and output will be monitored, as indicated by the resident's hydration status, risk for dehydration, and/or per physician's order. Intake and output is documented for each shift beginning with the 11 to 7 shift. Intake and output is totaled daily by the 3 to 11 shift nurse and the 24 hour totals are transcribed to the medication administration record. The facility failed to ensure a fluid restriction order was in place and that the fluid status was being monitored according to recommendation and facility policy.	F 698		
F 725 SS=G	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest	F 725		1/31/22

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F 725	Continued From page 130 practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on review of the clinical record, facility documentation, facility policy and interview for 4 of 6 residents (Resident #27, 44, 97, and 408), reviewed for wounds/pressure ulcers, the facility failed to ensure sufficient and consistent nurse staffing with the appropriate competencies to provide consistent ongoing care according to physician's orders, facility policy and professional standards to meet the residents highest practicable well-being, and for 1 resident	F 725	1.Resident #97□s care plan has been revised to meet the needs of the resident. 2. All residents have the potential of being affected by this alleged deficient practice. 3. Licensed staff will be educated to ensure: Weekly skin audits are completed. Air mattresses are provided to all residents at risk for pressure ulcers. Weekly skin assessments and	

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F 725	Continued From page 131 (Resident #700) the facility failed to ensure there was sufficient staffing to meet the residents needs. The findings include: 1. Resident #97s diagnoses included dementia and diabetes mellitus. Interview with RN #5 on 11/4/21 at 8:00 AM identified that she is the Regional Infection Preventionist, and that the facility does not have a full time RN Infection Preventionist to oversee the infection control program at this time. RN #5 indicated that the facility is in the process of reviewing applications for an Infection Preventionist. Interview with MD #1 on 11/5/21 at 1:38 PM identified when he conducts his wound rounds, he frequently does so by himself without the benefit of a facility nurse present. MD #1 indicated that he first became aware of Resident #97's stage 3 coccyx pressure ulcer on 10/12/21 via the resident's family member (Person #1). MD #1 indicated he was not informed of the pressure ulcer by facility staff and identified he had recommended on 10/12/21 a low air loss mattress. MD #1 identified after seeing the resident 2 additional times, he had to write an order directing staff to provide the low air loss mattress because the resident needed it and the staff had not provided it. MD #1 further indicated that although Resident #97's stage 3 pressure ulcer increased in size and was not improving, he had not changed the treatment modalities because it was his belief that the treatment was not being consistently done by staff, and that he was always encouraged staff to do the treatment and provide turning and repositioning.	F 725	documentation of the assessments. Treatments are being done to address identified skin issues as per the directives of the APRN and or MD. Offloading of residents heels per the MD or and or the residents care plan. 4. Random audit will be conducted daily to ensure compliance and results will be reviewed at quarterly QA/QI Meetings until substantial compliance is met. 5. The DNS and or the designee will be responsible for this POC. 2.R#27s care plan has been revised to meet the needs of the resident. All residents have the potential of being affected by this alleged deficient practice. Licensed staff will be educated on: Weekly pressure ulcer assessments will be completed and documented by the Infection Preventionist in the clinical record. Licensed staff will be educated on initiating an assessment if the Infection Preventionist is unavailable to complete weekly assessments. Notifying the APRN/MD of significant changes related to a pressure ulcer and or when there is no treatment in place for a pressure ulcer Consulting the dietitian for all pressure ulcers. Random audits will be conducted to ensure compliance and results will be reviewed at quarterly QA/QI Meetings until substantial compliance is met. The DNS and or the designee will be responsible for this POC.	

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F 725	Continued From page 132 The facility failed to conduct weekly skin checks according to the care plan between 7/16/21 -10/12/21, failed to provide an air mattress between 7/16/21 to sometime in November 2021 (staff were not able to provide that date), failed to ensure a registered nurse assessed the pressure ulcer, failed to do weekly wound assessments and document that assessment between the time the resident developed a stage II pressure ulcer on 8/26/21 to 10/12/21, over 6 weeks, when the wound doctor, MD #1, assessed the wound at a stage III pressure ulcer. Additionally, the facility failed to provide a treatment to the stage II pressure ulcer between 8/26/21 to 10/12/21, over 6 weeks at which time the wound had deteriorated to a stage III. Further, upon observations during the survey, the resident was not provided adequate offloading of the pressure ulcer according to the care plan and physician recommendations. Please cross reference F686. 2. Resident #27 was admitted to the facility on 7/28/21 with diagnoses that include diabetes, chronic kidney disease and dementia. Interview with RN #4 and RN #5 on 11/4/21 at 1:40 PM identified that pressure ulcers should be assessed by an RN weekly including measurements, however, for Resident #27, other than the first pressure injury evaluation done on 9/20/21, no other pressure injury evaluations were done. RN #4 and RN #5 indicated there has been inconsistent staffing, increased use of pool nurses and not a steady infection control nurse. Due to the staffing issues, weekly pressure ulcer assessments had not been done.	F 725	3. R#44□s care plan has been revised to meet the needs of the resident. All residents have the potential of being affected by this alleged deficient practice. Licensed staff will be re-educated to ensure: All wounds have a treatment in place. Weekly assessments are done weekly and documented in the clinical record. Random audits will be done weekly to ensure compliance and results will be reviewed at quarterly QA/QI Meetings until substantial compliance is met. The DNS and or the designee will be responsible for this POC. R#408 no longer resides in the building. All residents have the potential of being affected by this alleged deficient practice. Licensed staff will be re-educated to ensure: Care plans are being completed to address identified concerns related to each resident. Competency of wound care tasks is proficient. Random audits will be done weekly to ensure compliance and results will be reviewed at quarterly QA/QI Meetings until substantial compliance is met. The DNS and or the designee will be responsible for this POC.	

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F 725	Continued From page 133 The facility failed to ensure weekly skin checks were completed between admission - 11/4/21, failed to ensure weekly pressure ulcer assessments were completed after a DTI was identified on 9/20/21, failed to have the wound doctor evaluation the residents new pressure ulcer for over 3 weeks, and failed to ensure that the dietitian was consulted to ensure adequate nutrition for wound healing when Resident #27 developed a DTI on 9/20/21 Please cross reference F686. 3. Resident #44 was admitted to the facility in November 2019 with diagnoses that included malignant neoplasm of the duodenum, malignancy of the bone, and below the knee left amputation. Interview with the DNS on 11/4/21 at 12:20 PM indicated she did not see an RN assessment in Resident #44's clinical record of when the MASD on the coccyx or left buttock began in the nursing notes or assessments. The DNS could not definitely indicate when the MASD open area began based on the clinical record. The DNS indicated there was a treatment put into place on 2/26/21 but did not know why. The DNS indicated her expectation was when a nurse finds a new open area, he/she must get an RN assessment first then call the APRN/MD for a treatment order and call the family. The DNS noted her expectation was that all non-pressure and pressure areas were care planned when they start. The DNS did not indicate why the care plan was not updated with the MSAD non pressure open area, but it should have been.	F 725	R#700□s care plan has been revised to meet the needs of the resident. All residents have the potential of being affected by this alleged deficient practice. Nursing staff will be educated on ensuring supervision for resident at risk for falls. Nursing staff will be educated on answering family phone calls. Random audits will be done weekly to ensure compliance. The DNS and or the designee will be responsible for this POC.	

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F 725	Continued From page 134 An interview with DNS on 11/4/21 at 9:15 AM noted the infection control nurse was responsible to make sure the weekly wound measurements and treatments were in place for Resident #44 and do weekly wound rounds with the wound physician, however, the DNS noted there wasn't an infection control nurse from mid December 2020 until now, 11/2021. The DNS indicated they would have an infection control nurse for 3-4 weeks at a time but there was not a consistent infection control nurse at that time during March and April 2021. The DNS indicated the nursing supervisor, who could be from the agency, and would be different week to week, was responsible to round with the wound doctor to see residents, but would be busy, and not always help the wound doctor. The DNS noted the facility had staffing issues so there were times no one would go with the wound doctor. The DNS indicated if the wound doctor saw a resident and put an order in place, she expected the nurses to transcribe and do the treatment until the next week when seen again by the wound doctor. The DNS indicated she thought the treatment from 2/26/21 - 3/11/21 dropped off on 3/11/21 and the nurses would just assume it would just continue and not renew the treatment order. The DNS indicated the same response for what happened to the treatment that ended on 3/30/21, it dropped off and should have continued until 4/6/21 when the wound doctor resolved the wound. The DNS indicated she was not aware prior to surveyor inquiry and clinical record review that Resident #44 did not have a treatment in place from 3/11/21 - 3/16/21 and 3/30/21 to 4/6/21. The DNS indicated she was not aware of the grievance about from Resident #44 regarding the treatment to the wound not being done. The DNS	F 725		

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indicated if someone knew the treatments were not done per the APRN/wound physician orders the APRN/ Wound Physician should have been notified.

Interview and clinical record review with RN #4 on 11/4/21 at 1:45 PM indicated the non-pressure area for Resident #44 was not care planned but RN #4 would have expected the nurses to have care planned the area to the left buttock/coccyx area when it started. RN #4 indicated she had reviewed the clinical record for Resident #44 and was not able to find an RN assessment to indicated when the MASD to the coccyx or left buttock began around 2/26/21.

Interview and clinical record review with RN #4 on 11/5/21 at 9:46 AM indicated there was not a care plan done for the MASD to the coccyx or for Resident #44 and that he/she was being followed by the wound physician.

Interview with MD #1 on 11/10/21 at 11:30 AM indicated Resident #44's area was on the buttocks across the coccyx area. MD #1 indicated he would expect the nurses to follow his treatment orders week to week for Resident #44's plan of care.

Please cross reference F686.

4. Resident #408 was admitted to the facility in October 2019 with diagnoses that included dementia, heart failure, acute embolism, and thrombosis of unspecified deep vein of right lower extremity (on admission), idiopathic peripheral autonomic neuropathy, bilateral pulmonary embolisms, and edema.

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F 725	Continued From page 136 Interview and clinical record review with the DNS on 11/4/21 at 12:20 PM indicated The DNS indicated her expectation was when a nurse finds a new open area, he/she must get an RN assessment first then call the APRN/MD for a treatment order, call the family, and care plan the new area. The DNS noted there was so much agency nurses it was hard to keep track to what they do, but she tried. The DNS indicated her expectation was there would be a care plan in place for the right heel pressure area, but she did not see it in the clinical record. Interview with RN #4 on 11/5/21 at 9:46 AM indicated there was not a care plan for the right heel facility acquired pressure area for Resident #408. RN #4 indicated her expectation was for the right heel to be care planned when area started by nursing. Please cross reference F686. Although requested, the facility did not have a job description for oversight of wounds/pressure ulcers. Interview with the DNS on 11/4/21 at 3:16 PM identified that the facility does not have a dedicated Infection Preventionist (IP). The DNS indicated that the facility had an RN Infection Preventionist in the position from 10/6/20 to 12/14/20, however, the facility was unable to fill the position from 12/14/20 to 6/29/21 and was without an IP for 6 months. The DNS indicated that the position was filled on 6/29/21 and the RN that filled the position left the facility on 8/2/21 and that the facility has not been able to fill the position since then, 3 months. The DNS	F 725		

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identified that the facility is in the process of reviewing applications and interviewing.

Interview with the Administrator on 11/5/21 at 9:37 AM identified that he has been at the facility for 6 weeks. The administrator indicated he is aware that the facility does not have a dedicated IP and indicated that the facility is in the process of reviewing applications and interviewing.

Interview with the Medical Director, (MD #2), on 11/5/21 at 11:00AM identified that he has been with the facility for 6 months and was aware that the IP role was currently vacant. MD #2 indicated that consistent with other facilities, he would expect oversight of the wound program to be a part of the IP's role, and was not aware that specific duties and responsibilities as delineated by this facility did not include wound assessment and coordination of the wound doctors rounds and follow through of the treatment plan and wound program. MD #2 identified that the IP role in wound care is a necessary component of the job and indicated he was aware that there were some inconsistencies in wound management and identified that lack of consistent staff directly impacts the care of the residents, and that it was likely the reason for some of the issues identified at this time within the wound care program. MD #2 continued by stating that the Wound MD has his own electronic documentation system and that he was currently working to see how the facility could converge the 2 systems to be able to directly access MD #1's wound documentation. MD #1 did supply reports, so MD #2 was aware of the facility acquired wounds and was aware that MD #1 was also concerned about the inconsistency in staff caring for the residents.

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Interview with the DNS on 11/5/21 at 11:30 AM identified that the facility identified that it was the IP's role to oversee the wound care program and to round with the Wound Doctor (MD #1) every Tuesday. The DNS continued by stating the IP was responsible to observe the wound with MD #1 and document the weekly nursing assessment. The wound measurements would only be documented by the MD, but the remainder of the nursing skin/wound assessment would be completed by the IP. A log of residents that MD #1 evaluated was kept by the IP and would include information on changes in pressure wound and treatments. With the IP role being vacant, a RN would be designated to accompany the wound doctor on rounds and would be responsible to complete the log and to document the wound assessment. Ideally this should have been the DNS, the ADNS or a RN supervisor. After the last IP left in August 2021, nursing leadership positions began to become vacant, and the facility was unable to assign a consistent facility RN to round with MD #1 and complete the required documentation. The task was assigned at times to an agency RN and was not always the same consistent RN. The DNS identified that agency staff aren't as dedicated as regular staff to assure tasks are completed as assigned. The DNS further stated she believed this led to the inconsistencies in oversite and contributed to the lack of follow through on documentation, care plan and treatment plan completion. Currently the RN Supervisors role on all shifts are primarily filled by agency staff. She continued by stating that within the last few weeks, the administrator was able to contract specific agency RNs to fill the supervisor role at the facility on a more consistent basis and that they recently designated 1 specific agency RN who has a background in

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wounds to round with MD #1 and to be responsible for accurate documentation and wound log completion. She also identified that in collaboration with the Medical Director, Administrator and Corporate staff, a new nursing leadership model has been developed where additional management positions will be created.

Interview with the Administrator on 11/5/21 at 11:10 AM identified that he had been able to secure contracts with 2 agency RNs to work consistently at the facility within the last 2 weeks as an improvement initiative to address the identified inconsistencies in nursing care provision. The Administrator further identified he, the medical director, DNS and MD #1 had identified that the lack of regular facility staff had led to concerns of care provision.

A random review of staffing schedules dated 10/11/21 to 10/17/21 to determine the percentage of agency staff scheduled in the facility identified the following.

On 10/11/21 there were 62% agency staff.
On 10/12/21 there were 67% agency staff.
On 10/13/21 there were 60% agency staff.
On 10/14/21 there were 51% agency staff.
On 10/15/21 there were 62% agency staff.
On 10/16/21 there were 51% agency staff.
On 10/17/21 there were 33% agency staff.

Review of the prevention and management of pressure injuries policy procedure identified that residents with pressure ulcers injuries and those at risk for skin breakdown are identified, assessed, and provided appropriate treatment to encourage healing and/or maintenance of skin integrity. The policy further identified the

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necessary treatment and services will be provided to promote healing, prevent infection, and prevent new pressure injuries from developing and that that ongoing monitoring and evaluation are provided to ensure optimal resident outcomes.

Although requested, the facility was unable to provide a complete facility assessment that identified resident care needs and nurse competencies necessary to meet those needs.

The facility failed to ensure sufficient, competent and consistent nurse staffing to provide ongoing care according to physician's orders, facility policy and professional standards due to the lack of regular facility employed licensed staff.

5. Resident #700 was admitted to the facility on 11/13/21 with diagnoses that included difficulty in walking, weakness, hypertension, and malignant neoplasm of colon.

The care plan dated 11/13/21 identified Resident #700 was at risk for falls secondary to being newly admitted to the nursing home, generalized weakness, and previous history of falls. Interventions directed to assist of 2 using Gait belt device with transfer. Instruct to ask for assistance prior to attempting to transfer or ambulate as needed. Place call light within reach.

A physician's order dated 11/15/21 directed to Activity Order: Out of bed to chair as tolerated. Assist times one with Activity of Daily Living (ADL). Assist times one with transfers with Rolling Walker.

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F 725	Continued From page 141 The care plan dated 11/15/21 identified Resident #700 requires help with bed mobility, all functional transfers and ambulation due to weakness, recent hospitalization. Interventions directed to apply gait belt, transfer, and ambulate as ordered. The admission Minimum Data Set (MDS) dated 11/19/21 identified Resident #700 had intact cognition, activity occurred only once or twice with transfer, walking in the room and corridor. Review of documentation dated 12/1/21 identified Person #1 reported he/she was unable to contact and communicate with Resident #700 on multiple occasions for approximately 10 days since the resident ' s admission date. Person #1 indicated at times staff would pick up the phone and hang up the phone without answering. Person #1 indicated he/she asked Person #2 to go to the facility and check up on Resident #700 since the family was not able to contact a staff member in the facility via phone. Upon arrival to Resident #700 room on 11/24/21, Person #2 observed the resident on the floor by the bed. Interview with the DNS on 12/1/21 at 1:34 PM identified she was not aware that Resident #700 ' s family was attempting to contact the facility and was unable to reach a staff member. The DNS indicated the facility has been short of staff and utilizing the agency to fill in for licensed nurses and nurse's aides. The DNS indicated when staff are at the nurse's station the expectation is that they should answer the phone.	F 725		
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c)	F 726		1/31/22

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F 726	Continued From page 142 §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on review of the clinical record, facility documentation, facility policy and interview, the	F 726	The facility has completed annual competencies of the licensed staff.	

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F 726	Continued From page 143 facility failed to demonstrate that licensed staff had competencies to meet the needs of the residents. The findings include: Although requested, the facility was unable to provide documentation that any of the listed annual competency validations for staff licensed nurses and nurse aides had been completed or initiated for 2021. Interview with the DNS on 12/2/21 at 12:20 PM identified that she had started to complete the revalidation of regular staff during the summer of 2021 with the assistance of the corporate nurse educator, but she was unable to locate any of the documentation. The DNS continued by identifying that the facility staff development position had been vacant since August 2021. The facility had also gone live with an electronic medical record in August 2021, which also contributed to delaying competency validation and education. Additionally, due to a large influx of agency staff, agency orientation had placed a strain on resources available to complete the competency validations. Interview with the Human Recourses Director on 12/2/21 at 1:00 PM identified that the facility had a staff development nurse from 4/7/20 to 9/7/20, 5 months. The position remained vacant until 5/17/21 (8 months) when filled but was again vacant starting on 8/24/21. Currently the facility is recruiting for the position. A review of the facility assessment dated 3/10/20 identified that the competency schedule to be done for licensed staff and nurse aide on job specific orientation and annually included the following:	F 726	All residents have the potential of being affected by this alleged deficient practice. The Director of Nurses will ensure that upon hire and annually all nursing staff will demonstrate competency of nursing tasks identified as part of the nursing job description. Random audits will be done weekly to ensure compliance and results will be reviewed at quarterly QA/QI Meetings until substantial compliance is met. The DNS and or the designee will be responsible for this POC.	

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F 726	Continued From page 144 For Licensed staff (RN and LPN): Blood spill (with or without kit). Cardiovascular assessment. Choking with Heimlich. Clean dressing change. Use of infusion and feeding pump. Filling O2 portable tanks. Foley catheter insertion. Gastro occult/heme occult testing. GI assessment. Glucose testing/glucometer care. Hand hygiene. Insulin pen. Iv dressing change - central line. Post exposure to body fluids. Personal Protection Equipment (PPE). Respiratory assessment. Syringe safety. Trach care. Suctioning. Transfer with mechanical lift. TST-planting/reading. For Nurse Aides; Blood pressure monitoring. Blood spill (with or without kit). Catheter care. Choking with Heimlich. Denture care. Emptying catheter drainage bag. Filling O2 portable tanks. Hand hygiene. Incontinent care. Perineal care. Post exposure to body fluids. PPE. Pulse monitoring. Trach care.	F 726		

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F 726	Continued From page 145 Transfer with mechanical lift. A review of active nursing staff as of 12/1/21 identified that there were 29 facility employed nurse aides, 8 facility employed LPN ' s and 5 facility employed RN ' s. The facility was unable to produce documentation of competency validation for facility staff listed.	F 726		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on clinical record review, review of facility documentation, facility policy and interviews for three of four newly admitted residents (Resident #605 and #606 and Resident #607), the facility failed to ensure the admission medication orders were received by the pharmacy resulting in medication omissions and significant medication errors. The findings include: 1. Resident #605 was admitted to the facility on 12/4/20 with diagnoses that included hypertension, hyperlipidemia, COVID-19, and gastroesophageal reflux disease (GERD). Physician orders dated 12/5/20 directed Escitalopram Oxalate (a medication to treat depression) 20 milligrams (mg) by mouth daily,	F 760	1. Resident # 605, Resident #606, and Resident #607 no longer reside in the facility. 2. Any resident has the potential to be affected by this alleged deficient practice. 3. The Pharmacy Policy and Procedure Manual section, Ordering and Obtaining Medications was reviewed and remains current. 3. Licensed staff were provided education on the Pharmacy Manual section that identifies how to obtain medications from the pharmacy to ensure all medications are available for administration to residents. 4.Random audits will be conducted	1/31/22

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F 760	Continued From page 146 Flonase (a medication to prevent asthma attacks) 50 micrograms/activated clotting time (mcg/act) suspension spray daily, Clozapine (an antipsychotic medication) 12.6 mg by mouth twice a day, Lipitor (a medication to treat hyperlipidemia) 20 mg by mouth daily, Artificial Tears (a medication to treat dry eyes) solution to both eyes twice a day, Memantine (a medication to slow the progression of dementia) 14 mg by mouth daily, Pantoprazole (a medication to treat GERD) 40 mg by mouth daily, Prednisone (a steroidal medication to treat inflammation) 20 mg by mouth daily and Xarelto (a medication to treat and prevent blood clots) 20 mg by mouth daily. The Medication Administration Record (MAR) for 12/4/20, 12/5/20 and 12/6/20 identified the first dose of Escitalopram Oxalate was to be administered at 9:00 AM on 12/5/20, the first dose of Flonase was to be administered at 9:00 AM on 12/5/20, Clozapine was to be administered at 9:00 AM and 5:00 PM on 12/5/20, the first dose of Lipitor was to be administered at 9:00 PM on 12/5/20, Artificial Tears solution was to be administered at 9:00 AM and 5:00 PM on 12/5/20. The MAR further identified the first dose of Memantine was to be administered at 9:00 AM on 12/5/20, the first dose of Pantoprazole was to be administered at 9:00 AM on 12/5/20, the first dose of Prednisone was to be administered at 9:00 AM on 12/5/20, and the first dose of Xarelto was to be administered at 5:00 PM on 12/5/20. The MAR identified on 12/5/20, the scheduled 9:00 AM medications consisting of Escitalopram Oxalate 20 mg, Flonase 50 mcg/act suspension, Clozapine 12.6 mg, Artificial Tears, Memantine 14 mg, and Pantoprazole 40 mg were not administered as directed by the physician.	F 760	weekly to ensure all medications are ordered from the pharmacy to ensure availability for administration to residents until substantial compliance is achieved. The results of the audits will be presented at the QAPI as required. 5. The DNS or designee is responsible for the completion of this PoC.	

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The MAR identified on 12/5/20, the scheduled 5:00 PM medications consisting of Clozapine 12.6 mg, Xeralto 20 mg, and Artificial tears were not administered. Additionally, Lipitor 20 mg was not administered at 9:00 PM on 12/5/20 per physician's order.

The MAR also identified on 12/6/20, the scheduled 9:00 AM medications consisting of Escitalopram Oxalate 20 mg, Flonase 50 mcg/act suspension spray, Clozapine 12.6 mg, Memantine 14 mg, and Pantoprazole 40 mg were not administered per physician's order.

The MAR also identified on 12/6/20, the scheduled 5:00 PM medications consisting of Clozapine 12.6 mg, Artificial tears and Xeralto 20 mg were not administered. Additionally, Lipitor 20 mg was not administered at 9:00 PM on 12/6/21 per physician's order.

Interview with Pharmacist #1 on 11/10/21 at 11:30 AM identified Resident #605's medication order was received by the pharmacy on 12/5/20 at 3:30 AM and Resident #605 medications left the pharmacy for delivery to the facility on 12/6/20 at 6:00 AM.

2. Resident #606 was admitted to the facility on 12/4/20 with diagnoses that included hypertension, COVID-19, and gastroesophageal reflux disease (GERD).

Physician orders dated 12/5/21 directed Amlodipine (a medication to treat hypertension)10 mg by mouth daily, Eliquis (a medication to treat and prevent blood clots and stroke) 5 mg by mouth twice a day, Pantoprazole (a medication to

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treat GERD) 40 mg by mouth daily.

The Medication Administration Record (MAR) for 12/4/20 and 12/5/20 identified the first dose of Amlodipine was to be administered at 9:00 AM on 12/5/20, Eliquis was to be administered at 9:00 AM and 9:00 PM first on 12/5/20 and the first dose of Pantoprazole was to be administered at 9:00 PM on 12/5/21.

The MAR identified Amlodipine 10 mg at 9:00 AM on 12/5/20, Eliquis 5 mg at 9:00 AM on 12/5/20 and Pantoprazole 40 mg at 9:00 PM on 12/5/20 were not administered as per physician's order.

Interview and clinical record review with Acting Director of Nursing (ADON) on 11/10/20 at 11:25 AM identified medications were not administered because the medications were not available.

Interview with Pharmacist #1 on 11/10/21 at 11:30 AM identified Resident #606's medication order was received by the pharmacy on 12/5/20 at 2:18 AM and the medications left the pharmacy for delivery to the facility on 12/6/20 between 2:00 AM to 3:00 AM. Pharmacist #1 indicated medication was being delivered to the facility twice a day, at 2:00 PM and 2:00 AM during the week, Saturdays at 1:00 PM and 9:00 PM and Sundays at 12:00 PM and 9:00 PM. Pharmacist #1 identified STAT drivers were available for delivery of medications if necessary with a 4 hour turnaround time. It was unclear as to the reason scheduled medication was not administered after the pharmacy delivery on 12/6/20 at 6:00 AM.

Interview and clinical record review with ADON on 11/10/20 at 11:40 AM identified nurses were responsible to document in the MAR as to the

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F 760	Continued From page 149 reason medication was not administered, write a nurse's note documenting the reason medication was not administered. The ADON indicated ordering the medications from the pharmacy was the priority upon admission and the expectation was for the admitting nurse to fax the physician's order to the pharmacy as soon as medication transcription was complete. Although several medications were omitted for Resident #605, a significant medication omission of Xarelto (a medication to treat and prevent blood clots) 20 mg occurred on 12/5/20 and 12/6/20 and a significant medication omission of Eliquis (a medication to treat and prevent blood clots and stroke) 5 mg occurred for Resident #606 on 12/5/20.	F 760		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for	F 761		1/31/22

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F 761	Continued From page 150 storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on review of the clinical record, facility documentation and interviews for 1 of 3 residents (Resident #208) review for disposition of control drugs, the facility failed to accurately account for controlled drugs, and the facility failed to ensure the medication storage room was secured, and for three of five medication rooms the facility failed to ensure medications were stored safely in the medication refrigerator. The findings include: 1. Review of a Controlled Substance Disposition Record with RN #8 identified Resident #208 had Morphine Sulfate Solution (opioid analgesic indicated for pain relief) 100/5 ml with directions to administer 0.25 ml (5 mg) by mouth every six hours as needed for pain/shortness of breath. The Controlled Substance Disposition Record identified that on 10/30/21 (unable to identify written time) LPN #7 dispensed Morphine Sulfate solution 0.25 ml. subsequently, 29.25 ml of the solution was left in the bottle. Further review identified that on 10/30/21 (time not identified) LPN #7 dispensed a second dose of Morphine Sulfate solution 0.25 ml. subsequently, 29 ml of the solution was left in the bottle. Review of Resident #208's electronic Medication Administration Record (e-MAR) identified the resident received Morphine Sulfate solution 5 mg	F 761	1. Resident #208 no longer resides in the facility. 2. Any resident has the potential to be affected by this alleged deficient practice. 3. The facility policies titled, ProCare/Guardian Pharmacy and Medication Administration were reviewed and remain current. 4. Licensed staff were provided education on the facility polices titled, ProCare/Guardian Pharmacy and Medication Administration to ensure the medication room door is secured. Education was also provided to ensure controlled medication reconciliation is completed when the medication is removed for administration. 5. Random weekly audits will be completed to ensure medication room door is secured and controlled medication reconciliation is conducted when the medication is removed for administration to the resident until substantial compliance is achieved. The results of the audits will be presented at the QAPI as required. 6. The DNS and/or designee is responsible for the completion of this PoC.	

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F 761	Continued From page 151	F 761		

by mouth on 10/30/21 at 4:47 PM. Further review of e-MAR failed to identify that the resident received second dose of Morphine Sulfate solution on 10/30/21.

Interview with LPN #7 on 11/3/21 at 1:00 PM identified although on 10/30/21 she signed the Controlled Substance Disposition Record that she dispensed two doses of Morphine Sulfate solution 0.25 mg to Resident #208, she only dispensed and administered one dose of the medication. LPN #7 further identified that after dispensing the first dose to the resident, she realized that the amount of Morphine Sulfate solution left in the bottle was incorrect, so LPN #7 wrote a second dose as dispensed without taking the medication to correct the amount left in the bottle. LPN #7 identified she failed to notify the supervisor of the discrepancy.

Interview with RN #8 on 11/3/21 at 1:15 PM identified she was not aware of the discrepancy with the Morphine solution amount left in the bottle, otherwise she would have notified the DNS.

Interview with the DNS 11/3/21 at 2:00 PM identified she was not aware of the Morphine Sulfate solution discrepancy. The DNS further identified that she would have immediately started an investigation and complete Accident and Incident report.

Review of facility policy Controlled Substance handling directed staff to report any discrepancy in controlled drug count to the DNS as soon as possible. The director of designee investigates and makes every reasonable effort to reconcile all reported discrepancies. Document irreconcilable

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F 761	Continued From page 152	F 761		

discrepancies in a report to the DNS who notifies the Administrator and Consultant Pharmacist immediately if a major discrepancy or a pattern of discrepancies occurs, or if there is apparent criminal activity. The Administrator will consult with the Pharmacist concerning possible notification of police or other enforcement agencies.

2. Observation on 11/3/21 from 1:05 PM - 1:20 PM identified the East medication storage room door was open, and from entrance could visualize 3 open shelves with numerous bottles of over-the-counter medications, the treatment cart with medications on the top of the cart, the back counter had 10 blister packs of medications with residents names on them, and 2 large brown paper bags with IV medications. Medication storage room was not visible to LPN #4 from her medication cart around the corner next to room East 16.

Interview with LPN #4 on 11/3/21 at 1:20 PM noted she had thought she closed and locked the medication storage room door. LPN #4 noted the door was open and indicated the nursing supervisor must have went into the medication storage room because the 2 large brown paper bags with IV medications were not in the room earlier. LPN #4 closed the door, but it did not lock. LPN #4 indicated she had to turn the knob on the inside of the handle to lock the door.

Interview with NA #2 on 11/3/21 at 1:23 PM indicated everyone goes in and out of the nurse's medication storage room all day. NA #2 indicated the door was usually closed but not locked so staff can go in and out all day.

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F 761	Continued From page 153 Interview with the DNS on 11/3/21 at 1:30 PM identified that the medication storage room must have the door closed and be locked at all times and only the charge nurse had a key to the East Unit medication room. Review of facility Medication Storage Policy identified storage of medications will be limited to a locked medication room. 3. Review of the West Bay medication storage area on 11/1/21 with LPN #3 at 11:39 AM identified that the refrigerator temperature log lacked documentation of twice daily checks for October 2021 on twelve occasions on A.M shift and twenty-seven occasions on P.M. shift from October 1, 2021 thru October 31, 2021 the refrigerator temperature log lacked documentation as of 39 daily checks. There were unopened insulin pens stored in the refrigerator. Interview with LPN #3 on 11/1/21 at 11:42 AM identified that she was unsure of the frequency of when it should be checked and by whom. She indicated that she believes someone comes around and checks them. Review of Soundview medication storage area on 11/1/21 with LPN #2 at 12:00 PM identified that the refrigerator temperature log lacked documentation of twice daily checks for October 2021 on eighteen occasions on A.M. shift and nineteen occasions on P.M. shift from October 1, 2021 thru October 31, 2021 the refrigerator temperature log lacked documentation on 37 occasions. There were unopened insulin pens, insulin vials and Tylenol suppository's stored in	F 761		

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F 761	Continued From page 154 the refrigerator. In the same medication room was a second refrigerator that hold meds for the emergency box in which six signatures were not documented. Interview with LPN #2 on 11/1/2021 at 12:15 PM identified that the nurses are responsible for documenting the temperatures twice a day once in the morning and once in the evening. Review of East Rock medication storage area on 11/1/21 with interim Director of Nurses at 1:58 PM identified that the refrigerator temperature log lacked documentation of twice daily checks for October 2021 on eight occasions on A.M. shift and 14 occasions on P.M. shift from October 1, 2021 thru October 31, 2021 the refrigerator temperature log lacked documentation on 22 occasions. There were unopened insulin pens stored in the refrigerator. Interview with Interim Director of Nurses on 11/1/2021 at 2:05 PM identified that it is the responsibility of the nurses to check the temperatures twice a day in the AM and PM. The facility policy medication storage room/medication cart policy directs that vaccine refrigerator temperatures will be recorded twice a day to ensure proper temperature is maintained. The facility failed to ensure medications were stored safely in the medication refrigerator.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		1/31/22

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F 812	Continued From page 155 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility documentation and interview, the facility failed to maintain the kitchen in a sanitary manner. The findings include: During a tour of the dietary department on 11/1/21 at 11:36 AM with the Food Service Director (FSD #1) the following was identified: a. Fan located over the dishwashing machine area noted operating, aimed towards the food service preparation and cooking areas. The fan blades were noted with accumulation of dark matter, grease and dust. The fan guard cage was noted with accumulation of hanging/clinging dust.	F 812	1. A facility audit was conducted by Food Service Director to ensure fans in the kitchen are clean. 2. A facility audit was conducted by Food Service Director to ensure floors in the kitchen are clean and appropriate cleaning schedule is adhered to. 3. A facility audit was conducted by Food Service Director to ensure cleanliness in kitchen and appropriate cleaning schedule is adhered to. 4. A audit was done in the kitchen to ensure kitchen utensils are being stored in a sanitary manor. 5. A facility audit was conducted by Food	

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F 812	Continued From page 156 b. Floors under food preparation tables, stoves, dishwasher noted with food debris, cups, utensils and accumulation of dark matter at wall base/floor. c. Food preparation table shelves, drawers, and front surfaces noted with food drippings and accumulations. d. A container that FSD #1 identified as flour was noted to have a scoop immersed into the white substance. e. Inside of the microwave oven was noted with baked on food drippings/spills and splatter throughout. f. The food preparation area drawers (adjacent to the walk-in cooler) was noted to have accumulations of food debris, crumbs and drippings intermingled with plastic containers, cups and covers. g. The manual and the electric can openers at the protruding and or round metal cutter areas accumulation of thick black matter. h. Numerous fruit flies noted throughout the kitchen including over the tray line service area and steam table containing food. i. Three red food preparation surface sanitizer buckets noted in use by the FSD. Tested by the FSD for chemical concentration and found to not meet minimum required chemical concentration. All three were noted between 100-150 PPM. j. A plastic container identified as potato salad	F 812	Service Director to ensure pest control services and recommendations are adhered to in the kitchen. 6. A facility audit was conducted by Food Service Director to ensure appropriate chemical concentration for surface sanitizer buckets in the kitchen. 7. A facility audit was conducted by Food Service Director to ensure all foods maintain appropriate temperature. 8. A facility audit was conducted by Food Service Director to ensure that facility emergency food supply dates are not expired. 9. A facility audit was conducted by Food Service Director to ensure that food thermometers are calibrated per manufacturer guidelines. Digital thermometers that do not require calibration have been purchased. All residents have the potential of being affected by these alleged deficient practices. The kitchen staff have been re-educated on: 1. Ensuring fans are being clean daily per the kitchen cleaning schedule. 2. Floors are being cleaned every shift per the kitchen cleaning schedule. 3. The general kitchen is being maintained clean. 4. Ensuring that the flour scoop is being stored in a sanitary manor. 5. Following the recommendations of the pest control services. 6. Maintaining the appropriate chemical concentration for the surface sanitizer.	

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F 812	Continued From page 157 was noted adjacent to the steam tray line service area on top of a cooking tray over the sink. A temperature of potato salad was obtained by the FSD and noted to be 80 degrees. An additional temperature was taken with different thermometer and noted 60.3 degrees. k. Chicken was temperature tested and found to be 59.5 degrees. l. Ice point testing method of the facility Bimetal thermometer identified 50 degrees (32-degree Fahrenheit plus or minus 2 degree). Interview with the FSD #1 on 11/1/21 at 11:56 AM identified the sanitizer as a syn Quat 10 that for food contact surface disinfecting required 200 PPM. She further could not explain why the thermometer was inaccurate and was unable to provide any documentation related to calibration. The FSD indicated that although there was a cleaning schedule with assigned staff, was unable to explain why the identified areas were not clean. FSD #1 further identified that holding temperatures for hot cooked items need to be 145 degrees or higher and cold 40-45 degrees or lower due to preventing bacterial growth and other infection control concerns. A subsequent tour of the dietary department on 11/4/21 at 10:46 AM with Corporate FSD #2 identified that the facility emergency food supply had out of date products. The food items included Twenty (20) 32 oz containers of orange juice that had a use by date of 5/28/21 , Two (2) full cases (total 12) Smuckers grape jelly with no identifiable use by date, however each case was dated by facility	F 812	7. Appropriate food temperatures 8. Ensuring rotation of emergency food supplies to prevent the expiration of food items. 9.Ensuring the calibration of the thermometers per the manufacturer's guidelines. Digital thermometers have been purchase and do not require calibration. Random weekly audits will be conducted for the above audits for compliance and the results will be reviewed at QAPI meetings until substantial compliance has been met. The Administrator and/or designee are responsible for the completion of this PoC.	

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F 812	Continued From page 158 staff as 10/2020, Nineteen (19) 32 oz containers of apple juice with a use by date of 12/9/20, Ten (10) five pound containers of creamy peanut butter with a use by date of 8/2020. Interview with FSD #2 on 11/4/21 at 11:03 AM indicated that emergency food supply items should be monitored, dated properly and rotated yearly. Facility policy procedures (ServSafe) guidance identified that thermometers should be calibrated regularly. The facility cooking food policy procedure identified that steam table, chafing dishes, designed to hold food at 135 degrees or higher.	F 812		
F 835 SS=E	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, review of the clinical records, facility policies, facility documentation and interviews, the facility lacked effective	F 835	1. The facility has audited the clinical records to ensure timely notification of physician's with changes in resident	1/31/22

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F 835	Continued From page 159 administration to maintain the highest practicable physical, mental and psychosocial well-being of the residents. The findings include: The Administrator failed to: 1. Ensure timely notification of physician's with changes in resident condition. 2. Provide sufficient/competent/consistent nurse staffing to ensure 4 of 6 residents, (Resident #27, 44, 97, 408), reviewed for wounds/pressure ulcers, were provided care according to professional standards, facility policy and physician ' s orders. Subsequently, substandard quality of care was identified under F686. A random review of staffing schedules dated 10/11/21 to 10/17/21 to determine the percentage of agency staff scheduled in the facility identified the following. On 10/11/21 there were 62% agency staff. On 10/12/21 there were 67% agency staff. On 10/13/21 there were 60% agency staff. On 10/14/21 there were 51% agency staff. On 10/15/21 there were 62% agency staff. On 10/16/21 there were 51% agency staff. On 10/17/21 there were 33% agency staff. 3. Ensure a comprehensive infection control program was developed and maintained, including designating a specific individual person with the required training to oversee the infection control program and wound prevention programs. 4. Ensure adaquate supervision of Resident #54. As a result, the resident eloped from the facility, which went unnoticed for approximately sixty (60) minutes until the facility was notified by the local	F 835	condition. 2. The facility has audited the weekly staffing schedules to ensure sufficient competent staffing. 3. The facility has hired an Infection Control Nurse effective 12/8/2021. This licensed staff member is also responsible for wounds. 4. The facility has completed an audit of the residents at risk of elopement. All residents have the potential of being affected by these alleged deficient practices. Licensed staff and agency staff providing care in facility have been educated on: 1. Ensuring timely notification of significant changes to the APRN and or MD. 2. Empowering staff to seek out assistance if unsure of a task and or if additional assistance is needed to provide quality care. The facility is currently hiring new nursing staff to address staffing needs. 3. An infection Control Nurse has been hired and heads a comprehensive program. 4. Ensuring adequate supervision of resident at risk for elopement. Random weekly audits will be conducted of the above items for compliance and the results will be reviewed at QAPI meetings until substantial compliance is met. The Director of Nursing and/or designee is responsible for compliance with this	

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F 835	Continued From page 160 authorities. Subsequently, Immediate Jeopardy was identified under F689. Interview with RN #5 on 11/4/21 at 8:00 AM identified she is the Regional Infection Preventionist and that the facility does not have a full time RN Infection Preventionist to oversee the infection control program at this time. She indicated the facility is in the process of reviewing applications. Interview with the Administrator on 11/5/21 at 9:37 AM identified that he has been at the facility for 6 weeks. The administrator indicated he is aware that the facility does not have a dedicated IP and indicated that the facility is in the process of reviewing applications and interviewing. Interview with MD #1 on 11/5/21 at 11:00 AM identified he was aware that the facility did not have a full time Infection Preventionist. MD #1 indicated the Infection Preventionist should also oversee the Wound Control Program. Interview with the Administrator on 11/5/21 at 11:10 AM identified that he had been able to secure contracts with 2 agency RNs to work consistently at the facility within the last 2 weeks as an improvement initiative to address the identified inconsistencies in nursing care provision. The Administrator further identified he, the medical director, DNS and MD #1 had identified that the lack of regular facility staff had led to concerns of care provision. Review of the job description for the Infection Preventionist identified the primary purpose of job position is to plan, organize, develop, coordinate, direct and evaluate our Infection Control Program	F 835	plan of correction.	

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and its components in accordance with current federal, state, local and corporate standards, guidelines and regulations that govern such programs, and as may be directed by the Administrator and the Infection control committee to ensure that an effective Infection Prevention & Control Program is maintained. As the Infection Preventionist (IP), you will be responsible and accountable to carry out the assigned duties and report directly to the Director of Nursing Services and/or facility Administrator as well as the Corporate Infection Clinical specialist. The Infection Preventionist, under the direction of the Infection Control Committee, is responsible for the quality of resident care, as it relates to the investigation, control and prevention of infection within the facility. The IP job description continued by directing that the IP must maintain accurate and comprehensive documentation related to the facility Skin Integrity program.

Review of The Centers for Disease Control and Prevention guidance identified facilities should assign at least one individual with training in IPC to provide on-site management of their COVID-19 prevention and response activities because of the breadth of activities for which an IPC program is responsible, including developing IPC policies and procedures, performing infection surveillance, providing competency-based training of HCP, and auditing adherence to recommended IPC practices.

The facility job description for the Administrator directs that the primary purpose of the position is to direct day-to-day functions of the facility to assure the highest degree of quality care and services are provided to the residents of the facility and that the administrator is responsible

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F 835	Continued From page 162 and accountable for the overall quality of care.	F 835		
F 837 SS=D	Governing Body CFR(s): 483.70(d)(1)(2) §483.70(d) Governing body. §483.70(d)(1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and §483.70(d)(2) The governing body appoints the administrator who is- (i) Licensed by the State, where licensing is required; (ii) Responsible for management of the facility; and (iii) Reports to and is accountable to the governing body. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of policies and procedures and Governing Body bylaws, the facility failed to demonstrate an active (engaged and involved) governing body that is responsible for establishing and implementing policies regarding the management of the facility. The findings include: The Governing body failed to ensure the following; a. Implementation and annual review of an effective and comprehensive Quality	F 837	1. Facility will audit to ensure that QAPI occurs per regulation. 2. Facility review of Facility Assessment has been conducted and adjusted based on current facility needs. 3. Random monthly audits will be conducted for compliance and the results will be reviewed at QAPI meetings until substantial compliance is met. 4. The Administrator and/or designee is responsible for compliance with this plan of correction.	1/31/22

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Improvement program.

b. An identified frequency that the administrator reported to the Governing Body, how this communication would be done, how the Governing Body was to respond, as well as what specific types of problems and information (i.e., survey results, allegations of abuse or neglect, complaints, etc.) are reported or not reported directly to the Governing Body.

c. Oversight or involvement in the Facility Assessment.

Interview with the DNS on 11/4/21 at 3:16 PM identified that the facility does not have a dedicated infection preventionist and a main responsibility for this role was coordination of an effective infection control and wound program. The DNS indicated that the facility had an RN Infection Preventionist in the position from 10/6/20 to 12/14/20. The DNS indicated the facility was unable to fill the position from 12/14/20 to 6/29/21. The DNS indicated the facility was without an Infection Preventionist for 6 months (12/14/20 - 6/29/21). The DNS indicated the position was filled on 6/29/21 and that RN left the facility on 8/2/21 and the facility has not been able to fill the position since 8/2/21 (3 months 8/2/21 - to present). The DNS identified that the inconsistency in leadership of the infection control program had contributed to the lack of continuity in the wound management program.

Although requested, the facility was unable to provide documentation of any facility Quality Improvement or Infection Control minutes for 2020 or 2021. Additionally, the facility was unable to provide documentation of QAPI initiatives in

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place to address the lack of an IP, the facility's continued turnover in nursing leadership positions, and the large volume of agency nursing staff.

A review of the Administrator's job description identified that it lacked direction of a frequency that the administrator should report to the Governing Body, how this communication would be done, how the Governing Body was to respond, as well as what specific types of problems and information (i.e., survey results, allegations of abuse or neglect, complaints, etc.) that should be reported or not reported directly to the governing body.

Although requested, the Administrator was unable to provide any additional documentation in regard to the role of the administrator in the reporting requirements to the Governing Body.

A review of the Facility Assessment with the Administrator on 12/1/21 at 1:00 PM identified that the facility assessment was reviewed on 3/1/20 and he stated he could not locate any other documentation of a more recent review with a signature page. The signature page of the Facility Assessment included signatures that indicated review by the DNS, Administrator and Medical Director on 10/2020 but lacked signatures of the Governing Body. The Administrator continued that he had dated the first page of the document on 11/3/21 and stated he had done so on that day when he had provided the document during the survey and he was aware that he had provided an incomplete document at that time. The Administrator stated he had just started employment 6 weeks ago and could not explain why the Facility Assessment

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F 837	Continued From page 165 had not been reviewed since 10/2020 and since he was not present prior to the 6 weeks, he did not know why the governing body had not signed the document. Interview and review of unapproved corporate board minutes dated 9/2/20 with the Administrator on 12/2/21 at 11:00 AM identified that these were the minutes provided to him by the corporate office to meet the surveyor's request of Governing Body minutes stating that he was told that additional minutes were not available, and these dated 9/2/20 were unapproved. He continued by stating he was told additional minutes were not documented or completed due to COVID. The minutes lacked recommendations regarding the facility's quality of care issues. The minutes further identified that the sole manager constitutes the Governing Body and that the sole manager confirmed that a Governing Body meeting will be held annually. The Facility's Governing Body and Management bylaws directed that the Governing Body will review the Quality Assurance Plan at least annually and make recommendations as needed.	F 837		
F 838 SS=D	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the	F 838		1/31/22

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facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include:

§483.70(e)(1) The facility's resident population, including, but not limited to,
(i) Both the number of residents and the facility's resident capacity;
(ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;
(iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population;
(iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and
(v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

§483.70(e)(2) The facility's resources, including but not limited to,
(i) All buildings and/or other physical structures and vehicles;
(ii) Equipment (medical and non- medical);
(iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;
(iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;
(v) Contracts, memorandums of understanding,

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F 838	Continued From page 167 or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on review of facility documentation, policy and interview the facility failed to review and update the facility assessment, as necessary, and at least annually. The findings include: A review of the Facility Assessment with the Administrator on 12/1/21 at 1:00 PM identified that the facility assessment was entitled reviewed on 3/1/20, and he stated he could not locate any other documentation of a more recent review with a signature page. The signature page of the Facility Assessment included signatures that indicated review by the DNS, Administrator and Medical Director on 10/2020 but lacked a signature of the Governing Body. The Administrator continued that he had dated the first page of the document on 11/3/21 and stated he had done so on that day when he had provided the document during the survey and he was aware that he had provided an incomplete document at that time. The Administrator stated	F 838	1. The facility conducted, documented, and reviewed a facility wide assessment. 2.The facility will complete a comprehensive review of Facility Assessment at least annually and/or as necessary. 3. The Facility Assessment will be reviewed at QAPI as required. 4.The Administrator and/or designee is responsible for compliance with this plan of correction.	

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F 838	Continued From page 168 he had just started employment 6 weeks ago and could not explain why the Facility Assessment had not been reviewed since 10/2020 and since he was not present prior to the 6 weeks, he did not know why the Governing Body had not signed the document.	F 838		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observation, review of clinical records, review of facility documentation, and interviews, the facility failed to ensure that the Quality Assurance (QA) Committee identified, discussed deficient practices and/or developed and implemented plans of action to correct the identified deficiencies. The findings include: The regulation of Quality Assurance is not met as evidenced by: Please refer to F550, F580, F585, F602, F644, F657 F658, F684, F686, F689, F692, F697, F698, F725, F726, F760, F761, F812, F835, F837, F838, F842, F867, F880, F882, F925, and F947. Additionally, the regulation of Quality Assurance is not met as evidenced by repeat noncompliance	F 867	1. Facility will ensure that QAPI meetings are conducted per policy. 2. Facility will ensure that QAPI meetings include wound reports, recruitment and retention, as well as COVID. 3. Monthly audits will be completed to ensure compliance and will be reviewed at QAPI meetings until substantial compliance is met. 4. The Administrator and/or designee is responsible for compliance of this plan of correction.	1/31/22

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F 867	Continued From page 169 with the following regulations: F550, F580, F684, F686, F689, F697, F698, F761, F812, and F880. Although requested, the facility was unable to provide documentation of QAPI initiatives in place to address the identified quality deficiencies, specifically the continuity of care related to wound/pressure ulcer management, infection control and nurse staffing. The facility's Quality Assurance Performance Improvement (QAPI) directs that the facility must develop systems that monitor care and services, review findings, investigate and develop action plans to prevent reoccurrence.	F 867		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 880		1/31/22

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F 880	Continued From page 170	F 880		

arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and

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F 880	Continued From page 171 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, facility documentation,	F 880	1.The facility has re-educated all staff on	

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F 880	Continued From page 172 facility policy, and interviews, reviewed for infection control, the facility failed to ensure staff followed the facility dress code policy regarding hand/fingernail hygiene and the facility failed to ensure handwashing, sanitizing and mask storage during meals, and for 1of 3 residents (Resident #309) reviewed for infection control, the facility failed to ensure staff wore personal protective equipment (PPE) for a resident on isolation precaution according to facility policy. The findings include: 1. Observations on 11/1, 11/3, and 11/4/21 identified the following staff with long fingernails: a. Interview with Resident Care Assistant (RCA) #1 on 11/1/21 at 11:30 AM identified she was not aware that her fingernails cannot be as long as they are. She indicated that the facility did not give her an in-service regarding long fingernails (nail hygiene) during orientation. b. Interview with LPN #1 on 11/1/21 at 11:41 AM identified she is from the staffing agency. LPN #1 indicated that the agency nor the facility in-serviced her regarding her long fingernails (nail hygiene). c. Interview with LPN #9 on 11/3/21 at 10:02 AM identified she is from the agency. She indicated that she was not aware that her fingernails cannot be as long as they are. She identified that the agency and the facility did not in-service her regarding her long fingernails (nail hygiene). d. Interview with NA #3 on 11/3/21 at 10:05 AM identified she is from the staffing agency. She indicated that she was not aware that her	F 880	fingernail hygiene, hand hygiene, and proper use of PPE. 2.All residents have the potential of being affected by this alleged deficient practice. 3. Random audits will be done weekly to ensure compliance and results will be reviewed at quarterly QA/QI Meetings until substantial compliance is met. 4. The DNS and or the designee will be responsible for this POC.	

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fingernails cannot be as long as they are. She identified that the agency and the facility did not in - service her regarding her long fingernails (nail hygiene).

Subsequently, a handwashing/hand sanitizing in-service dated 11/3/21 identified to ensure that your nails are cut to an appropriate length as not to inflict injury during care of the resident. It is part of the dress code policy to keep your nails short when coming to work at all times of your schedule shift. If nails are not at the appropriate length - bacteria harbors underneath this is an infection control issue.

e. Interview with RCA #2 on 11/4/21 at 6:48 AM on 11/1/21 at 11:30 AM identified she was not aware that her fingernails cannot as long as they are. She indicated that the facility did not give her an in-service regarding long fingernails (nail hygiene) during orientation.

f. Interview with NA #8 on 11/4/21 at 9:52 AM identified she is from the agency. She indicated she was not aware that her fingernails were too long. She indicated that the agency and the facility did not in- service her regarding her long fingernails (nail hygiene).

g. Interview with LPN #7 on 11/4/21 at 10:30 AM identified she is from the agency. She indicated that she was not aware that her fingernails cannot be as long as they are. She indicated that the agency and the facility did not in- service her regarding her long fingernails (nail hygiene).

h. Interview with LPN #10 on 11/4/21 at 10:32 AM identified she was aware that her fingernails were too long, and she has not had a chance to

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go to the nail salon.

i. Interview with NA #6 on 11/4/21 at 10:33 AM identified she was aware that her fingernails were too long, and she has not had a chance to go to the nail salon

j. Interview with LPN #11 on 11/4/21 at 10:37 AM identified she was aware that her fingernails were too long, and she has not had a chance to go to the nail salon. She indicated she will address the issue.

Interview with RN #5 on 11/4/21 at 9:00 AM identified she was not aware of the issue. RN #5 indicated her expectation is that all nursing staff are to follow the facility employee dress code standards policy. RN #5 indicated it is an infection control issue and the facility will be in-servicing the nursing staff.

Interview with the DNS on 11/4/21 at 11:53 AM identified she was aware of the issue when it was brought to her attention at the beginning of the week. The DNS indicated the long nails have the potential to cause injuries to the residents during care. She also, indicated the long nails are an infection control issue due to microorganism underneath the nails. The DNS indicated an in-service was started on 11/3/21 regarding the nursing staff handwashing and fingernails being too long. The DNS indicated she will educate the agencies and the agencies staff.

Review of the facility employee dress code standards policy directed all employees must adhere to the following dress code standards: Hands must be clean and properly care for. Direct and indirect care employees are required to trim

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nails to a safe/reasonable length of the fingertip. Any ornamental items attached to fingernails should be securely fastened to assure resident safety.

Review of the Resident Care Assistant (RCA) job description identified the primary purpose of your job position is to provide the resident with a clean, orderly and comfortable environment in accordance with current federal, state and local standards, guidelines and regulations that govern the facility as may be directed by your supervisor. As an RCA, you are responsible and accountable to carry out your assigned duties and report directly to the Licensed charge nurse. Major duties and responsibilities: answer call bells of the residents. Assist resident who are not on aspiration or swallowing risks during meals. Assist residents in dressing and personal hygiene. Assist NA's during provision of with residents requiring 2-staff assistance except in mechanical transfer. Assists in getting resident weights. Transport residents.

Center for Disease Control and Prevention (CDC) - Nail Hygiene
Appropriate hand hygiene includes diligently cleaning and trimming fingernails, which may harbor dirt and germs and can contribute to the spread of some infections, such as pinworms. Fingernails should be kept short, and the undersides should be cleaned frequently with soap and water. Because of their length, longer fingernails can harbor more dirt and bacteria than short nails, thus potentially contributing to the spread of infection.

Center for Disease Control and Prevention (CDC) - Hand Hygiene in Healthcare Settings-Core

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Nail length is important because even after careful handwashing, Health Care Workers (HCWs) often harbor substantial numbers of potential pathogens in the subungual spaces. Numerous studies have documented that subungual areas of the hand harbor high concentrations of bacteria, most frequently coagulase-negative staphylococci, gram-negative rods (including Pseudomonas spp.), corynebacterial, and yeasts.
Natural nail tips should be kept to ¼ inch in length.
A growing body of evidence suggests that wearing artificial nails may contribute to transmission of certain healthcare associated pathogens. Healthcare workers who wear artificial nails are more likely to harbor gram-negative pathogens on their fingertips than are those who have natural nails, both before and after handwashing.

The facility failed to ensure staff followed the facility dress code policy regarding hand/fingernail hygiene.

2. Observations on 11/3/21at 11:45 AM in the dining room with 14 residents present identified the Memory Care Coordinator (MCC) put on a pair of gloves without washing her hands or hand sanitizer prior. The MCC went to Resident #44 cut up the spaghetti on the plate and handed Resident #44 the fork and moved the coffee cup closer to Resident #44 after he/she had used it and touched resident #44 on the shoulder to encourage resident to eat. MCC went to the steam table and with the right hand placed on top of steam table., MCC received another Styrofoam container and went to another resident and

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assisted with the set up and touched the resident ' s hand. MCC continued with same gloves and set up Resident # 3. Then MCC set up Resident #13. MCC when over to assist Resident #38 who was touching the garbage can lid, so MCC touched the lid of the garbage to prevent resident from opening it and escorted the resident by the arm from the garbage can over to a table, went to the steam table, got food and then brought it over to the resident and set up the food, cut up spaghetti and touched Resident #38's hand to give a fork, and touched Resident #38 ' s coffee cup. MCC removed the dirty gloves, and did not wash hands or use hand sanitizer.

During lunch mealtime in dining room 6 residents surgical face masks were hung off the arm of the wheelchair. Masks hanging on wheelchairs were Residents #3, 13, 62, 76, 92, and 94.

An interview with the DNS on 11/3/21 at 12:05 PM noted there were 6 residents eating lunch with their surgical masks hanging off the handle on the back of the wheelchair in the dining room. The DNS indicated the mask were not to be hung off the back of the wheelchair they should have been discarded when the resident received their food and given a new mask after the resident was done eating and going back to their room. Additionally, the DNS indicated the staff should not be wearing gloves to pass the trays. The DNS indicated the staff should be washing their hands or using hand sanitizer between residents especially if they touch residents items, the resident, or the garbage can.

An interview with MCC and DNS present on 11/3/21 at 12:10 PM indicated the staff were not using gloves before to pass meal trays but the

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staff were advised to wear gloves but could not recall who gave her that directive. MCC indicated she wears one pair of gloves to pass the trays and cut up food and set the residents up and after she finishes setting everyone up, she will remove those gloves and put on another pair of gloves to feed. MCC indicated there was a sink in the room but there were no hand sanitizers because it was a dementia unit.

An interview with the DNS on 11/3/21 at 12:44 PM indicated she started education with staff regarding handwashing and hand sanitizing during meals and masks cannot be stored on the wheelchair.

Review of Mandatory Inservice Attendance dated 11/3 - 11/4/21 indicated masks for residents should not be hung on the wheelchair arm. Staff should discard the mask when residents are set up for meals in dining rooms and replace with a new mask after meals. Additionally, no gloves are to be worn to pass trays.

Review of Mandatory Inservice Attendance dated 11/3-11/4/21 indicated staff are to ensure to hands are sanitized between each resident and when you exit resident room. During mealtime, please hand sanitize before we touch the resident ' s food. Ensure you hand sanitize each time after passing each resident tray in their room. Please dispose of resident masks after their meals do not hang them on the wheelchair, ensure that residents have a new mask after meals.

Review of facility Emergency COVID-19 Infection Control Policy dated 5/15/20 indicated the facility will follow the most current CDC, CMS, and State

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of Connecticut DPH guidance on infection control related to COVID 19 for the care of residents.

Review of Hand Hygiene Policy indicated hand hygiene was indicated before and after direct resident contact, after completing a task for one patient area and before moving to another station, after contact with items or surfaces at resident area, after handling any contaminated items.

Although requested, a facility policy for use and storage of surgical masks for residents was not provided.

3. Resident #309 was admitted to the facility on 10/28/21 with diagnoses that included Covid 19, acute respiratory failure, chronic obstructive pulmonary disease.

The care plan dated 11/1//21 identified Resident #309 was admitted with a diagnosis of Covid 19. Interventions included transmission-based precautions. redirect resident when coming out of room. Educate on the importance of maintaining precautions to prevent transmission of Covid 19.

Observations on 11/1/21 at 11:27 AM identified LPN #1 entered Resident #309 ' s room without Personal Protective Equipment (PPE) on. Observation also identified LPN #1 exited out of room without washing her hands.

Interview with LPN #1 on 11/1/21 at 11:31 AM identified that she is an agency nurse and does not usually work on that unit. LPN #1 indicated that she is aware that the resident is Covid positive and is on isolation precautions. LPN #1

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F 880	Continued From page 180 also indicated that she should have put on her Personal Protective Equipment however she stated she was pressed for time and walked away from the interview. Interview with interim Director of Nurses at 11/1/21 at 12:00 PM identified she was not aware of the issue. The interim Director of nurses indicated her expectation is that the staff should have followed the Covid 19 transmission-based precaution policy. Review of the Covid 19 facility assessment policy identified that any person with a known or suspected Covid 19 infection, that staff wear gloves, isolation gown, eye protection and an a N95 mask or a higher-level respirator if available. The Covid 19 facility assessment policy also identified that when a Covid 19 is identified in the facility, staff wear all recommended Personal Protective Equipment for the care of all residents on the unit regardless of symptoms. The facility failed to ensure staff wore personal protective equipment (PPE) for a resident on isolation precaution according to facility policy.	F 880		
F 882 SS=E	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4)(c) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field;	F 882		1/31/22

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F 882	Continued From page 181 §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. §483.80 (c) IP participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on review of facility documentation and interviews the facility failed to designate an individual as the infection preventionist (IP) who is responsible for the facility ' s IPCP. The findings include. Interview with RN #5 on 11/4/21 at 8:00 AM identified she is the Regional Infection Preventionist and that the facility does not have a full time RN Infection Preventionist to oversee the infection control program at this time. RN #5 indicated the facility is in the process of reviewing applications.	F 882	1. Any resident has the potential to be affected by this alleged deficient practice 2. A qualified candidate was hired by the facility and has commenced employment. 3. The Infection Preventionist is responsible for the facility Infection Prevention Control program to ensure compliance with state and federal regulations. 3. The DNS will monitor the position for any vacancy to ensure facility compliance with the Infection Control Prevention Program. 4. The results will be presented at QAPI	

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F 882	Continued From page 182 Interview with the DNS on 11/4/21 at 3:16 PM identified that the facility does not have a dedicated IP and that the facility had an RN IP in the position from 10/6/20 to 12/14/20 but was unable to fill the position from 12/14/20 to 6/29/21. The DNS indicated the facility was without an IP for 6 months (12/14/20 - 6/29/21). The DNS indicated the position was filled on 6/29/21 and that IP left the facility on 8/2/21 and the facility has not been able to fill the position since 8/2/21 (3 months 8/2/21 - until present). The DNS indicated the facility is in the process of reviewing applications and interviewing. Interview with the Administrator on 11/5/21 at 9:37 AM identified he has been with the facility for 6 weeks. The Administrator indicated he is aware of the facility does not have a dedicated infection preventionist. The Administrator indicated the facility is in the process of reviewing applications and conducting interviews. Interview with MD #1 on 11/5/21 at 11:00 AM identified he was aware that the facility did not have a full time IP and indicated the IP should also oversee the Wound Control Program. Review of the job description for the Infection Preventionist identified the primary purpose of job position is to plan, organize, develop, coordinate, direct and evaluate our Infection Control Program and its components in accordance with current federal, state, local and corporate standards, guidelines and regulations that govern such programs, and as may be directed by the Administrator and the Infection control committee to ensure that an effective Infection Prevention & Control Program is maintained. As the Infection Preventionist (IP), you will be responsible and	F 882	as required.	

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F 882	Continued From page 183 accountable to carry out the assigned duties and report directly to the Director of Nursing Services and/or facility Administrator as well as the Corporate Infection Clinical specialist. The Infection Preventionist, under the direction of the Infection Control Committee, is responsible for the quality of resident care, as it relates to the investigation, control and prevention of infection within the facility. Review of The Centers for Disease Control and Prevention guidance identified facilities should assign at least one individual with training in IPC to provide on-site management of their COVID-19 prevention and response activities because of the breadth of activities for which an IPC program is responsible, including developing IPC policies and procedures, performing infection surveillance, providing competency-based training of HCP, and auditing adherence to recommended IPC practices.	F 882		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility documentation and interview the facility failed to implement pest control recommendations to control flies and maintain kitchen in a sanitary manner. The findings include: During a tour of the dietary department on 11/1/21 at 11:36 AM with the Food Service Director (FSD #1) numerous fruit flies were noted throughout	F 925	1. The Facility has completed deep cleaning of the kitchen. 2. All residents have the potential of being affected by this alleged deficient practice. The kitchen staff have been educated on: Ensuring adequate cleaning of the kitchen and or ensuring the recommendations of the pest control services are being completed timely.	1/31/22

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F 925	Continued From page 184 the kitchen including over the tray line service area and steam table containing food. During tour of dietary department and other facility areas on all days of the survey noted numerous fruit flies. Review of facility pest management invoices noted ongoing / monthly pest control. Review identified an invoice dated 8/4/21 that identified provision of treatment to the kitchen areas for flies. Subsequent pest control invoice dated 9/10/21 that identified "kitchen still not cleaned to satisfaction, treatment for flies was completed but will not produce results as desired until deep cleaning is completed". Interview with the FSD #1 on 11/1/21 at 11:56 AM indicated that pest control comes in monthly but could not explain why the kitchen continued to have flies. The FSD further indicated that although there was a cleaning schedule with assigned staff, she was unable to explain why the identified kitchen areas were not thoroughly cleaned.	F 925	3. Random weekly audits will be conducted for compliance of cleaning schedule and to ensure the recommendations of the pest control services are being completed timely. The results of these audits will be presented at the QAPI as required. 4.Administrator and/or designee is responsible for compliance for this plan of correction.	
F 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews	F 947		1/31/22

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F 947	Continued From page 185 and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: F947 Based on review of the clinical record, facility documentation, facility policy and interview, the facility failed to provide the required in-service training for nursing assistants. The findings include: Although requested the facility was unable to provide documentation that any of the listed competency validations/in-service training for NAs had been completed or initiated for 2021. Interview with the DNS on 12/2/21 at 12:20 PM identified that she had started to complete the revalidation of regular staff during the summer of 2021 with the assistance of the corporate nurse educator, but she was unable to locate any of the documentation. She continued by identifying that the facility staff development position had been vacant since August. The facility had also gone live with an electronic medical record in August which also contributed to delaying competency validation and education. Additionally, due to a large influx of agency staff, agency orientation had placed a strain on resources available to	F 947	1. Facility has completed audits of annual education requirement for nursing assistants. 2.All residents have the potential of being affected by this alleged deficient practice. 3. Annual in-service education of nurses aides will be ongoing and guidelines will be met. 3. Random monthly audits will be conducted to ensure compliance of the required in-service training for nursing assistants and the results will be reviewed at QAPI meetings until substantial compliance is met. 4. The Administrator and/or designee is responsible for compliance with this plan of correction.	

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complete the competency validations.

Interview with the Human Recourses Director on 12/2/21 at 1 PM identified that the facility had a facility staff development nurse from 4/7/2020 to 9/7/2020. The position remained vacant until 5/17/21 (8 months) when filled but was again vacant starting on 8/24/21. Currently the facility is recruiting for the position.

A review of the facility assessment dated 3/10/20 identified that the competency schedule to be done for NAs on job specific orientation and annually included the following:

" Blood pressure monitoring
" Blood spill (with or without kit)
" Catheter care
" Choking with Heimlich
" Denture care
" Emptying catheter drainage bag
" Filling O2 portable tanks
" Hand hygiene
" Incontinent care
" Perineal care
" Post exposure to body fluids
" PPE
" Pulse monitoring
" Trach care
" Transfer with mechanical lift

A review of a listing of active nursing staff as of 12/1/21 identified that there were 29 facility employed NAs.

The facility was unable to produce documentation of competency validation or inservice training for facility staff listed.

Colonial Health & Rehab Center of Plainfield, LLC
"Family First"
16 Windsor Avenue, Plainfield, CT 06374 TEL. (860) 564-4081

eRegulation Tracking No. PR2022-032

August 1, 2023

Written comments of Curtis Rodowicz, Administrator and Co-Owner, of Colonial Health and Rehab Center of Plainfield LLC, Concerning the enhanced and unfunded DPH staffing proposed regulation (PR2022-32) changes for Nursing Homes.

Members of the committee and colleagues. My name is Curtis Rodowicz, I am a third generation Co-Owner and Administrator at Colonial Health and Rehab Center of Plainfield LLC located in Plainfield, Connecticut. Colonial has been providing nursing home care in our community for the past forty plus years. We are a 90-bed nursing home, and we have 132 employees working at our facility. We are proud members of the Connecticut Association of Health Care Facilities (CAHCF).

We provide comments today on the spirit of this regulatory change that is proposed. No one would disagree that we would love to enhance skilled nursing services and provide increased staffing ratios to our residents. In fact, Senator Osten directly stated to the DPH Commissioner this same sentiment. However, Senator Osten also made our industry's points very clear regarding the proposed changes. In summary, it will unquestionably have a fiscal impact as the language does not allow licensed staff to count with CNA staff towards the total direct care 3.0 as directed by the legislature. It is extremely concerning that after the recorded testimony that Senator Osten had with DPH Commissioner Manisha Juthani, MD that the proposed regulation insinuates that there is no fiscal impact. Senator Osten was very clear about this concern and the lack of coordination between DPH and DSS to evaluate the language changes and how they would have an increased fiscal impact. DPH only affirmed its position that there is no fiscal impact and has made a false misrepresentation to these proposed regulations price tag.

As I previously testified in the Health in Human Service the climate of our healthcare labor market can best be defined in one word as "disintegrating". Not much has changed in the market since my February 16, 2023 testimony except that our nursing home experienced a significant increased labor cost coupled with this additional proposed legislation without any REQUIRED funding.

For our center DPH's proposed regulation will generally require a minimum of four CNAs in the night shift timeframe (9p-7a) instead of three – a 33.33% increase in demand for night shift CNAs. As a result, Colonial needs to hire an additional CNA for eight hours per day for every day of the year (i.e. 8 hours * 365 days = 2,920 worked hours annually), which equates to one full-time thirty-two hour position and one part-time twenty-four (24) hour position every week, both with applicable benefits and paid hours for holiday, sick and PTO. This requirement similarly applies to hours on first and second shifts.

DPH's proposed regulation will cause a substantial increase in demand for CNA labor on all three shifts. As any introductory course in economics teaches, when demand increases, if overall supply in the market is going to meet it, the overall price must rise. Here, the price of CNA labor must rise substantially across the board to meet the substantial increase demanded by DPH's new proposed regulation. Simply put, current wage rates cannot be used to determine the cost of adding the new staff member as they do not exist in the workforce.

In sum, Colonial requested on 4/20/2023 from DSS to fund $613,527 annually, effective March 1, 2023, by increasing Colonial's daily Medicaid rate accordingly. We received pro-rated relief for $.89 which equates to $19,580 for our facility annually. We cannot meet the requirement without our request being fully funded.

The enhanced language requiring Licensed staff to be counted separately and distinctly from CNA staff is just unacceptable. While we remain in compliance with a Direct Care 3.0 total, we have not met the stringent, and arbitrary hours per patient day that was manufactured from anecdotal information obtained by DPH. These prescriptive hours requirements by job classification coupled with the time frames create a cookie cut approach to healthcare. Our facilities are different and require the flexibility to identify the staffing needed at certain times. For instance, not all facilities staff 7am-3pm, 3pm-11pm, and 11pm-7am shifts. We have staffing that met our residents' demand to be up before 7 am so our shifts for CNA's start at 5:30am. We have that flexibility without these proposed changes, and DPH should not support a one size fits all pattern. Colonial currently staffs an average of ALL RN, LPN, and CNA time of 3.822 but that includes administrative nursing, and all these staff members are directly involved in resident care. They ALL should count towards a combined total of hours per day on a weekly basis.

How do we currently fill positions without a healthcare workforce?

- Pay bonuses, hold over staff for 12 hour or double shifts.
- Pay exorbitant agency rates and fuel continuity concerns.
- Poach – we offer free health insurance and higher wages than our competitors and exacerbate the vicious cycle
- We offer a free CNA training course with 38 current graduates (Costs $85,000 per year which we did not have prior to the healthcare staffing crisis).
- Support Eastern Connecticut Healthcare Regional Sector Partnership, EWIB and other Strategic Workforce Development Opportunities.
- Advertise (We currently have 10 CNA positions open)

Implementing this proposed regulatory change will also have a direct impact on resident referrals and exacerbate access concerns. As the same staff available in our limited pool of certified and licensed staff migrate to better offers facilities will be forced to not accept residents based on the inability to staff up to the minimum in this regulation. Colonial will continue to implement its staffing strategies which include purging staff from other centers in an attempt to maintain occupancy statistics and remain financially viable. Clearly there will be losing facilities and that loss will translate to bed loss, bankruptcy, closures, and the devastating effects of evicting residents from their homes.

Lack of CT Workforce (RN, LPN, CNA)

In order to enforce any recommendation for a staffing level of 3.0, with the DPH language decoupling of the combined Licensed and CNA staffing hours as a total, Connecticut has an obligation to ensure that it has a workforce available before such a drastic increase could even be considered. Have you conducted a needs assessment for these added positions needed? Have you considered the fiscal impact with providers and DSS? Have you forecasted enrollment and graduation rates? When will you have the resources to demand such a change?

If the staff are not currently readily available to the workforce there is no way providers can meet this mandate.

Is the state securing a pool from outside of Connecticut that providers can utilize to fill vacancies? Is the military being called in to backfill vacancies that facilities demonstrate they can not reasonably fill? Is DPH intentionally proposing these regulations to increase Civil Monetary Penalties to further destabilize the fragile infrastructure?

If this proposal was ever to be approved these circumstances must be answered and demonstrate the resources are present or will be in at a future date.

If there is a comprehensive plan to ensure adequate workforce and financial resources from DSS then there should exist phase in requirements for facilities to strive towards meeting these new benchmarks.

Reason for phase in: *"there is only one way to eat an elephant: a bite at a time."*

Recommendation: Reverse **PR2022-032**

Sincerely,

Curtis Rodowicz
Administrator

Comments related to Proposed Regulation Concerning: Nursing Home Staffing Ratios
Tracking Number:PR2002-032

August 3, 2023

My name is George Kingston and I am the Administrator of Westside Care Center, a 162-bed skilled nursing facility located in Manchester, CT. Westside Care Center is part of the iCare Health Network, which operates eleven skilled nursing facilities in Connecticut. I have been an Administrator for over thirty years the last eleven years working with iCare.

I am writing today to express my deep concern regarding the State of Connecticut, Department of Public Health's (DPH) implementation of the nursing home minimum staffing.

My major concerns lie in the inability to recruit the staff needed, incremental cost of this unfunded mandate, and removal of the combined cap in favor of two distinct, arbitrary caps.

In my thirty years of practice in the long-term care arena I have never seen a staffing crisis as significant as what currently exists in the industry. While the crisis may have begun with COVID, the after-effects have continued years later. In my own facility, I currently am recruiting for 120 hours of R.N. time, 168 hours of LPN time and 160 hours of C.N.A. time which is currently being filled by expensive contract staff and overtime. In response to this staffing shortage I have increased benefits and wages in an effort to be more attractive to job seekers. I have dedicated employees whose main responsibility is the recruitment and on-boarding of staff. This proposal exacerbates an already challenging situation.

My second concern is the cost of this proposed, unfunded mandate. A quick review of my staffing levels compared to the proposal would increase my salary and benefit costs by $957,000 dollars per year. This incremental cost far exceeds my financially struggling facility's bottom line.

Lastly, the individual requirements for nurses and aides assumes all nursing home residents and their care needs are identical. This simply is not the case. At the most basic review, the proposed mandate assumes all nursing homes have residents with the same acuity levels. This contradicts the CT Medicaid Acuity-Based Reimbursement system implemented in July 2022.

In closing, increased staffing for nursing homes is an admirable idea, the goals, however laudable, are in direct conflict with the current reality that the industry is already suffering from a staffing shortage. Even if funding were secured to cover the incremental expense, finding the additional staff would prove to be an insurmountable.

I would be happy to discuss these points in greater detail as you consider the regulation.

Sincerely,

George Kingston

Administrator
Westside Care Center

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August 1, 2023

Comments on DPH Proposed Regulation (PR2022-32)

To the Department of Public Health:

My name is Russell Schwartz. I am the Director of Operations for Avon Health Center, in Avon, CT & West Hartford Health & Rehabilitation Center in West Hartford, CT. I am also a partner of Douglas Manor in Windham, CT. Combined my facilities total 370 beds, with more than 450 employees. Our residents include traditional long-term care, short-term/subacute patients, and Alzheimer's/dementia residents.

I am a second-generation nursing home operator. My family has been in the long-term care field for more than 50 years. Growing up around the nursing homes, I developed an affection for our residents, and got the calling to work in the field. I find great satisfaction caring for our residents, and ensuring they continue to have a good quality of life. We are committed to providing high quality care and services for our residents, that deserve to live their remining years with dignity.

The DPH proposed regulations for direct care staffing of 3.0 hours per resident per day conflicts with the legislation passed last year. The intent of the staffing increase was to allow facilities the flexibility to manage their staffing patterns to meet the needs of its residents. While I am not opposed to an increase in direct care staffing, I strongly oppose how DPH has interpreted the State legislative requirements within their proposed regulations. For decades the 1.9 hours per resident per day staffing minimum was **a combination of licensed nursing and nurse's aide** personnel. However, as the proposed regulations are currently written, DPH has separated the total minimum hours per day between licensed and nurse's aide and increased the nurse aide minimum from 1.26 hours per resident per day to 2.16 hours. This is more than a 70% increase in the minimum nurse's aide staffing requirement. Also as written, the

proposed regulations limit our flexibility to staff according to resident needs. It is also based on staffing over 2 (12) hour shifts, where most facilities staff on 3 (8) hour shifts.

The past few years have been increasingly difficult to recruit and retain staff. So many healthcare workers have left the field. I have resorted to using agency staff to cover open positions at a very high cost, which has not been reflected in our Medicaid rate. We pay almost 2 times our normal hourly rates to the pools. Without using the nurse pool, I would have to restrict new admissions and/or close beds due to lack of staff. This creates bed-lock at the hospitals, resulting in a higher cost of care for these patients. We continue to be challenged with recruitment of nurses and CNAs. The workforce just does not seem to be there.

An increase in the minimum staffing requirements is ill-timed. It does not take the current labor crisis into consideration, nor the significant cost the new minimums will have on facilities Any mandate should be phased in to allow us to reach desired levels; include all staff that take part in providing direct care, not just nursing; and waive any penalties during the staffing shortage. This unfunded mandate will put CT nursing homes in greater peril. I strongly oppose the proposed minimum staffing regulations as written and ask that you substantially change the proposed regulations to benefit the residents we serve.

As it is currently written, adequate funding is not provided by the Legislature to adequately reimburse these additional costs. Only $500,000 was allocated in the legislation last year, which is totally inadequate to meet the requirements of the proposed staffing regulations for all CT facilities. DSS had to pro-rate this small amount of funding between those facilities requesting additional resources. It became immediately clear that the DPH proposed regulations would require significantly more funding than was authorized. Any staffing requirements must be fully paid for by Medicare and Medicaid.

Imposing mandated staffing patterns with penalties for not meeting them during the worst staffing crisis we have seen is just wrong. I appreciate and support the need for higher staffing patterns to ensure proper care. But this is not the time. You will force more facilities to close and create additional job losses. My family has worked hard over the many decades to operate quality facilities. Our life's work will be put at risk of failing if we can't meet mandated staffing numbers.

Thank you.

Public Testimony for Connecticut Department of Public Health Hearing re
Regulations Concerning Minimum Staffing Requirements
August 1, 2023

Submitted by Liz Stern, Stonington, CT
(In honor of family members and friends who live in nursing homes)

I write today with the utmost regard and respect for the work that Commissioner Juthani and members of the Department of Public Health do daily. As a long time family advocate I can not help but ask what more can be added to the hours and hours of testimony given by hundreds of family members, nursing home residents, nursing home staff, ombudsman and members of the CT CGA Aging Committee and Public Health regarding the need to increase staffing levels.

Residents are suffering. Current staff are overworked. And never do we call out the inequities between the attention given to child care and public education versus care denied to our elderly and disabled who must live in nursing homes. The time is long overdue to legislate, train staff, and enforce current regulations and increase direct care to ensure quality care.

I suggest that any person who does not support an increase to a national standard of 4.0 hours/direct care/day spend one week in the bed of a randomly selected Connecticut nursing home. I have witnessed deplorable care in too many nursing homes. DPH is called regularly and made aware of unsafe conditions due to poor staffing. There is nothing to add to the current testimony that has accumulated over the last several legislative sessions.

Please enforce the current staffing levels and work to increase direct care ratios in the future.

Respectfully,
Liz Stern
Stonington, Connecticut

To: Department of Public Health

Re: 3.0 Staffing Minimums PR2022-032, eRegulations - Regulation Making Record For Tracking Number PR2022-032 (ct.gov)

Civita Care Center at Milford is located on 2028 Bridgeport Avenue, Milford CT, 06460. 120-bed skilled nursing facility located in a shoreline town providing the local population with care for decades. We have 112 employees, and I am the Administrator. I started in this facility in 1992 as a Dietary Director, found the job to be rewarding and went back to school to become an Administrator and did my AIT at this facility in 2006. I have a great staff that is trying hard to recover from the pandemic.

We are not opposed to increased Connecticut's direct care staffing minimum from 1.9 to 3.0, but we are strongly opposed to how specifically DPH has interpreted this state legislative requirement in the proposed regulations and how DPH is currently implementing the requirement.

Please consider these comments and request that you substantially revise the proposed regulations.

There are major problems with how DPH has proposed increasing the direct care minimum staff from the outdated 1.9 hours to 3.0 hours of direct care staff per resident per day.

There are four main areas of concern:

THE PROPOSED REGULATION WRONGLY INCREASES THE CNA MINIMUMS FROM 1.26 TO 2.16 HOURS OF PER DAY.

This one-size fits all approach removes [name of facility] flexibility in assigning staff to address the care needs of our residents….

THE PROPOSED REGULATION REVERSES THE PUBLIC HEALTH CODE RULE THAT APPROPRIATELY COUNTED DIRECT CARE LICENSED STAFF AND CNA STAFF TOWARD MEETING THE MINIMUM STAFFING STANDARD.

It won't lead to better care and will likely worsen the situation by writing the rule this way….

THE PROPOSED RULE DOESN'T REFLECT MODERN NURSING HOME STAFFING BECAUSE IT DOESN'T COUNT ALL THE STAFF THAT ARE PROVIDING DIRECT CARE

In addition to the CNAs, and direct care provided by licensed nurses, many more positions should be included, such as….

The rule should also include additional licensed staff that are providing direct care.

THERE IS AN INSUFFICENT SUPPLY OF WORKERS

Our facility is facing the most significant staffing challenges we have ever experienced….

THE AMOUNT OF MEDICAID RESOURCES THE STATE MADE AVAILABLE FOR COMPLIANCE WITH THE DPH INCREASED MINIMUM STAFFING RULE IS SIGNFICANTLY INADEQUATE

We thought that the state legislature was making sufficient Medicaid resources available to the Department of Social Services to assure nursing homes had the resources to comply with the anticipated DPH minimum staffing rule, but DPH put out a policy that requires significantly more resources. For example, just consider the unfunded costs just for additional CNAs that the proposed rule requires our facility to hire or contract for…

This would mean ….

The unfunded costs are…

That DSS had to prorate the true costs down to [indicate the specific amount or percentage] based on the insufficient amount of money in the budget shows clearly that DPH imposed a rule that required a much more substantial funding amount. Our nursing simply does not have the resources to cover this unfunded state mandate….

Please make substantial changes to this proposed regulation. It will make matters worse for our nursing facility, our staff, and our residents.

Touchpoints
Rehab at Manchester

To whom it may concern,

My name is James Herstell and I have been a Food Service Director for 34 years in healthcare. I have dedicated my life to serve residents and most recently came out of retirement to continue my life's work.

We currently care for 120 residents at Touchpoints at Manchester and employee 140 staff. We strive to provide quality care to all our patients. It was difficult to staff our building before COVID and has been even harder after the pandemic. We have seen more staff leaving the industry and nobody to replace them.

I constantly see "help wanted" signs for every industry out there and ours is no different. The biggest difference is we don't have the funding to support adding more staff.

I am asking to help us find alternative ways to support our residents instead of a near impossible staffing mandate. Thank you for your time.

James Herstell
Food Service Director, Touchpoints at Manchester

Part of the iCare Health Network

333 Bidwell Street, Manchester, CT 06040
Tel: 860-533-3086 Fax: 860-645-4888
www.touchpointsatmanchester.com

Comments from Connecticut's Legal Services Programs Regarding
Proposed DPH Regulation PR2022-032, Concerning Nursing Home Staffing Levels
August 14, 2023

My name is Jean Mills Aranha and I am volunteer attorney at Connecticut Legal Services. I recently retired after practicing Elder Law there for almost fifteen years. Connecticut's Legal Services Programs are private non-profit law firms that provide free legal services to low-income residents of Connecticut, including residents of nursing homes. I served as an appointee to the Governor's Nursing Home and Assisted Living Oversight Working Group (NHALOWG), and on its Staffing Levels subcommittee.

Connecticut's Legal Services Programs support the increase in nursing home staffing levels mandated in PR2022-032, but will continue to support efforts to increase those levels beyond the 3.0 standard and meet recommendations for 4.1 hours of direct care per resident per day as outlined below. We also would urge DPH to reject and correct the level of staffing required for recreational staff as it does not reflect the intent of the legislation that PR2022-032 implements (also see discussion below).

Connecticut's elderly and disabled population has suffered greatly and disproportionately during the COVID-19 pandemic. While the pandemic laid bare many deficiencies in care within skilled nursing facilities, it did not create all of them. Nor will the easing of the pandemic cure such deficiencies. PR2022-032 implements the minimum staffing ratios for nurses and nurse's assistants enacted by legislation passed in 2021. These provisions will improve the quality of care and make a needed positive difference in the lives of the residents of long-term care facilities. However, we need to continue to increase staffing in these facilities and bring levels up to the longstanding recommendations from federal experts, the NHALOWG and what was initially endorsed by the 2021 Legislature's Public Health Committee in SB 1030.

Inadequate staffing in nursing homes is a longstanding problem. In 1987, Congress passed the federal Nursing Home Reform Act, requiring every nursing home to have sufficient staff to care properly for its residents. Specifically:

> The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable level of physical, mental, and psychological well-being of each such resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population…[1]

[1] 42 C.F.R. §483.35.

Federal law does not mandate any specific number of hours of care that must be provided. However, in 2000, the federal Department of Health and Human Services issued a report to Congress after nearly ten years of studying the relationship between nursing staff levels and quality of care for residents. Facilities staffing at lower levels had residents with increased risk of bedsores, malnutrition, abnormal weight loss, and preventable hospitalizations.

The study found that a minimum of 4.1 hours of nursing care per resident, per day, was needed to meet the federal quality standards at that time.[2] Resident acuity has only increased during the last 20 years, so a similar study today would almost certainly find an even higher necessary minimum.

It's clear that nursing homes with more staffing had better outcomes during the pandemic. A 2020 Connecticut specific report by the research organization Mathematica found that "[n]ursing homes with higher staffing ratings had significantly fewer cases and deaths per licensed bed."[3] An additional academic study looking at COVID-19 infection incidence and death in Connecticut nursing homes found that "[a]mong facilities with at least 1 confirmed case, every 20 minute (per resident day) increase in RN staffing was associated with 22% fewer confirmed cases…Among facilities with at least 1 death, every 20 minutes increase in RN staffing significantly predicted 26% fewer COVID-19 deaths."[4] The New York State Attorney General reported that New York City facilities with the lowest staffing ratings had almost twice the death rate of facilities with the highest staffing ratings.[5]

But staffing levels are not important just during a pandemic. Many studies have found that staffing levels are too low in many nursing homes.[6] The National Consumer Voice for Quality Long-Term Care has long advocated for increased staffing, to prevent pressure ulcers, infections, malnutrition, dehydration, injuries from falls, preventable hospitalizations and death. Nurses and aides can't provide quality care if there aren't enough of them.[7] Connecticut's Legal Services Programs have supported raising nursing home staffing levels for many years for the same reasons.

The pandemic did not cause the staffing deficiencies in care in nursing homes, although it exacerbated them. Now that our attention has been focused on the needs of these residents, and after they have suffered the highest proportion of pandemic illness and death, we owe it to them to make improvements in our long-term care facility systems for the future. The new minimum of 3.0 hours of care per resident per day is a modest improvement, given that federal studies

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[2] U.S. Centers for Medicare and Medicaid Services, Abt Associates Inc. *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Report to Congress: Phase II Final.* Baltimore, MD: CMS; 2001.
[3] *A Study of the COVID-10 Outbreak and Response in Connecticut Long-Term Care Facilities, p.19,* Mathematica Final Report, September 30, 2020, DPH #2021-0041.
[4] *COVID-19 Infections and Deaths among Connecticut Nursing Home Residents: Facility Correlates.* Li,Y., Temkin-Greener, H., Gao, S., Cai, Xueya, doi:10.1111/jgs.16689.
[5] New York State Office of the Attorney General Letitia James, *Nursing Home Response to the COVID-19 Pandemic,* pp. 28-29, Revised January 30, 2021.
[6] See, for example, *The Need for Higher Minimum Staffing Standards in U.S. Nursing Homes,* Harrington, C., et al., Health Services Insights 2016:9 13-19 doi:10.4137/HIS.S38994.
[7] https://theconsumervoice.org/betterstaffing

have recommended a minimum staffing standard of 4.1 hours of care per resident per day. This 4.1 hour staffing standard was established over 20 years ago, and has been backed by further study since. Increased staffing standards also offer the State potential cost savings, as unnecessary hospitalizations are reduced by better care.

The proposed regulation also implements a change to the number of therapeutic recreational staff in long-term care facilities. The pandemic also showed that the number of social workers and recreational staff in most facilities is too low. These staff are vital to the well-being of the residents, and there are too few of them. The NHALOWG Working Group found that the **ratios** of residents to these staff should be lower.

Unfortunately, in the drafting of P.A. 21-185, the Working Group's recommendation for a lower ***ratio*** of residents to staff was mistakenly drafted as a lower ***number*** of recreational staff. While the proposed regulation follows the directive of the legislation, we do not believe it correctly expresses what legislators and advocates intended to be the result. Therefore, we do not support this portion of the proposed regulation.

Thank you for your attention to our comments on these important issues.

Jean Mills Aranha
Connecticut Legal Services, Inc.
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Testimony to the Department of Public Health

Public Hearing regarding Proposed Regulations for Nursing Home Staffing Ratios (PR2022-032)

August 1, 2023

Presented by Mag Morelli, President
LeadingAge Connecticut

My name is Mag Morelli and I am the President of LeadingAge Connecticut, a statewide membership association representing not-for-profit and mission-driven provider organizations serving older adults across the continuum of aging services and including thirty-five skilled nursing facilities. On behalf of LeadingAge Connecticut, I want to thank you for this opportunity to present testimony expressing our concerns with the proposed regulations for nursing home staffing ratios and specifically to the proposed ratios for direct care.

Let me begin by stating that LeadingAge Connecticut supports the new statutory minimum nursing home staffing ratio of 3.0 hours of direct care per resident day. We share the Department of Public Health's (the "Department") goal to ensure Connecticut's older adults receive quality nursing home care and understand that maintaining appropriate staffing patterns is essential to achieving that goal. We object, however, to the proposed breakdown of the legislated 3.0 hours of direct care into two separate minimum staffing ratios; one placed on licensed nursing personnel and one placed on nurse's aide personnel. Licensed nursing personnel includes both registered nurses (RN) and licensed practical nurses (LPN), while nurse's aide personnel include just certified nurse aides (CNA).

The Department's proposed regulations creating separate minimum staffing ratios for licensed nurses and certified nurse aides are not authorized by statute. In fact, the legislature considered and rejected use of these categories, and modeled the fiscal impact of the minimum staffing legislation on a 3.0 overall staffing ratio without these breakout categories. The legislature rejected the breakouts for good reason. The breakout categories are contrary to the philosophy and intent of the state's newly implemented nursing home acuity-rate system. They will work against various high quality nursing home staffing models that may rely upon a high level of licensed staff. And finally, from a practical perspective, the lack of flexibility within the ratios will expose quality, well-staffed nursing homes to potential costly penalties if they struggle to find coverage for last-minute staff absences.

It is important to note that the proposed regulations were issued as policies and procedures that took effect on March 1, 2023. As a result, we are already seeing how these rigid standards impact quality care and the ability of facilities to staff to meet resident needs.

Public Act 21-185 and Legislative Intent

The enabling legislation, Public Act 21-185, was initially raised as Senate Bill 1030 in the 2021 state legislative session. As originally proposed, Senate Bill 1030 called for a minimum staffing level of 4.1 hours of direct care per resident day, as well as specific minimum ratios per licensure and certification category. In our testimony opposing this bill, LeadingAge Connecticut stated to the Public Health Committee that we understood their interest in raising the state's minimum nursing home staffing requirements contained in the Public Health Code, but reassured them that regardless of the statutory minimum, both the state's Public Health Code and the federal oversight regulations required nursing homes to staff at a level to meet the needs of residents. We also testified at the time and continue to maintain that mandating specific and separate ratios of RNs, LPNs and CNAs goes against this basic concept of adjusting your staffing pattern to meet the needs of the residents and also flies in the face of the state's new acuity-based reimbursement system.

The General Assembly considered all the testimony provided on raised Senate Bill 1030 and subsequently modified the final language of the bill by removing the specific and separate ratios for RNs, LPNs and CNAs and instead adopting one combined minimum staffing level of 3.0 hours of direct care per resident day. The final language was passed by the state legislature and signed into law by the Governor as Public Act 21-185 and then codified in Connecticut General Statutes §19a-563h. Clearly these proposed regulations are not consistent with the statute and do not reflect the intent of the legislature's final action on Public Act 21-185. Instead, they revert back to imposing the separate minimum staffing levels that were soundly rejected by the legislature.

The proposed regulations also restructure the current Public Health Code formula for calculating the minimum staffing levels, resulting in an unanticipated increase in the minimum staffing level requirement for CNAs. The Public Health Code currently contains a total direct care minimum requirement of 1.9 hours of combined licensed nursing and certified nurse's aide hours per day. Of those 1.9 hours, at least .64 hours need to be provided by licensed nurses. The proposed regulations would completely separate the two categories of staff and would now require at least 2.16 CNA hours per day, regardless of the amount of licensed nursing care hours provided. This restructuring of the Public Health Code formula was never contemplated during the legislative process, was not authorized by the legislation and has resulted in many more nursing homes being impacted than originally anticipated by the legislature.

The same proposed requirements that are now in effect as policies and procedures have had a demonstrably negative impact on many nursing homes across the state. More than one hundred nursing homes have had to modify their staffing patterns to meet the newly imposed minimum CNA staffing level of 2.16 hours, even though the vast majority of them were already staffing at or above 3.0 hours of combined direct care personnel. The legislature never anticipated or intended such a widespread impact on staffing patterns and the increased number of nursing homes affected by the unanticipated methodology utilized by the Department has resulted in a materially larger fiscal impact of Public Act 21-185.

We also note that while the regulations propose to restructure the Public Health Code formula for calculating the minimum staffing levels, they inexplicably maintain the two-shift structure of

7 a.m. to 9 p.m. and 9 p.m. to 7 a.m. The two-shift structure again does not reflect the intent of the legislation which put forth a per day minimum staffing level which we contend should be calculated over a 24-hour daily schedule. Once again, the use of a 24-hour daily calculation allows for discretion and flexibility when managing staffing patterns to meet the needs of the residents. We propose that the division into two shifts be removed and replaced with a daily minimum calculation.

Legislative Intent as Demonstrated by Fiscal Impact

Through Public Act 21-2, June special session, the state legislature appropriated up to $500,000 in state funding (to be matched by federal funds) to the Department of Social Services for each of the fiscal years ending June 30, 2022 and June 30, 2023, to support the 3.0 minimum nursing home staffing requirement passed in Public Act 21-185. This amount was estimated by the Office of Fiscal Analysis to recognize and reimburse for the total amount of increased staffing costs created by the new statutory minimum staffing level and was calculated using the 2019 nursing home cost report data. This cost report data indicated that only a relatively small number of nursing homes were providing less than 3.0 hours of combined direct care per resident day and would therefore be in need of additional funding. In addition, in the 2022 legislative session, the legislature enacted a budget that phased-in a true, rebased calculated rate for all nursing homes using that same 2019 cost report data, thus theoretically fully reimbursing the staffing costs of nursing homes that were already staffing at or above the minimum of 3.0 hours.

The funding appropriated by the legislature is now proving to be woefully insufficient due the manner in which the Department has implemented the statutory minimum staffing levels through the aforementioned policies and procedures that mimic the proposed regulations. As a result of the policies and procedures effective on March 1, 2023, seventy-two nursing homes stepped forward and applied for the new funding because they were not meeting one or the other minimum ratio, even though they may have been meeting the overall 3.0 direct care minimum. This was a number much higher than estimated during the legislative process and the Department of Social Services just recently informed the applicants that they will receive only a fraction of what they requested because the original appropriation was intended to fund a much smaller number of nursing homes that were staffing under 3.0 hours of combined direct care personnel. This result again highlights the fact that these proposed regulations do not reflect the legislative intent of the governing statute and completely undermined the legislative intent to recognize staffing costs.

Acuity-Base Rate System Philosophy

The state is currently phasing in a new acuity-based rate system for the nursing home sector. The system is intentionally designed to reimburse at a higher rate of payment when a nursing home's resident case mix reflects a higher level of acuity because the nursing home is expected to meet the needs of higher acuity residents with higher skilled and/or higher levels of direct care staff. This methodology assumes a level of flexibility in setting staffing patterns throughout the day to meet the needs of those residents. However, such flexibility may be thwarted by the Department's rigid requirements imposing specific minimum staffing categories for licensed nurses and certified nurse aides.

Staffing Patterns

One staffing pattern does not fit all needs. The needs and underlying conditions of nursing home residents vary widely—as do the skills and capacity of health care professionals. The regulations should recognize this and be more accommodating to staffing patterns designed to meet the varied needs of residents. While the role of the CNA is vitally important, the proposed regulations place an unanticipated increase in mandated CNA hours that may not fit into certain established and suitable staffing patterns. The direct care provided to a nursing home resident is not just personal care. Residents also receive direct nursing care such as medication administration, treatments and nursing assessments. Nursing care must be provided by a registered or licensed practical nurse and some nursing homes have chosen to staff with a higher number of nursing positions. In addition, emerging models of resident care look to the use of other licensed professionals such as occupational and physical therapists. Specialized nursing home units may require the expertise of health care professionals such as respiratory therapists or specially trained licensed nurses. We therefore urge the Department to move back to the intended minimum of 3.0 hours of *combined* direct care so as not to constrain the development of diverse and appropriate staffing patterns. In addition, we propose that the regulations grant the Department waiver authority to approve other acceptable, appropriate and possibly cutting-edge staffing patterns that may fall outside of traditional designs.

Workforce Realities and Discretion in Enforcement

The regulations must accommodate and recognize the circumstances surrounding isolated periods of unanticipated staffing levels that violate the minimum staffing level. The data shows that LeadingAge Connecticut members staff at levels above the 3.0 minimum. Many maintain a five-star staffing pattern and all of them are striving to hire more staff. But the current workforce situation is making this effort to hire licensed and certified staff very difficult. This situation not only impacts a nursing home's routine scheduling of staff, but also has a significant impact on their ability to arrange for coverage when scheduled staff call out – particularly if they call out with little notice. For example, the call out of one or two CNAs at the start of a shift may cause a nursing home to fall beneath the proposed minimum staffing ratio for CNA coverage, even as the nursing home attempts to fill the slot and even if the nursing home is able to provide adequate coverage through the use of LPNs and RNs. The regulations must be able to recognize that providers are operating under severe workforce shortages and allow for the Department's discretion when evaluating the circumstances and responses to isolated periods of unanticipated staffing levels.

In summary, we cannot support these regulations as proposed and request that they be revised to not only reflect the clear intent of the state legislature, but also to take into consideration the needs, structure and evolving nature of high-quality nursing home staffing patterns and practice. We share the same goal of providing quality nursing home care to every nursing home resident and stand ready to work collaboratively with the Department to develop regulations that will achieve this goal.

Submitted by Mag Morelli, President of LeadingAge Connecticut
110 Barnes Road, Wallingford, CT 06492, mmorelli@leadingagect.org, (203) 678-4477, leadingagect.org

ARK
HEALTHCARE &
REHABILITATION

July 29, 2023

Comments on DPH Proposed Regulation (PR 2022-32)

To the Department of Public Health:

My name is Janet Woxland, I am the Administrator at Ark Health Care and Rehabilitation at Branford Hills in Branford CT and have been the administrator at this facility for over 10 years. Ark Health Care and Rehabilitation at Branford Hills has been providing care in our community for over 43 years. We are a 190-bed nursing home and we have over 170 employees working at our facility around the clock twenty – four seven to take care of our patient population.

I started my career as a CNA and moved up the ranks to be a registered nurse ultimately gaining my administrator's license. As the administrator, more importantly as a nurse, my job is to ensure regulatory compliance within the facility and provide the highest quality of care to my patients. As a 4-star CMS quality rated facility we are not only a preferred provider for Yale New Haven Health Systems but also a first-choice provider for Aetna providing quality outcomes and a UHC Navi health valued partner. We recently received the honor of being ranked 4th in CT for Best Nursing Homes 2023 by Newsweek.

We are not opposed to the increased Connecticut's direct care staffing minimum, but we are strongly opposed to how specifically DPH has interpreted this State legislative requirement in the proposed regulations and how DPH is currently implementing this requirement.

I'm writing to ask you to make major changes to this proposed regulation. A meaningful solution to improving quality care is not found in increasing the CNA minimums from 1.26 to 2.16 hours per day. This one size fits all approach removes Ark Healthcare & Rehabilitation at Branford Hills flexibility in assigning staff to provide the necessary care and services to our ever-changing resident population. Our residents being admitted to our facility are more medically complex and require the attention of Licensed professionals such as nurses and APRN's. The proposed regulation reverses the PHC rule that appropriately counted direct care licensed staff and CNA staff toward meeting the minimum staffing standard.

The proposed regulation does not reflect the current nursing home staffing because it doesn't count all the staff that are providing direct care. As the adage says it takes a village to raise a child; it takes all staff in the skilled nursing facility to care for a resident. The rule should include additional licensed staff that provide direct care. From the MDS nurse, along with Staff Development Nurse, ICP, the CNA unit secretary all play a role in providing quality care to our residents. These additional positions should be included when taking into consideration the direct care numbers.

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Touchpoints
Rehab at Manchester

August 7 2023

To whom it may concern,

My name is Michael Briggs and I have been the Maintenance Director at Touchpoints at Manchester for over 7 years and have been in the eldercare field for over 30. I took the position many years ago because I love working with my hands and have stayed in the field because I came to love working with and helping this frail population.

I have a lot of concerns about the way the direct care minimum staffing requirement will affect our population and my fellow employees. I think I speak for most everyone when I say we would love to have the additional staffing for our residents but not at the cost of hurting the industry I have grown to love. By adding these extra staff without adding additional funding to help support this change will create a great financial burden for ours and other facilities like us. The challenge of finding the added staff is another mountainous challenge altogether. Please bring this mandate back to the table and consider all involved so it will work for all of us.

Sincerely
Michael Briggs
Maintenance director

Part of the iCare Health Network

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www.touchpointsatmanchester.com

Touchpoints
At Manchester

To Whom this May Concern,

The new DPH 3.0 Direct Care Minimum Staffing Regulations is an unfeasible proposal at this time. This new proposal will cause harm to the healthcare system and our facility in major ways. I am a current employee of Touchpoints at Manchester, which is a 127-bed facility with currently 140 employees.

Prior to the COVID-19 outbreak staffing was a challenge and continues to be an immense barrier post COVID-19. Since before the outbreak staffing and pay rates did not warrant longevity in the healthcare industry. After multiple health issues and deaths of many healthcare workers filling and maintaining staffing has posed challenges.

Our goal is to provide the best quality of care to all. With the new proposal we would have to turn away many sick/injured/ and disabled admissions that we currently take on with normal staffing regulations. Residents are cared for and our staff goes above and beyond to make sure this happens. Our nursing homes lost more workers than any discipline during the COVID-19 outbreak which lasted multiple years. Facilities were forced to take on the sick patients without proper PPE or safety regulations which lead to multiple deaths.

The residents require familiar faces and regular staffing on a regular basis. Residents whom suffer with mental illness such as dementia would live in fear, as we would require agency staffing. This is not at all best practice and is an immense fee to the facility. By placing this proposal into action would cause a downgrade in patient care which is only unfair to those who rely on us.

Over these last few years healthcare workers have overcome immense adversity. We are the frontline heroes that you were praising. Proposing this new guideline will just cause more harm to the healthcare industry. We ask that you please do not raise the staffing minimum and find other ways to help support the healthcare industry other than burdening us further.

Thank you,

Mia DeStefano, LMSW

Behavioral Health Social Work Director

Touchpoints at Manchester.

333 Bidwell Street, Manchester, CT 06040
Tel: 860-533-3086 Fax 860-645-4888

Lord Chamberlain Nursing & Rehabilitation Center
7003 Main Street, Stratford,
CT 06614-1397
Tel: (203) 375-5894 Fax:
(203) 375-1199
www.rydershealth.com

July 27, 2023

Comments on DPH Proposed Regulation (PR2022-32)

To the Department of Public Health:

My name is James Bergers. I am the administrator at Lord Chamberlain Nursing & Rehabilitation Center in Stratford, Connecticut. Lord Chamberlain has been providing nursing home care in our community for 55 years. We are a 190- bed nursing home, and we have over 250 employees working at our facility.

We are not opposed to increased Connecticut's direct care staffing minimum from 1.9 to 3.0, but we are strongly opposed to how specifically DPH has interpreted this state legislative requirement in the proposed regulations and how DPH is currently implementing the requirement.

I request that you substantially revise the proposed regulations.

There are major problems with how DPH has proposed increasing the direct care minimum staff from the outdated 1.9 hours to 3.0 hours of direct care staff per resident per day.

There are several main areas of concern:

THE PROPOSED REGULATION WRONGLY INCREASES THE CNA MINIMUMS FROM 1.26 TO 2.16 HOURS OF PER DAY.

This one-size fits all approach removes Lord Chamberlain flexibility in assigning staff to address the care needs of our residents.

THE PROPOSED REGULATION REVERSES THE PUBLIC HEALTH CODE RULE THAT APPROPRIATELY COUNTED DIRECT CARE LICENSED STAFF AND CNA STAFF TOWARD MEETING THE MINIMUM STAFFING STANDARD.

It won't lead to better care and will likely worsen the situation by writing the rule this way.

THE PROPOSED RULE DOESN'T REFLECT MODERN NURSING HOME STAFFING BECAUSE IT DOESN'T COUNT ALL THE STAFF THAT ARE PROVIDING DIRECT CARE

In addition to the CNAs, and direct care provided by licensed nurses, many more positions should be included, such as….

The rule should also include additional licensed staff that provide direct care.

THERE IS AN INSUFFICENT SUPPLY OF WORKERS

Our facility is facing the most significant staffing challenges we have ever experienced.

THE AMOUNT OF MEDICAID RESOURCES THE STATE MADE AVAILABLE FOR COMPLIANCE WITH THE DPH INCREASED MINIMUM STAFFING RULE IS SIGNFICANTLY INADEQUATE

We thought that the state legislature was making sufficient Medicaid resources available to the Department of Social Services to assure nursing homes had the resources to comply with the anticipated DPH minimum staffing rule, but DPH put out a policy that requires significantly more resources. For example, just consider the unfunded costs just for additional CNAs that the proposed rule requires our facility to hire or contract for.

That DSS had to prorate the true costs down to [indicate the specific amount or percentage] based on the insufficient amount of money in the budget shows clearly that DPH imposed a rule that required a much more substantial funding amount. Our nursing simply does not have the resources to cover this unfunded state mandate….

Please make substantial changes to this proposed regulation. It will make matters worse for our nursing facility, our staff, and our residents.

Comments related to Proposed Regulation Concerning: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

July 28, 2023

I am Chief Financial Officer for the last 19 years at iCare Health Network for 11 Connecticut nursing facilities. The purpose of this letter is to express concern for the State of Connecticut, Department of Public Health's (DPH) implementation of the nursing home minimum staffing. From my perspective, there are 5 main issues with the implementation:

1) **DPH grossly exceeded the legislative intent** of the authorizing statute. The statute indicated that the staffing level would be set at 3 hours per patient per day for direct care. In no way did the statute indicate that DPH was authorized to implement two mutually exclusive caps established (2.16 for Certified Nurse Aides and 0.84 for nurses) that happen to add up to 3. There was no study performed by DPH at their own admission during industry calls in developing these caps. Having two caps does not reflect patient need. A patient or group of patients may need more nurse's aides than nurses, or vice versa. The regulation had been a combined cap for decades which provided flexibility to meet patient needs as appropriate.

2) **DPH erroneously limited** its definition of "direct care" which was different than the fiscal note used by the CT Legislature to establish the Statute. The fiscal note used the definition of Direct Care contained in CT Medicaid cost report rules. These rules consider all levels of nurses and nurse's aides to be "direct care" and include all paid hours. The fiscal note compared the 3-hour mandate to paid hours and not on-site worked hours. DPH elected to narrow the definition to only nurses that provide daily on-site care to real-time needs of patients which is a subset of nurses involved in the overall care of the resident.

3) **This is an unfunded mandate.** The CT Department of Social Services (DSS) provided reimbursement opportunities based on the comparison of a combined 3 hour per patient day to a combined paid hours of 3 hours per patient day and it was concluded as few as 4 providers would need additional reimbursement. When providers learned that DPH was exceeding its statutory authorization many providers requested additional relief and received only a fraction of the requested amounts.

   DPH indicated in its proposed regulations that there would be no fiscal impact to the State. This is completely inaccurate. I encourage the State Agencies and legislative support systems, including DPH, DSS, Office of Policy & Management (OPM), Office of Fiscal Analysis (OFA) and the Office of Health Strategy (OFS), to collaborate and reissue the fiscal impact for this regulation process. The State should then reimburse providers in full for this mandate. The State Medicaid Plan Amendment, State Statutes and

Regulations have a general theme and requirement to fund nursing homes for the reasonable cost of patient care in nursing homes. These costs are matched by the federal government at 50%.

I met with the OFA personally in Spring 2023 when learning of the mandate and provided an analysis using CMS payroll data for nursing homes. The data shows an industry fiscal impact of over $77M with an additional 111,000 nurses and 1.6M nurse's aides hours per year. I will discuss the impossibility of meeting this requirement in number 5 below.

4) **The proposal fails to consider the CT Medicaid Acuity-Based Reimbursement System.** On 7/1/2022 DSS implemented an acuity-based reimbursement system for nursing homes. It considers a nursing facility with an average acuity to be a 1.0 acuity and facilities with higher and lower acuity to be more or less than that benchmark. The lower the acuity, the lower the CT Medicaid reimbursement and vice versa. The underlying system used for this Connecticut's system used the CMS RUG-48 reimbursement methodology which itself was driven from of an exhaustive federal time study called Strive[1] . The Strive study connected time needed for patient care with acuity and the acuity with reimbursement. Since DSS implemented this acuity-based system, DPH should consider the underlying patient needs based on acuity. A facility with lower acuity should have a commensurate reduction in any minimum staffing requirement promulgated by DPH.

5) **There is a severe and unprecedented staffing shortage.** The staffing crisis facing nursing facilities is well documented by nursing home trade organizations[2], the media[3] and others. There have been parallel efforts by Federal officials to increase nursing home staffing levels that have received significant negative feedback from the industry, Congress and the media. Well intended efforts to increase staffing levels in nursing homes need to include a long-term multifaceted effort by the government, industry and stakeholders that includes but is not limited to immigration reform, staff training program development, and tuition forgiveness programs or related tax credits.

The Federal Bureau of Labor Statistics data indicates that over 210,000 jobs in the nursing home sector have been lost since the beginning of the pandemic. I encourage DPH to commission the State Labor Department to analyze nursing home worker employment data and develop a feasibility study to implement the proposed mandate.

Please consider the above, delay the implementation of the mandate and fully fund the impact to Connecticut nursing home providers.

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[1] https://www.cms.gov/medicare/medicare-fee-for-service-payment/snfpps/timestudy

[2] https://www.ahcancal.org/News-and-Communications/Fact-Sheets/Letters/AHCA%20Letter%20to%20President%20Biden%20-%20Staffing%20Mandate.pdf

[3] https://www.wsj.com/articles/green-card-backlog-fuels-shortage-of-nurses-at-hospitals-nursing-homes-4f0b0e44

I would be happy to discuss any or all of these points with you as you consider the regulation.

Sincerely,

Michael S. Plausse
Chief Financial Officer
iCare Health Network

Milford Health & Rehabilitation Center

August 1, 2023

Comments on DPH Proposed Regulation (PR2022-32)

To the Department of Public Health:

My name is Joanne Jinete. I am the Administrator at Milford Health & Rehabilitation Center in Milford, Connecticut. Milford Health & Rehabilitation Center has been providing nursing home care in our community for many years. We are a 120 bed nursing home, and we have approximately 165 employees working at our facility.

I am writing to ask you to make major changes to this proposed regulation.

I have been an Administrator for twenty – five years and have never seen such challenging times like those that I have experienced in the last several years and we are still experiencing challenges. Prior to COVID, we had no issues with staffing. Staff longevity was one of our most prideful points of difference that we spoke about to all of our residents, families and visitors. Now we are embarrassed to discuss how we cannot fill positions and we have to utilize outside agencies to take care of our residents. There are not enough staff to fill all of the open positions in all the nursing homes in CT. We are all competing with each other to hire staff and it is a wage battle. We are dealing with all of this on a daily basis and still no funding from the State.

To hear about this staffing proposal ratio for direct care and have no funding from the State is absolutely upsetting and discouraging. Where is the support after all we went through? The new formula staffing mandate does not help if we have to increase the c.n.a. minimum from 1.26 to 2.16. This will ultimately hurt the patients at the hospitals and the hospital networks if we have to refuse new admissions because we cannot meet these new staffing requirements. This will also burn out all current Nursing Home HealthCare workers and will push all of the those dedicated health care workers including Administrators that have worked for this industry right out the door.

On behalf of Milford Health & Rehabilitation Center, I am asking that you do not pass this proposal. If you have not worked in a Nursing Home for the last several years then you are not aware of what we go through each day. Therefore, an unfunded mandated direct care minimum staffing cannot be mandated if the current staffing challenges have yet to be resolved.

Thank you for allowing me the opportunity to express my views on this proposal. I am certain at the end you will support the Nursing Homes in order to continue to provide quality care to our patients.

Sincerely,

Joanne Jinete

Administrator

Touchpoints
Rehab at Manchester

August 7, 2023

To whom it may concern,

My name is Patrick Neagle and I am the current Administrator of Touchpoints at Manchester, located in Manchester, CT. I have worked as an Administrator for 13 years serving residents in Connecticut and Massachusetts. I chose this profession because of my father and grandmother, both of whom dedicated their lives to serving our geriatric population.

The population at Touchpoints at Manchester is not a typical long-term care facility. We care for short term rehab however we also have a 66-bed secured behavioral unit. We can for residents with multiple psychiatric diagnosis in addition to their comorbidities. I am constantly impressed with our staff that handles these challenging behaviors.

Along with most buildings, we have seen the most challenging time our industry has ever faced. The COVID pandemic pushed us to our limits and showed us what we are capable of. I could not be prouder to work with a team that worked countless days and hours to keep our residents safe. It is not something I will ever forget.

Implementing a direct care minimum staffing requirement is a good idea. I don't think you will find many operators that would disagree. We would, however, disagree with the way in which it is implemented. This needs to be a well thought out plan including timeframes, recruitment efforts and above all a way to properly fund it. That is all we are asking. Please work with us on how to properly move forward with an initiative of this magnitude so that we can do so appropriately. Thank you for your time.

Patrick Neagle, Administrator Touchpoints at Manchester

Part of the iCare Health Network

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CAHCF/CCAL
Connecticut Association of Health Care Facilities
Connecticut Center for Assisted Living

August 1, 2023

eRegulations Tracking No. PR2022-32 – Public Hearing Comments on Department of Public Health Proposed Regulations Concerning Minimum Staffing Level Requirements for Nursing Homes

Thank you for this opportunity to verbally present the views of the Connecticut Association of Health Care Facilities and the Connecticut Center for Assisted Living (CAHCF/CCAL) at this August 1, 2021 agency public hearing on the proposed regulations concerning minimum staffing level requirements for nursing homes. My name is Matthew V. Barrett. I am president and CEO of CAHCF/CCAL, a Connecticut trade association that includes one hundred and sixty-four (164) skilled nursing facility members. CAHCFCCAL is located on 213 Court Street, Middletown, CT 06457.

Introduction --- Support for 3.0 Minimum Staffing Standard but Substantial Revisions Recommended to the DPH Implementing Policies, Procedures and Proposed Regulations

The skilled nursing facility members of CAHCF/CCAL recommend substantial revisions to the proposed regulations.

At the outset of this agency public hearing, It is important to state that CAHCF/CCAL agrees with the policy goal of increasing staffing levels to 3.0 hours per resident per day as directed by the General Assembly consistent with the state appropriations adopted for this purpose – as informed by the estimated fiscal impact as to the overall statutory increase of minimum staffing levels from a total of 1.9 hours to 3.0 hours of direct care per resident per day – an increase of 1.1 hours or nearly 60%. The reason that the association is recommending significant revisions to the proposed regulations is explained in the specific method the agency has chosen to implement the substantial increase from 1.9 to 3.0 hours. The association asserts that the agency has violated the clear meaning intent of the Section 19a-563h of the general statutes, first in agency policies and procedures issued and effective March 1, 2023 and in these proposed regulations, which mirror the agency policies and procedures.

That the agency proposed regulations and issued policies and procedures violate the clear meaning and intent of the 19a-563h has already been expressed formally by the association in its Petition for Declaratory Rulings Regarding the Applicability of the CGS Section 19a-536h submitted to the Department of Public Health on February 28, 2023. The full petition is attached and we ask that it be included in today's public hearing record. Because the proposed agency

regulations are the same as the issued policies and procedures, CAHCF/CCAL asserts that proposed regulations violate 19a-563h for the same reasons expressed in the petition.

Proposed Regulations Should be Substantially Revised to Align with the Available Appropriations and Clear Meaning and Intent of the Enabling State Statute / CAHCF/CCAL Petition for a DPH Declaratory Rulings

As presented in the declaratory ruling petition, and for today's agency public hearing record, CAHCF/CCAL asserts: (1) Under The Plain Meaning Of Section 19a-563h(a), Nursing Homes Satisfy The Minimum Staffing Level Requirement Of 3.0 Hours Of Direct Care Per Resident Per Day With 3.0 Hours Of Total Nursing And Nurse's Aide Personnel Time; (2) The Legislative History And Fiscal Impact Analysis Supports The Plain Meaning Interpretation; (3) The General Assembly Specifically Rejected Minimum Staffing Levels By Licensure Status, Opting Instead To Preserve Staffing Flexibility Based On Resident Needs; (4) The DPH Policies and Procedures Violate the Statute, Do Not Comport With The Fiscal Impact Analysis and Available Appropriations, And Are Inconsistent With DSS' Interpretation And The Medicaid Increased Rate Application Process.

Once more, the main issues of concern is not in opposition to the 3.0 standard. The concern is in the harmful and costly implications of removing the longstanding flexibility of directing staff to meet the specific care needs of residents by inflexibly mandating the RN, LPN and CNA hours. This can be summarized in an excerpt from the Petition for Declaratory Rulings submitted to DPH:

> Despite the plain language of Section 19a-563h and the opposition during the legislative process for mandatory staffing ratios – including by DPH's Acting Commissioner – DPH nevertheless has mandated in the Policies and Procedures not just an increase in the minimum staffing to 3.0 hours of direct care per resident per day, but also a specific minimum for nurse aide staffing of 2.16 hours per resident per day, requiring: (i) for licensed nursing personnel (RNs and LPNs), 0.57 hours per patient during day shifts (7 a.m. to 9 p.m.) and 0.27 hours per patient during night shifts (9 p.m. to 7 a.m.); and (ii) for CNAs, 1.6 hours per patient during day shifts (7 a.m. to 9 p.m.) and 0.56 hours per patient during night shifts (9 p.m. to 7 a.m.). In addition, the Policies and Procedures add an ambiguous definition of direct care. These interpretations are clearly contrary to the legislative intent evidenced in the final fiscal analysis dated May 27, 2021, which is uses 2019 cost report data to conclude a nominal fiscal impact resulting from the passage of Section 19a-563h.[1]
>
> Given that the General Assembly rejected any allocation of minimum hours among different nursing staff categories, it is clear that the state legislature intended to leave specific staffing choices to the individual nursing homes, which are in the best positions to

[1] Notably, in filing the Notice of Intent to Adopt Regulations concerning these minimum staffing requirements, DPH failed to include the Fiscal Note, including estimated costs or revenue impact on the State required under the regulation-making process in Connecticut. *See* Conn. Gen. Stat. § 4-168(a).

assess the specific needs of individual patients and determine specific staffing to meet those patients' needs.

The General Assembly's decision to leave specific staffing choices to individual nursing homes is evident given the significant fiscal impact that mandatory staffing ratios would pose for nursing homes and the State. As discussed *supra*, the initial Fiscal Note on the original draft of S.B. 1030 made clear that imposing the minimum of 4.1 hours of direct care per resident per day, plus imposing mandated staffing ratios, would cost DSS as much as an additional $200 million per year. The second Fiscal Note, addressing the amended version of S.B. 1030 that both reduced the minimum hours from 4.1 to 3.0 of direct care per resident per day and eliminated all mandatory staffing ratios, anticipated increased costs of between $300,000 and $500,000 per year. DSS then had an additional $500,000 allocated for Medicaid costs for subsequent fiscal years, reflecting the clear intent to allocate to DSS additional funding to cover only the increase in minimum staffing levels to 3.0 hours *without* accounting for additional costs of mandatory staffing ratios. The DPH Policies and Procedures do not take these financial impacts into account, and would impose an unfunded mandate that the legislature expressly chose not to impose, thus violating the statute.

Not only do the Policies and Procedures violate the plain language and legislative intent of Section 19a-563h, they represent a significant, overreaching departure from DPH's *existing* regulations regarding staffing ratios for nursing homes. *See* Conn. Agencies Regs. § 19-13-D8t(m). These regulations – which were the sole source of minimum staffing levels for nursing homes before the enactment of Section 19a-563h – permitted nursing homes to staff 1.5 hours of the total minimum 1.9 hours of direct care with any combination of "total nursing and nurse's aide personnel" based on patient needs; only 0.4 hours of the minimum time was expressly allocated for licensed nursing professionals. DPH cannot regulate beyond this without specific legislative authority, approval, and funding.
Yet, the Policies and Procedures as written have significant fiscal impact, in stark contrast with the nominal impact included in the fiscal analysis. The legislature clearly intended for the minimum staffing ratio to be established as a combined total of licensed nursing staff and nurse's aide personnel, consistent with the existing Public Health Code methods. Instead, DPH has created two separate minimum staffing levels, one for licensed nursing staff and one for nurse's aide personnel, which is a major change that will significantly increase the fiscal impact and require staffing modifications for over 100 nursing homes. In addition, in at least two presentations on the new Policies and Procedures, DPH has incorrectly claimed that the new Policies and Procedures only increase the total minimum staffing levels by 0.46 hours per day. This is clearly incorrect, as the minimum staffing levels are increased by 1.1 hours per day overall (from 1.9 to 3.0) and the Policies and Procedures establish for the first time minimum staffing levels for nurse's aide personnel, at a level of 2.16 hours per patient per day.

The Policies and Procedures undermine and contradict the plain language of Section 19a-563h and its clear legislative intent, and implement mandates that the legislature specifically sought to avoid when it modified the proposed legislation to delete staffing ratios. In addition, substantively the Policies and Procedures are not supported by proper

procedure and/or substantial evidence. While the General Assembly authorized DPH to implement interim policies and procedures, DPH was not given authority to ignore the plain language of the statute or its legislative history. Accordingly, the Policies and Procedures that mandate particular minimum staffing ratios to meet the minimum staffing levels for nursing homes violate Section 19a-563h, and its purpose and intent. In addition, to the extent that DPH intends to craft regulations that incorporate any staffing ratios, for the same reasons set forth above, those regulations also would violate Section 19a-563h.

The General Assembly intended to preserve flexibility for nursing homes to determine how best to meet the new minimum staffing level requirements based on individual patient needs, not arbitrary, fixed staffing ratios. Section 19a-563h must be read to allow nursing homes to make those staffing decisions, so long as the minimum mandate of 3.0 hours of direct patient care is achieved and staffing is sufficient to meet patient needs (pages 13-15).

Additional Recommendations:

CAHCF/CCAL also recommends that the agency consider the following additional views as it formulates a final regulation:

1. Staff are simply not available to fill open positions given the severe staffing shortages now being experienced;

2. Sufficient state funding has not been made available for compliance, and therefore the proposed regulations are a clear unfunded state mandate;

3. The DPH proposed rule reverses a several decades long policy of appropriately allowing providers the appropriate flexibility to combine direct care licensed nursing hours with nurse aide hours to comply with the new 3.0 minimum direct care staffing requirement---this DPH policy reversal has effectively and significantly increased the CNA minimum from 1.26 hours to 2.16 hours per resident per day. This is especially costly and harmful to patient care noting that almost all Connecticut skilled nursing facilities are providing direct care staffing well above the 3.0 proposed state minimum, and would be in compliance, were it not for DPH removing this essential direct care staffing flexibility;

4. In addition to how patient care may be undermined when unfunded state mandates are imposed as here, many providers assert that considerable harm is caused by the DPH proposed regulations as compliance may only be achieved with greater use of inconsistent agency staff and less resources available for licensed direct care staff, or that operators are forced to turn away patients who no longer need hospital care and who would benefit from the valuable services of Connecticut's skilled nursing facilities.

5. CAHCF/CCAL skilled nursing facility providers are very discouraged e proposed regulation reverses the ability to meet the minimum staffing requirement in a way that best meets the specific needs of their facility residents, and instead requires specific minimums for CNAs vs. licensed direct care staff.

6. Many skilled nursing home providers have expressed how the inflexible proposed staffing minimums increases the on contracted nursing staffing agencies given the severe shortages of workers, and how this is not the approach the providers believe is best, and note how increasing minimums carelessly, like raising the CNA to 2.16 will further increase agency staff usage, which in not the optimal consistent assignment approach to care;

7. The definition of direct care staff should be inclusive of all licensed and non-licensed staff who provide care to residents beyond the RN, LPN, and CNA staff in a comprehensive approach needed to provide holistic care.

8. Implementation should be phased-in over a period of three years and include an initial pilot or demonstration component. Regulatory enforcement should never be solely based on isolated incidences when a facility may fall below any minimum staffing mandate on a single shift when the facility can demonstrate they meeting the care needs of their residents with sufficient overall staff as how been a state and federal requirement for decades;

9. The proposed regulations should include waiver provisions during periods of documented staffing shortages.

10. To demonstrate that the state has insufficiently provided the promised resources needed to comply with the staffing mandate, please note that the Department of Social Services has reported that 72 skilled nursing facilities applied for $21.4 million in increased Medicaid funding to comply with the new mandate, but that because there was only $500,000 appropriated for this purpose, the agency was forced to prorate the requested amounts downward to only a fraction of the requested amount---well below 10% of the requested amount. This means that some 90% of the true costs of implementing the new requirements are an unfunded state mandate. On this point, the DPH fiscal impact associated with the proposed regulation misstates the real fiscal impact on both DSS and the skilled nursing facilities. Note CAHCF/CCAL has estimated the overall cost of compliance to be approximately $77 million;

For the reasons expressed above, CAHCF/CCAL requests substantial revisions to the proposed regulations.

Respectfully submitted,

Matthew V. Barrett
President/CEO
CAHCF/CCAL

Name: Bond, David
Submission Date: 7/21/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

I am a Nursing Home Administrator and am very concerned with this proposed regulation. We have made huge increases and improvements to our wages and benefits over the last few years to try to return our staffing levels back to the level prior to the Covid 19 outbreak (when we lost about 1/3 of our nursing department staff). We have been using Agency Pool staff since then to supplement our base staffing, while having a few shifts per year prior to 2020. Unfortunately, a large percentage of pool staff are not vested to the residents or the facility and the customer service and overall quality of care is not nearly as good. Furthermore, the absence rate of scheduled Agency Pool staff is at twice as bad as our regular staff and last minute replacements are even more difficult putting more stress on the existing staff to try to make up for it. If there was a greater supply of available nursing staff and we had the funding to support the increased staffing, I would not be opposed. The proposed regulation does nothing to help the issues causing the shortage of nursing staff at nursing homes and would just make it even more difficult for the nursing homes to staff. If I were a politician, I would be working on legislation that eases and encourages immigration for nursing staff from foreign countries as well as funding schools to encourage children to enter nursing careers. The current and future demographics clearly demonstrate that need.

Name: Greenwald, David
Submission Date: 7/24/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

attached letter

Name: Stern, Elizabeth
Submission Date: 7/26/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

Public Testimony for Connecticut Department of Public Health Hearing re Regulations Concerning Minimum Staffing Requirements
August 1, 2023

Submitted by Liz Stern, Stonington, CT
(In honor of family members and friends who live in nursing homes)

I write today with the utmost regard and respect for the work that Commissioner Juthani and members of the Department of Public Health do daily. As a long time family advocate I can not help but ask what more can be added to the hours and hours of testimony given by hundreds of family members, nursing home residents, nursing home staff, ombudsman and members of the CT CGA Aging Committee and Public Health regarding the need to increase staffing levels.

Residents are suffering. Current staff are overworked. And never do we call out the inequities between the attention given to child care and public education versus care denied to our elderly and disabled who must live in nursing homes. The time is long overdue to legislate, train staff, and enforce current regulations and increase direct care to ensure quality care.

I suggest that any person who does not support an increase to a national standard of 4.0 hours/direct care/day spend one week in the bed of a randomly selected Connecticut nursing home. I have witnessed deplorable care in too many nursing homes. DPH is called regularly and made aware of unsafe conditions due to poor staffing. There is nothing to add to the current testimony that has accumulated over the last several legislative sessions.

Please enforce the current staffing levels and work to increase direct care ratios in the future.

Respectfully,
Liz Stern
Stonington, Connecticut

Name: Colaci, Joseph
Submission Date: 7/26/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

The Ct SNF industry continues to be exposed to rampant use of temporary staffing agencies, at double the cost of in-house staff. Pre-COVID our organization of (8) facilities used zero temporary staff, now averages over $650,000/month.The additonal costs are not reflected in our Medicaid rates.Temporary staff are frequently no call/no show, with no accountability for leaving the facility uncovered. These same temporary staff will often refuse to follow facility policies or take assignments they deem to be too difficult.There is no question that resident quality of care declines when provided by agency staff.

Name: Dumont, Craig
Submission Date: 7/27/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

for your Review and Consideration. Please See attached. I would be happy to speak further about this should you have any questions.

Respectfully Submitted

Craig Dumont, RD, LNHA

Name: Perry, Angela
Submission Date: 7/27/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

Please accept testimony on behalf of the staffing DPH proposed regulation.

Regards,

Angela

Name: Andreoli Muscarella, Virginia (Ginger)
Submission Date: 7/27/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

I am in favor of the Proposed Regulation Concerning: Nursing Home Staffing Ratios Tracking Number PR2022-032

As Conservator for my father, Fred Andreoli, I have been his Advocate for the past five years. As time goes by the issue with Staffing has only worsened.

My father is currently a resident at Chesterfields Health Care/Apple Rehab in Chester, CT.

Increased staffing is "IMPERATIVE" in order to provide a "SAFE HOME" for my father and other residents.
Increased staffing is "IMPERATIVE" for residents to receive the proper daily care they deserve.

My father and other residents suffer with short staffing. They are forced to eat in their rooms "ALONE" for meals, missing out on their opportunity to socialize with other residents in the Dining Room because we are short staffed.

Meals sit on trays for up to an hour for residents who are not able to feed themselves.
Residents are missing showers and spending hours without being changed. The odor in the HOME clearly shows this is an issue at times.

ONE CNA CANNOT BE EXPECTED TO PROVIDE PROPER CARE TO 20+ RESIDENTS.

The NEGLECT needs to stop, proper CARE need to start here!

OUR FAMILY MEMBERS DESERVE BETTER.

Thank you.

Sincerely,

Virginia Andreoli Muscarella
166 Winthrop Road
Deep River, CT 06417
Cell: 860.395.9016

Name: Bergers, James
Submission Date: 7/28/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

July 27, 2023

Comments on DPH Proposed Regulation (PR2022-32)

To the Department of Public Health:

My name is James Bergers. I am the administrator at Lord Chamberlain Nursing & Rehabilitation Center in Stratford, Connecticut. Lord Chamberlain has been providing nursing home care in our community for 55 years. We are a 190- bed nursing home, and we have over 250 employees working at our facility.

We are not opposed to increased Connecticut?s direct care staffing minimum from 1.9 to 3.0, but we are strongly opposed to how specifically DPH has interpreted this state legislative requirement in the proposed regulations and how DPH is currently implementing the requirement.

I request that you substantially revise the proposed regulations.

There are major problems with how DPH has proposed increasing the direct care minimum staff from the outdated 1.9 hours to 3.0 hours of direct care staff per resident per day.

There are several main areas of concern:

THE PROPOSED REGULATION WRONGLY INCREASES THE CNA MINIMUMS FROM 1.26 TO 2.16 HOURS OF PER DAY.

This one-size fits all approach removes Lord Chamberlain flexibility in assigning staff to address the care needs of our residents.

THE PROPOSED REGULATION REVERSES THE PUBLIC HEALTH CODE RULE THAT APPROPRIATELY COUNTED DIRECT CARE LICENSED STAFF AND CNA STAFF TOWARD MEETING THE MINIMUM STAFFING STANDARD.

It won?t lead to better care and will likely worsen the situation by writing the rule this way.

THE PROPOSED RULE DOESN?T REFLECT MODERN NURSING HOME STAFFING BECAUSE IT DOESN?T COUNT ALL THE STAFF THAT ARE PROVIDING DIRECT CARE

In addition to the CNAs, and direct care provided by licensed nurses, many more positions should be included, such as?.

The rule should also include additional licensed staff that provide direct care.

THERE IS AN INSUFFICENT SUPPLY OF WORKERS

Our facility is facing the most significant staffing challenges we have ever experienced.

THE AMOUNT OF MEDICAID RESOURCES THE STATE MADE AVAILABLE FOR COMPLIANCE WITH THE DPH INCREASED MINIMUM STAFFING RULE IS SIGNFICANTLY INADEQUATE

We thought that the state legislature was making sufficient Medicaid resources available to the Department of Social Services to assure nursing homes had the resources to comply with the anticipated DPH minimum staffing rule, but DPH put out a policy that requires significantly more resources. For example, just consider the unfunded costs just for additional CNAs that the proposed rule requires our facility to hire or contract for.

That DSS had to prorate the true costs down to [indicate the specific amount or percentage] based on the insufficient amount of money in the budget shows clearly that DPH imposed a rule that required a much more substantial funding amount. Our nursing simply does not have the resources to cover this unfunded state mandate?.

Please make substantial changes to this proposed regulation. It will make matters worse for our nursing facility, our staff, and our residents.

Name: Plausse, Michael
Submission Date: 7/28/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

My comments are contained in a PDF attachment.

Name: Schwartz, Russell
Submission Date: 7/29/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

I have attached my comments on PR2022-032

Name: ,
Submission Date: 7/31/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

It is my opinion and observation that there is not enough staff to take care of STC or LTC SNF patients. I have taken daily notes while my dad was in the SNF with missed personal care, missed meals, lack of fluids and trial and errors with overmedication used as a chemical restraint. My father was walking, driving and completing all ADLS at home in JUNE of 2022. JULY was the admission month for rehab after a 2 week stay at L&M and by OCT 2022 he was a Hoyer lift patient-could not walk and a total feed most days, depending on the meds used. I have gone to the SNF everyday and changed soiled bed linens, fed meals, changed clothes, shaved/washed face and hands, wash ups, clipped nails, mom did foot care and things she felt comfortable doing. What happens when family is not there to do this job? The staff cannot keep up with patient care. An aide told me she was there 2 weeks and was quitting stating I can't keep up with 33 patients and only 2 aides working on this floor I am burnt out.

I got my CNA license in 2006 and saw that aides had 10 to 11 patients a shift and now I see that its 16 patients. I do homecare and we have 5 patients a day in 7.5 hour shift. It takes about a half hour to assist with showers and dressing, it takes 1 hour for a total care patient and two aides working with one patient in the home for total care and transfer from bed to chair using the hoyer lift, then feeding taken more time and that's one patient with two aides! The patients in SNF are not getting the care they need and I have witnessed this from JULY 2022 to March 2023. My dad died, he was dehydrated, over medicated and left in bed with food in his teeth, and sour smelling body odors. This is inhumane. The patient and staff ratio needs to change asap. No body should be treated as poorly as these and no one should have to work in these conditions.

Name: Doroghazi, Anna
Submission Date: 7/31/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

Please see attached for AARP CT's comments regarding proposed regulations regarding nursing home staffing ratios (PR2022-032). For additional information or clarification, please contact Anna Doroghazi: adoroghazi@aarp.org or 860-597-2337. Thanks for the opportunity to comment on this important issue.

Name: White, William
Submission Date: 7/31/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

Good Morning, please see attached testimony.

Name: Abramson, Lewis
Submission Date: 7/31/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

We are not opposed to increased Connecticut?s direct care staffing minimum from 1.9 to 3.0,
but we are strongly opposed to how specifically DPH has interpreted this state legislative requirement in
the proposed regulations and how DPH is currently implementing the requirement.

Name: Katz, Jay
Submission Date: 7/31/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

I uploaded testimony.

Name: Quarles, Denise
Submission Date: 7/31/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

Please see attached letter. Thank you for your time and consideration on this very important matter.

Denise Quarles
Regional Director of Operations

Name: Heilweil, Nathan
Submission Date: 7/31/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

The DPH proposed staffing requirements will not benefit resident care as intended. With shortages of skilled and experienced CNAs it will force Nursing Homes to use outside agency staff, who does not know the resident or the facility. The current ratios of counting LPN and Rn times lends itself to the current labor situation in Connecticut and benefits resident care.
Your proposal may be well intended but the unintended consequences will not be beneficial to my resident population.
thank you
Nathan Heilweil, LNHA

Name: Kraus, Jonah
Submission Date: 7/31/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

Please see my testimony that is attached.

Thank you.

Name: DeMio, Richard
Submission Date: 7/31/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

Please see attached PDF.

Name: Shahen, Janet
Submission Date: 7/31/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

Proposed regulation for minimum staffing requirement comments.

Name: Rowland, Chad
Submission Date: 7/31/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

PR2022-032 Civita Care Center at Milford

Name: Woxland, Janet
Submission Date: 7/31/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

ATTACHED LETTER

Name: Rappaport, Irma
Submission Date: 7/31/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

I am asking for a vote in favor of increasing nursing staff and also not a vote to decrease recreational staff. In order for the nursing home residents to have a good quality of life, there needs to be enough staff to give person-centered care for their physical, emotional, and social needs - taking them outside in good weather, having a conversation with them, spending the time necessary to help them eat and drink and change their briefs, and noticing if they are declining in any way.

Name: Thomas, Adrian
Submission Date: 7/31/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

THE PROPOSED REGULATION REVERSES THE PUBLIC HEALTH CODE RULE THAT APPROPRIATELY COUNTED DIRECT CARE LICENSED STAFF AND CNA STAFF TOWARD MEETING THE MINIMUM STAFFING STANDARD.

Name: Rodowicz, Curtis
Submission Date: 8/1/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

Please see attached comments for PR2022-32

Name: Morelli, Mag
Submission Date: 8/1/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

Please see the attached comments from LeadingAge Connecticut.

Thank you.

Name: Gaudioso, Marian
Submission Date: 8/1/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

Please see attached letter.

Name: Barrett, Matthew
Submission Date: 8/1/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

Please find attached the August 1, 2023 written testimony of CAHCF/CCAL for the public hearing record

Name: Fischer, Reuven
Submission Date: 8/1/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

SEE ATTACHED LETTER

Name: Rosenbloom, Marion
Submission Date: 8/1/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

8/1/2023

To Whom This May Concern,

I am writing this letter on behalf of myself and my fellow residents. My name is Marion Rosenbloom and I am a longtime resident at Willows Center in Woodbridge. I am coming up on three years of living at this center. I want to express my concerns as a longtime resident and I am in favor of the state minimum of 3.0 for staffing in nursing homes.
My concerns are as follows:
I am a hoyer lift, due to not being ambulatory. Since, I am a hoyer lift it takes a bit longer for me to get up and ready in the morning. At times, if I do not have my regular CNA on my schedule for that day, that knows my routine. Unfortunately, at times I end up missing the morning activity due to getting taken care of at a later time due to being a hoyer lift. It takes a lot of time and effort to get me up.
I have a colostomy bag and I am able to take care of it myself. However, recently I have been running into issues where there has been a delay in me getting my supplies due to a provider change. I typically change my bag twice a day. I have finally received my order. I do not feel I should have to worry about my supplies and that I won?t have my supplies to be able to care for myself.
This is like a domino effect, if the state doesn?t change their regulations. The staff in nursing homes will continue to be overworked and overwhelmed. Ultimately, leaving us resident?s to suffer the most. I find myself worrying quite often on who will be taking care of me and at what times I will receive my care because I do not always have my typical CNAs caring for me. I feel I should not have to worry about when I will be cared for, my needs should be a given. I appreciate you taking the time to read my letter and hearing my concerns.

Sincerely,

Marion Rosenbloom

Name: Naccarato, Mary
Submission Date: 8/1/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

I firmly encourage you to vote in favor for the increase in the nursing staff but do not vote for the decrease in recreational staff as this is a quality of life issue

Name: Rayel, Michael
Submission Date: 8/1/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

See attached File

Name: Shapiro, Eileen
Submission Date: 8/2/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

I support increasing all staffing at nursing homes directly involved with resident care. As someone who has a relative who has resided in different nursing homes for many years, it is my observation that more is needed.

Name: Shapiro, Eileen
Submission Date: 8/2/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

I'd like to add to my previous comment. I do not support a reduction in recreational staffing. They are involved in patient care as well as nurses and social workers.

Name: Pitogo, Maria
Submission Date: 8/2/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

the DPH proposal is very short sighted and does not factor in that the present regs are working to the resident's benefits. Making nhs add untrained or agency staff who are unfamiliar with the residents and the facility does not improve care. I feel that the present regs counting lpn and rn hours works and let's not disrupt the system

Name: Rosenberg, Aaron
Submission Date: 8/2/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

I would hope that legislators strengthen the care of residents in nursing homes. They need the best medical care as well as recreational programing.

Name: Jinete, Joanne
Submission Date: 8/2/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

Comments on DPH PROPOSED REGULATION (PR2022-32)

Name: Healy , Erin
Submission Date: 8/2/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

Please consider these comments and requests that you substantially revise the proposed regulations.

Name: Fritz, Robert
Submission Date: 8/3/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

Seeking to revise proposed regulation due to impact on nursing home. See attached letter.

Name: Jones, Marisa
Submission Date: 8/3/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

I am writing to ask you to make some significant changes to this proposed regulation. We do not oppose an increase in the direct care staffing minimum as outlined in the public health code, but we strongly oppose how DPH is proposing the implementation of the requirement. Please see attached for detailed comments. Thank you

Name: Giamattei, Elizabeth
Submission Date: 8/3/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

I have been working as a LPN for 18years mostly short term rehab units. The staffing has never been enough to care for patients. Since COVID-19 staffing has become so bad I've seen units with up to 38 patients left with 2 CNA's trying to do the best they can. Some facilities are threatening staff with the mandate law that was approved January 1st telling staff they will be fired if they do not stay to cover call outs. At one facility I witnessed this being used as a regular practice. The stress of working short staffed on extremely busy units especially short term rehab has taken its toll on many nurses and CNA's. Short term rehab units have very acutely ill patients who require more time and attention. The long term care units also need increased staffing, as I have seen the stress when staff is rushing that it takes on all patients. The staffing situation needs an immediate attention passing this increase time is essential.

Name: Thomas, chioma
Submission Date: 8/4/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

Please see attachment

Name: Kingston, George
Submission Date: 8/4/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

Please see attached comments

Name: Sanderson, Theresa
Submission Date: 8/4/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

My name is Theresa Sanderson and I have been the administrator of West Hartford Health & Rehabilitation Center (WHHRC) in West Hartford, Connecticut, for the past 20 years. WHHRC is a 160-bed skilled nursing facility with sub-acute, dementia and long-term units. This facility has been independently owned by the same owner since 1977. WHHRC employs over 200 dedicated people from the surrounding community. We have unprecedented longevity and loyalty among staff. At the most recent ?Years of Service? ceremony celebrating our staff, we had employees honored who have worked here up to 42 years. Unfortunately, we have recently had staff retire that we can not replace.

We are a CMS five-star overall quality facility and the preferred provider for all three large area hospitals. This facility recently acquired American Heart Association Certification.

In addition to devoting my career to long term care administration, I have also achieved the American College of Health Care Administrators (ACHCA) credentials of Certified Nursing Home Administrator (CNHA) and Fellow of ACHCA (FACHCA). I recently received the National Administrators Board (NAB) credential of Health Services Executive (HSE). I currently serve as the National Board Chair of the American College of Health Care Administrators.

During my 30-year career, I have experienced staffing crisis, but nothing like what we are going through post pandemic. Despite being a high-quality home, we have been unable to fill the Registered Nurse Infection Preventionist position since 2020. The salary expected for this position is too high for our independent nursing home to afford. We have recently lost several of our RN/LPN charge nurses to hospitals because the rate of pay is significantly higher than we are able to pay. Any staffing minimum must include help with paying nursing staff a higher rate in order to be competitive with hospitals and agencies.

This competitive market challenges us to be more creative with recruitment. In the past year we have sponsored two certified nurses? aides? classes. We hire uncertified staff and pay them an hourly rate to take the course. We also pay for the course. This has helped slightly but is prohibitively expensive.

The replacement agency/pool contracts are two or three times the hourly rate of a staff nurse. This is impossible to maintain. The agencies for temporary staff have taken advantage of the staffing crisis and continue to push their hourly rates even higher. Any long-term use of them agencies will put us out of business.

If you do require a staffing minimum there are more than ?nurses? that perform critical care for our residents. Our social services routinely pass trays for meals, assist with answering call lights, and other necessary tasks. The physical and occupational therapy team performs activities of daily living (ADL) for our residents which include washing, dressing, transfers and grooming. They should absolutely be counted toward a staffing minimum requirement. The nursing management team, although they spend much of their time performing administrative tasks, spend a great deal of time pitching in to help. They do wound care,

assist charge nurses with medications, answer call lights and perform ADL?s for residents. Even I answer call lights and pass meal trays. All staff who work in nursing homes contribute towards caring for the residents, not just nurses and certified nursing aides.
In summary, I am fortunate enough to have a long history in the business and work for a quality skilled nursing facility. My analysis of the current staffing crisis is:
? Nursing homes Medicare/Medicaid rates must be high enough allow us to offer nurse salaries competitive with the hospitals and temporary staffing agencies.
? Agencies are taking advantage of the staffing crisis and caps must be placed on their fees.
? Staffing requirements must include nursing administration, therapy staff, social services and recreation in their numbers, at a minimum.
This free-standing, independently owned skilled nursing facility does not have the resources to fund new staff, even if they were available to hire. An unfunded staffing mandate is unreasonable.

Sincerely,

Theresa Sanderson, CNHA, FACHA, HSE
Administrator

Name: Martin-Davis, Charmaine
Submission Date: 8/4/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

see attach letter

Name: Elmes, Shannon
Submission Date: 8/4/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

The residents throughout nursing homes deserve to have facilities completely staffed in order to receive adequate care. Nursing, CNA's, and recreational therapists are the main individuals who impact a resident's stay. Without fully staffed buildings are residents may not be receiving the care they truly deserve. To receive the care, they truly deserve nursing and recreational therapists need to be receiving the pay that they deserve. Without adequate funding the staffing will just not be possible.

Name: Rodriguez, Heather
Submission Date: 8/4/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

The Proposed Regulation Concerning: Nursing Home Staffing Ratios

Tracking Number: PR2022-032 needs to be reconsidered and revised.

Name: Pacifico, Lisa
Submission Date: 8/5/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

I am a Physical Therapist working in a SNF. I have been a PT for 39 years and it is sad to see the changes in Healthcare. We are admitting more involved patients with greater care needs with less staffing. COVID has also affected Healthcare with many workers leaving the field. When looking at the ratio of caregivers to patients the condition of the patients needs to be considered as many of them are extremely debilitated requiring assist of two people for care. It is hard to hear both patients and their families feeling like they are being neglected because of the wait time for their medications and care. The pay for Healthcare Workers also needs to be considered. To hear staff leaving for other jobs because of more money is disheartening? we are taking care of people. Consider a loved one being a patient in Short Term Rehab or Long Term care, I?m sure you wouldn?t want them to feel Neglected.

Name: Konczyk, Shirley
Submission Date: 8/6/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

I am a resident at Middlesex Healthcare Center. Our facility has been through difficult times. My fellow residents and I fought to get this facility brought back to where it belongs. Ct. Mirror wrote an article mentioning this facility. While Tami Reilly was here as a consultant, things were looking up. Since she has left, and Donna has taken over for 8 hours a week, it is not enough. The schedule appears to have enough staff scheduled to work but when the day arrives, the staff that are supposed to be here call out. Agency has taken over and many times, the Athena staff does not want to put up with working for them. Agency staff do not know the policies, procedures and do not ensure that staff are doing their jobs correctly or doing what is appropriate. The residents do not trust the Agency supervisor as they do not follow through with what the residents concerns are. I myself have had a supervisor from agency threaten me and asked me if I had legal representation. Only after I informed her that a staff member was sleeping in an empty residents room and banged on the wall waking me up. Turned out that the Agency Aide and Supervisor were friends and later I found the Aide Sleeping at the nursing station next to the supervisor. I have had to take an hour to find someone to give me my pain meds. If I want ice, at times I will be lucky if I can find someone on the unit to help me. I have had to go to another unit to ask and have that unit's Aide get me ice. I have been told to just push my call bell and someone will come to you. Well, I have done that. It has been over an hour for someone to respond to the bell and one time nobody came at all. The bell was turned off at the nursing station and nobody came to my room to help me. What if I had fallen out of bed. Nobody came to my room at all. So, if I was hurt, it would not have been discovered until the next meal delivery. Staff are also frustrated. At least the ones Employed by Athena. This facility was directed to no longer accept patients. Now they can accept patients but they still do not have the staff to support the new patients. They recently put a new patient near the nursing station as the patient needs close monitoring by a nurse. That great when we have a nurse on the unit for the shift but that is very rare. Some Aides close her door because she cries at night and they do not want to listen to her. That is close monitoring? Half of this facility is still empty because of all of the violations that were found (See attachment). To have this facility have 186 pages of violations and due to Covid DPH would not investigate our complaints. So for the entire Covid restrictions, me and my fellow residents were neglected and abused. DPH after a year finally investigated. The damage was done and the folks that did the damage now are working at other facilities still harming those of us that depend on their care. If you use 'Google" you can search Athena Nursing home newspaper article and read what Athena has done at its facilities. It is still happening and more staff are needed. I hope that Athena's reputation has not destroyed getting consistent staff that is needed for the residents to feel safe and that learn what each patient requires on a daily basis to make their day better. The ratio of 1 hour a day is not even met for a resident. More realistic

system needs to be put in place. I am lucky if I see a staff member for 10 minutes a day. That includes, meal delivery, ice, Medications and passing them in the hallway to simply say "Hello". The ratio system does not work. Whomever is coming up with these ideas clearly does not have a loved one in a facility or has any idea what goes on in facilities. There were not even enough DPH staff to investigate our issues at Middlesex Healthcare Center. During the day there are plenty of staff. After hours and weekends, you can barely find anyone. It is less than a skeleton crew that works and what is written on the schedule does not match the requirements or what is actually here. There also is no accommodations for those who require psychiatric assistance for a 24 hour period. Social workers only spend a few minutes with them but those with Psych issues that act out all day disrupt the entire facility and then the Aides have even less time taking care of medical patients without psych issues. Then frustrations elevate a great deal. We need to stop putting bodies in positions to only make it look good on paper. We need to put bodies in positions that actually do the job they were hired to do. Service is being sacrificed and our residents are the one's who pay the ultimate price. At times, that means costing them their lives because improper or lack of care given to them.

Name: Briggs, Mike
Submission Date: 8/8/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

Please see my attached testimony.

Name: Herstell, James
Submission Date: 8/8/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

Please see my attached testimony.

Name: Melendez, Tyina
Submission Date: 8/8/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

Please see my attached testimony

Name: Mckee, Cassondra
Submission Date: 8/8/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

Please see my attached testimony

Name: Neagle, Patrick
Submission Date: 8/8/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

Please see my attached testimony

Name: Destefano, Mia
Submission Date: 8/8/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

Please see my attached testimony

Name: Lazure, Cristina
Submission Date: 8/8/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

Please see my attached testimony.

Name: Quarti, MaryJane
Submission Date: 8/8/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

My husband has been a resident at two snf: Hughes Health and Rehab in West Hartford 2/23-5/23, and Marlborough Health and Rehab 5/23 to present. At the beginning of his stay at Hughes nursing and cna staffing were adequate. Once the decision to close was approved levels dropped precipitously as staff began to leave and pool personnel became more common. I made the decision to move Ken to Marlborough due to their 5-star Medicare rating and promise of low pool staffing. This hasn?t been the case. In addition overall staffing levels are inadequate to perceived case load. Weekdays are often short but weekends and holidays are very short staffed. My husband developed a decubitus ulcer due to inadequate turning in bed which subsequently required hospitalization for I&D. In addition he lost 10 pounds in 2 weeks due to inadequate supervision while eating and or feeding by cnas for expediency sake of often cold and unpalatable food. He rarely received oral care unless I gave it to him. I filed a complaint with DPH.

Good cnas and nurses are some of the hardest working providers in healthcare. They are undercompensated, often under appreciated and suffer for their patients when they can not give adequate care.

There is one product in a nursing home: care. It is beyond time to provide the support in staffing and compensation.

Name: Martin, Penni
Submission Date: 8/10/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

Comments on proposed regulation PR2022-32

Name: Green, Carlene
Submission Date: 8/10/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

Re: Comments on DPH Proposed Regulation(PR2022-32)

Name: Giamattei, Elizabeth
Submission Date: 8/10/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

I have been a Licensed Practical Nurse in CT since 2006. I have been working in chronic care facilities/nursing homes since 2006. Since COVID-19 staffing has become unbearable. The amount of patients we are expected to care for is impossible. I have seen many bad situations over 18 years because no one nurse should have to care for 30+ patients no matter what their status is long or short term. Most facilities mix the short and long term together, which creates even more stress and confusion. Short term rehab patients are more acutely ill and have PICC lines and other devices that require more time and attention to detail. Recently I have found we are all overwhelmed and the facilities could care less. They are overworking nurses with excessive patient assignments then will mandate nurses because they can not find any help. Yes they are even threatening us with termination and reporting of our licenses to state DPH. We are forced to take on 30+ patients with minimal CNA staff. I was left on a 11pm to 7am shift with 66 long term care dementia unit with 2 CNA's recently. We were so overwhelmed and patients were left without care. I was unable to prevent my own father from being subjected to this environment and when I realized what was going on I immediately removed him and he past away 1 month later. Please do not let this continue. Facilities are filling beds to max but do not have the staff to care for them. Please I have been talking with many nurses recently and everyone of them is stressed, overwhelmed and considering leaving nursing as am I. Facilities can not find help because they also don't want to pay anyone fair wages. Right now with inspections behind its literally not safe at some of these facilities. When we go to management and tell them we are not able to get our work done nothing is done. There are many changes that need to be made in the nursing homes PLEASE for safety of everyone patients and staff this regulation needs to be Law. Everyone is aware of the unfortunate incidents that occur daily in nursing homes, more staff will help prevent these from occurring. Thank you

Name: Ellis, Sharon
Submission Date: 8/14/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

Please find my comments on attached file

Name: L'Abbe, Maureen
Submission Date: 8/14/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

please see attached

Name: Hackling, Raymond
Submission Date: 8/14/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

Please see my comments attached.

Name: Gonzalez, Emily
Submission Date: 8/14/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

Please see attached

Name: Seguinot, Julie
Submission Date: 8/14/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

Please see my comments below

Name: DeRing, Jessica
Submission Date: 8/14/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

I am writing today in reference to eRegulation Tracking No. PR2022-032 re: proposed DPH minimum staffing regulation. I am Jessica DeRing, I have been an administrator for 25 years in the SNF setting. I am discouraged that the proposed regulation reverses the ability to meet the minimum staffing requirement in a way that best meets the specific needs of our facility residents. We are still experiencing a shortage in staffing needs

Name: Breault, Allison
Submission Date: 8/14/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

Comments related to Proposed Regulation Concerning: Nursing Home Staffing Ratios
Tracking Number: PR2022-032
August 14, 2023

I am Chief Clinical Officer at iCare Health Network representing 11 Connecticut nursing facilities. The purpose of this letter is to express concern for the State of Connecticut, Department of Public Health?s (DPH) implementation of the nursing home minimum staffing. As a Registered Nurse for the past 40 years working in acute care, home health, hospice and now long term care I am seriously concerned about the ability of any facility to meet this unfunded mandate during a time of a critical nursing shortage. The Federal Bureau of Labor Statistics data indicates that over 210,000 jobs in the nursing home sector have been lost since the beginning of the pandemic. The staffing crisis facing nursing facilities is well documented by nursing home trade organizations2, the media3 and others. There have been parallel efforts by Federal officials to increase nursing home staffing levels that have received significant negative feedback from the industry, Congress and the media. Well intended efforts to increase staffing levels in nursing homes need to include a long-term multifaceted effort by the government, industry and stakeholders that includes but is not limited to staff training program development and tuition forgiveness programs or related tax credits.

Additionally, the statute indicated that the staffing level would be set at 3 hours per patient per day for direct care. In no way did the statute indicate that DPH was authorized to implement two mutually exclusive caps (2.16 for Certified Nurse Aides and 0.84 for nurses) that happen to add up to 3. There was no study performed by DPH at their own admission during industry calls in developing these caps. Having two caps does not reflect patient need. A patient or group of patients may need more nurse?s aides than nurses, or vice versa. The regulation had been a combined cap for decades which provided flexibility to meet patient needs as appropriate. Additionally, on 7/1/2022 DSS implemented an acuity-based reimbursement system for nursing homes. It considers a nursing facility with an average acuity to be a 1.0 acuity and facilities with higher and lower acuity to be more or less than that benchmark. The lower the acuity, the lower the CT Medicaid reimbursement and vice versa. The underlying system used for this Connecticut?s system used the CMS RUG-48 reimbursement methodology which itself was driven from of an exhaustive federal time study called Strive1 . The Strive study connected time needed for patient care with acuity and the acuity with reimbursement. Since DSS implemented this acuity-based system, DPH should consider the underlying patient needs based on acuity. A facility with lower acuity should have a commensurate reduction in any minimum staffing requirement promulgated by DPH.

I encourage DPH to commission the State Labor Department to analyze nursing home worker employment data and develop a feasibility study to implement the proposed mandate.
Please consider the above, delay the implementation of the mandate and fully fund the impact to Connecticut nursing home providers.

2 https://www.ahcancal.org/News-and-Communications/Fact-Sheets/Letters/AHCA%20Letter%20to%20President%20Biden%20-%20Staffing%20Mandate.pdf
3 https://www.wsj.com/articles/green-card-backlog-fuels-shortage-of-nurses-at-hospitals-nursing-homes-4f0b0e44

Thank you
Allison Breault, RN, MS
Chief Clinical Officer
iCare Health Network

Name: Aranha, Jean Mills
Submission Date: 8/14/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

Please see my comments in the Attachment below.

Name: Beaudoin, Rosemary
Submission Date: 8/14/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

Reverse this policy!

Name: Bettigole, Michelle
Submission Date: 8/14/2023
Agency: Department of Public Health
Subject: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

August 14, 2023

Comments on DPH Proposed PR2022-032

To the Department of Public Health:

Thank you for the opportunity to provide comments on DPH Proposed Rule PR2022-032. My name is Michelle Bettigole. I am both a registered nurse and a licensed nursing home administrator in the State of Connecticut. In those capacities, I have served senior citizens of Connecticut for over thirty years. I am currently the Chief Senior Care Officer for Ascentria Care Alliance, responsible for a network of five non-profit nursing homes in New England including Lutheran Home of Southbury (LHS) in Southbury, Connecticut. LHS has been providing nursing and rest-home care in our community for over 100 years. Currently, we serve more than 285 senior citizens in the State of Connecticut with over 236 employees.

Lutheran Home of Southbury is a member of Ascentria Care Alliance, one of the largest nonprofit, human service organizations in New England. With many locations throughout the region, Ascentria serves children, youth and families; persons with developmental disabilities and mental illness; refugees, including unaccompanied refugee minors; as well as older adults and has done so for over 150 years.

While we are not opposed to an increase to Connecticut?s direct care staffing minimum from 1.9 to 3.0, we are concerned about how the Department of Public Health (DPH) has interpreted this state legislative requirement in the proposed regulations and how DPH is currently implementing the requirement.

Our concern stems from one main element in the implementation proposed by DPH:

?Staffing Challenges: There is currently a national shortage of healthcare workers, and this trend is likely to continue for the foreseeable future. DPH?s interpretation of the State requirement can only be met by increasing staffing. This is a challenge for LHS and other skilled nursing providers for several reasons. First, qualified candidates are simply not available for hire as so many healthcare workers have left the workforce. New workers are not entering the healthcare field where pay is low, and the work is hard. Second, both for-profit and non-profit nursing homes are competing for the same limited supply of candidates, driving wages higher and making recruitment and retention a tremendous challenge. We do not have the resources to fund new staff positions even if they were available to hire.

We are proud to say that at Ascentria we are addressing the healthcare workforce crisis with two initiatives:

?CNA Training: In order to meet the ongoing workforce challenge, LHS has been sending staff members for training to become certified nursing assistants at our cost since 2021. We have helped over a dozen candidates become certified nursing assistants, but that total remains a fraction of the caregivers we need.

?Human Development Center: In order to provide pathways for career advancement for healthcare workers and others at our organization, we are taking the groundbreaking step to create the Human Development Center (HDC) within our organization. Supported by privately raised funds, the HDC will provide a comprehensive set of resources to our employees, many of whom are from under-resourced communities. We will work to understand the challenges our employees face and create a set of wraparound services to mitigate those challenges enabling our employees to thrive professionally and personally.

We want to be clear that we do not oppose a meaningful 3.0 minimum staffing rule. However, we do have serious concerns about the mandated rules for implementation put forth by DPH without a clear pathway to recruit and train the appropriate caregivers. We believe that the intended goal of the state?s proposed legislation is to maximize the quality of care received by nursing home residents. DPH?s plans for implementation will make it more difficult for skilled nursing centers like Lutheran Home of Southbury to remain focused on meeting the needs of our residents in a manner that has benefited our residents for over 100 years.

We respectfully ask that the Department of Public Health consider revising its proposed regulation to address these concerns. We want to be part of a solution that works for all nursing homes in Connecticut and would welcome the opportunity to join any committee that may materialize in this matter.

Respectfully,

Michelle R. Bettigole, RN, MS/MSN
Chief Senior Care Officer

PARKWAY PAVILION
HEALTH & REHABILITATION CENTER
A Wachusett Healthcare Facility

August 1, 2023

Comments on DPH Proposed Regulation (PR2022-32)

To the Department of Public Health:

My name is Marisa Jones, and I am the Executive Director at Parkway Pavilion Health and Rehab Center in Enfield, Connecticut. Parkway Pavilion is a longstanding provider of nursing care in the community of Enfield with 130 skilled beds and over 140 employees. We are proud members of the Connecticut Association of Health Care Facilities (CAHCF) and a recent recipient of an AHCA Bronze Quality Award.

I am writing to ask you to make some significant changes to this proposed regulation. We do not oppose an increase in the direct care staffing minimum as outlined in the public health code, but we strongly oppose how DPH is proposing the implementation of the requirement. There are major problems with how DPH has proposed increasing the direct care minimum staff from the outdated 1.9 hours to 3.0 hours per resident per day.

Our primary areas of concern with this regulation are as follows:

1. The proposed regulation wrongly increases the CNA minimums from 1.26 to 2.16 hours of care per resident per day and reverses the Public Health Code rule that appropriately allowed for licensed staff hours to be counted toward meeting the minimum staffing standard. This approach eliminates our flexibility to staff the facility to meet the needs and acuity of our residents. If implemented, this will not create better outcomes but will likely worsen the situation.
2. In theory the proposed regulation looks good on paper but, it is impossible to meet. There is an insufficient supply of workers to meet the needs of our healthcare facilities. We have seen a mass exodus of workers since the start of the pandemic, and we have not seen this right itself yet. Our facility has been facing the most significant staffing challenges we have ever experienced. Over the past two years, we have exhausted all efforts to recruit staff to work at Parkway Pavilion. We have increased rates on an annual basis, offered sign-on bonuses, refer a friend bonuses, offered flexible scheduling through online platforms such as Indeed and Apploi and offered to sponsor candidates to become certified nursing assistants (CNAs), to name a few. Unfortunately, all of these efforts have not been effective enough to fill our open CNA positions, resulting in us needing to use agency staff at an exorbitant cost. In addition to the cost, the use of agency staff doesn't allow for us to have consistent assignments for our residents which is a best practice we strive for. It is a constant struggle to find balance for our staff so that they do not face burnout.
3. The proposed regulation doesn't take into consideration the modern nursing home staffing model. In order to best meet the needs of our residents, we utilize a collaborative approach including our entire interdisciplinary team. This regulation doesn't count all the staff that are providing direct care on a daily basis. In addition to the CNAs, direct care is provided by licensed nurses, occupational therapists and physical therapists, to name a few. This rule should account for all of these staff members providing direct care to meet our residents' needs.
4. The amount of Medicaid resources the state made available for compliance with the DPH increased minimum staffing rule is significantly inadequate. We thought that the state legislature was making sufficient resources available to the Department of Social Services to assure nursing homes had the

necessary resources to comply with this anticipated staffing rule, but this proposed regulation requires significantly more resources. Our nursing home's labor-related costs began a dramatic rise last Fall and are showing no sign of relenting. This is a direct result of our team having no choice but to turn to staffing agencies to help staff our building to ensure our residents get the care they deserve. Using these nurse staffing agencies has been a measure of last resort at our nursing home. However, like so many other nursing homes we have had no other option. The financial consequences have been enormous. We are seeing unbelievable spikes in the costs of staffing agencies. For example, many staffing agencies charge additional fees for the difficult to fill shifts, weekend and off shifts, or the agency staff will not pick up shifts unless an additional incentive is added to their already exorbitant pay rates.

5. The public health code does not reflect the reality of the three shifts most nursing homes use as their staffing template. It is currently written for two 12-hour shifts and this should be updated to be a more accurate reflection of staffing ratios per shift.

In closing, the above reasons are why we are requesting that the proposed DPH regulation (PR2202-32) be substantially revised. Implementation of the regulation as it is now proposed will only make matters worse for our nursing facility, staff and residents. We are not opposed to a meaningful increase to our minimum staffing levels to update the outdated public health code ratios but not the one being currently proposed.

On behalf of every at Parkway Pavilion, thank you for your time and consideration.

Sincerely,

Marisa Jones

Marisa Jones

Executive Director

July 31, 2023

Comments on DPH Proposed Regulation (PR2022-32)

To the Department of Public Health:

My name is Janet Shahen. I am an Administrator at Village Green of Bristol, Nursing and Rehabilitation Center in Forestville, Connecticut. Village Green of Bristol has been providing nursing home care in our community for 55 years. We are a 95 bed nursing home, and we have 147 employees working at our facility.

We are not opposed to increasing Connecticut's direct care staffing minimum from 1.9 to 3.0, but we are strongly opposed to how specifically DPH has interpreted this state legislative requirement in the proposed regulations and how DPH is currently implementing the requirement.

Now after the COVID-19 pandemic and public health emergency, I can say that our nursing home, the residents we serve, and our employees, continue to be challenged like no other time in our history of providing services in Connecticut.

There are major problems with how DPH has proposed increasing the direct care minimum staff from the outdated 1.9 hours to 3.0 hours of direct care staff per resident per day.

These are the main areas of concern:

THE PROPOSED REGULATION WRONGLY INCREASES THE CNA MINIMUMS FROM 1.26 TO 2.16 HOURS OF PER DAY.

This one-size fits all approach removes Village Green of Bristol's flexibility in assigning staff to address the care needs of our residents. Registered Nurses are in short supply in the state and many new graduates are seeking hospital settings versus a skilled nursing facility. Certified Nursing Assistants are in short supply as well due to the competitive job availability. Today, we continue to9 make little progress to hire staff. They simply are not in the workforce! If this mandate results in fines for not meeting the staffing mandate, facilities will close and residents and patients will suffer. The other reason the mandate will not work is the failure to have adequate funding from the State of Connecticut. It is impossible to consider a staffing mandate unless there is a major influx of workers and funding provided.

THE PROPOSED REGULATION REVERSES THE PUBLIC HEALTH CODE RULE THAT APPROPRIATELY COUNTED DIRECT CARE LICENSED STAFF AND CNA STAFF TOWARD MEETING THE MINIMUM STAFFING STANDARD.

It won't lead to better care and will likely worsen the situation by writing the rule this way.

Genesis HealthCare • Village Green of Bristol • 23 Fair Street • Forestville, CT 06010 • genesishcc.com
860-589-2923 Tel • 860-589-3148 Fax

THE PROPOSED RULE DOESN'T REFLECT MODERN NURSING HOME STAFFING BECAUSE IT DOESN'T COUNT ALL THE STAFF THAT ARE PROVIDING DIRECT CARE

In addition to the CNAs, and direct care provided by licensed nurses, many more positions should be included, such as Occupational Therapists, Speech Therapists and Physical Therapists, Infection Preventionist, Wound Nurse, and ADNS.

THERE IS AN INSUFFICIENT SUPPLY OF WORKERS

Our facility is facing the most significant staffing challenges we have ever experienced. Never before have we experienced the ravaging inflation and severe staffing issues that are not addressed in the budget recommendation. Our facility needs more resources to boost the pay of our extraordinary employees, but the State does not address funding to support us.

THE AMOUNT OF MEDICAID RESOURCES THE STATE MADE AVAILABLE FOR COMPLIANCE WITH THE DPH INCREASED MINIMUM STAFFING RULE IS SIGNIFICANTLY INADEQUATE

We thought that the state legislature was making sufficient Medicaid resources available to the Department of Social Services to assure nursing homes had the resources to comply with the anticipated DPH minimum staffing rule, but DPH put out a policy that requires significantly more resources. For example, just consider the unfunded costs just for additional CNAs that the proposed rule requires our facility to hire to meet the staffing mandate. More funding is needed in the budget to address what each facility needs and is facing to help with the unbelievable inflation and increased labor cost.

We need to continue to provide the quality care that our facility is recognized for, and most recently received national recognition in obtaining the ACHCA Silver Award for quality.

That DSS had to prorate the true costs down based on the insufficient amount of money in the budget shows clearly that DPH imposed a rule that required a much more substantial funding amount.

Our nursing facility simply does not have the resources to cover this unfunded state mandate! It does not create the workers for us and it will only worsen our present situation by putting us out of compliance with a new mandate we can't possibly achieve.

In conclusion, this is why we are requesting the proposed DPH regulation be substantially revised to address these concerns.

Please make substantial changes to this proposed regulation.

Thank you. I would be happy to answer any questions you may have.

Janet Shahen RN, MBA, NHA

Janet Shahen
Administrator

ARK
HEALTHCARE &
REHABILITATION

July 27, 2023

Comments on DPH Proposed Regulation (PR2022-32)

To the Department of Public Health:

My name is Reuven Fischer and I **am** Nursing Home Administrator of Ark Healthcare & Rehabilitation at St Camillus in Stamford, Connecticut. Our facility **has been providing nursing home care in our community** for over 35 **years. We are a** 124 **nursing home, and we have** over 115 **employees working at our facility.**

I am writing to you regarding Department of Public Health's proposed and unfunded state mandated 3.0 direct care minimum staffing requirement. As a company and facility, we **are not opposed to increased Connecticut's direct care staffing minimum from 1.9 to 3.0, but we are strongly opposed to** the timing of this mandate, **DPH's** interpretation of the **state legislative requirement in the proposed regulations and how DPH is currently implementing the requirement.**

At the forefront of the skilled nursing community concerns is lack of applicants and qualified and licensed individuals to fill the needs and shifts at our facility. The Covid-19 pandemic drove many seasoned professionals in nursing positions to retirement or to leave the industry in search of less stressful and labor intensive work. As a result of this mass-exodus, facilities have had no choice but to meet the existing requirements through pool or utilizing overqualified nurse managers to fill holes in the schedules. The agency pool field has become oversaturated with competition and astronomical rates for nursing positions that many never dreamed of encountering when looking to plug a shift hole or call out. Directors and Administrators receive calls and communications on a daily basis from the newest and greatest agencies in town, offering competitive, but still unreasonably high costs for assistance in delivering care. All of these factors, in combination with the burnout and exodus from Covid-19, have made continuity of care an almost, unattainable goal.

There are legitimate concerns with the **DPH** proposal for **increasing the direct care minimum staff from the outdated 1.9 hours to 3.0 hours of direct care staff per resident per day.**

Included in this mandate is a proposed regulation increasing the CNA minimums from 1.26 to 2.16 hours of care per patient per day. What was once an option for how a facility would staff its building, with additional licensed personnel or nurse's aides to fulfill the mandated 1.26 hours beyond required licensed nursing personnel (from .64 to a total of all personnel at 1.90) is no longer a decision at the discretion of the

facility or company. While I agree that increased staffing is a worthy and important cause that this industry needs, the timing and unreachable increases, especially for nurse's aides by 171% of the previous threshold is detrimental to facilities. Taking away the ability of the facility to use its own judgement and approach for attaining minimum staffing of all personnel based on its unique patient population and care needs will create insurmountable challenges. These blanket mandates completely negate the need for review of resident assessments, facility assessments, diagnoses, and plans of care as they related to determining staffing. The department of public health has determined those numbers regardless of such factors and information.

To compound this extremely high requirement for specific nursing job classifications in an environment and post pandemic world, the definition of "direct care staff" applying to "licensed nursing personnel and certified nursing aides that are engaged in direct health care services, that include but are not limited to, personal care services for residents of nursing homes". The new verbatim of the regulations does not allow for Directors of Nursing, Assistant Directors of Nursing, as well as other managers and personnel who have RN, LPN, and CAN credentials and training who may provide direct care related to the area of responsibility under their job title.

The unfortunate reality of this mandate shows that the necessary funding to back this DPH requirement has not been allocated by the Department of Social Services. Expenses and inflation continue to haunt operators and corporations as well as individual consumers. How can operators and corporations be expected to foot the burden of complying with this inappropriately timed mandate when the DPH and DSS are not working together for the best outcomes for the providers, population, and citizens of Connecticut?

As a patient advocate and liaison that is involved with the daily operations and dealings of staffing, patient care, logistical planning and strategy to better our care and position in the immediate long term care environment and industry, I implore the Department of Public Health to listen and heed to the warning signs and statements by providers and operators regarding this mandate. It is imperative that this mandate be revised to reconcile the challenging factors surrounding the staffing crisis in long term care and provide operators and facilities with the necessary resources, funding, and reachable thresholds to provide care to the citizens of this state

Respectfully yours,

Reuven Fischer, LNHA

Reuven Fischer, LNHA
Administrator
Ark Healthcare and Rehabilitation at St. Camillus
494 Elm Street
Stamford, CT 06902
Telephone: (203) -325 -0200
Fax: (203) 353-0550

7/31/2023

DPH Proposed Regulation (PR2022-32)

To the Department of Public Health:

Greetings to DPH. My name is Chioma Thomas, and I am currently the administrator at Civita Care Center at Danbury, located in Danbury, CT. This facility has been in existence since 1976 and has been providing care to the community at large since then. We are a 120-bed facility and do our best to ensure that we provide the best possible care to those in Danbury and surrounding areas.

It is imperative that the DPH understand some of the challenges we nursing homes are facing when it comes to meeting staffing needs. Since the pandemic, staffing regulations have changed, and we are expected to follow those rules. I am not resistive to the increase when it comes to minimum staffing, but I am rather concerned with the violations and the imposed regulations that the department has implemented or is requiring us to follow. However, we are faced with numerous staffing challenges daily. For example: increased agency costs, increased employee callouts, licensed staff walking off the job, and no call no show employees without just cause.

There are major areas that the department could be of great assistance to nursing homes. For instance- providing more and free nursing school programs, putting a cap on agency costs, and working closely with nursing homes so that the DPH can understand the challenges that we are facing and find a better solution to these problems. Our facility is facing the most significant staffing challenges we have ever experienced, especially when we schedule staffing over the required amount but yet we are still faced with people not showing up to work for no reason due to no fault of our own, increase call out, agency requesting "crisis rate" due to last minute request to meet facility needs.

In conclusion, it is imperative that the state look at these concerns that have been shared and we at our facility are requesting proposed DPH regulation be significantly adjusted to address these concerns.

Thanks much, we appreciate you listening and addressing his concerns promptly.

Sincerely

Chioma Thomas, LNHA

Chioma Thoma

107 OSBORNE ST DANBURY, CT 06810

civita
CARE CENTER *at Danbury*

203.792.8102 | CIVITADANBURY.COM

Touchpoints Rehab at Bloomfield
An Innovative Skilled Nursing Facility
iCare

Comments related to Proposed Regulation Concerning: Nursing Home Staffing Ratios
Tracking Number: PR2022-032

August 4, 2023
I am the Administrator of Touchpoints At Bloomfield. The purpose of this letter is to express concern for the State of Connecticut, Department of Public Health's (DPH) implementation of the nursing home minimum staffing. From my perspective, there are the main issues with the implementation:

My facility has found it extremely challenging to find, hire and retain employees for these additional mandated hours. In today's unthinkable healthcare staffing shortage, there are not enough nurses and certified nurses aid to actually fill the required hours that this mandate has implemented. We are competing with ever other facility within Connecticut for the same pool of candidates.

I also do not feel that it was within DPH's authorization to implement the two caps (2.16 for Certified Nurse Aides and 0.84 for nurses). In the past both of these job classifications were able to be combined so that the facility was able to meet the needs of the residents based on the acuity.

This mandate has not come with financial compensation to help cover the huge financial burden we are incurring with the additional staffing. DPH erroneously indicated in its proposed regulations that there would be no fiscal impact to the State. Not only are we challenged by the additional staffing cost but we are having to offer and pay premium salaries like never before due to the severe staffing shortages again with no financial relief or assistance in site.

In 2022 DSS implemented an acuity-based reimbursement system for nursing homes. Due to the type of at-risk residents that my facility cares for, our CT Medicaid reimbursement is often below the 1.0 thresh hold. Again, this has a direct effect on our financial ability to pay for the additional staff needed for patient care based on the mandated 3.0. If facilities are going to receive a rate of less than the 1.0 based on the acuity and assumed needs of the residents then the staffing mandate of 3.0 should be adjusted down to reflect that need.

Please do not hesitate to contact me to discuss further.

Regards,

Heather Rodriguez, LNHA

Administrator

Hebrew Center
for Health and Rehabilitation

August 3, 2023

Comments on DPH Proposed Regulation (PR2022-32)

To the Department of Public Health:

My name is Penni Martin, and I am the Administrator for Hebrew Center for Health & Rehabilitation Center a 257-bed skilled nursing facility located in West Hartford. I have been in the nursing home industry for over 25 years and a Nursing Home Administrator for 20 years. Hebrew has over 200 employees We are affiliated with National Heath Care Associates. We are active members of the Connecticut Association of Health Care Facilities (CAHCF).

I am writing to ask you to make major changes to this proposed regulation. We are not opposed to increased Connecticut's direct care staffing minimum from 1.9 to 3.0, but we are strongly opposed to how specifically DPH has interpreted the state legislative requirement in the proposed regulations and how DPH is currently implementing the requirement.

The proposed regulation reverses the public Health code rule that counted direct care licensed staff and CNA staff toward meeting the minimum staffing standard. It won't lead to better care and will likely worsen the situation by writing the rule this way. The rule should also include direct care provided by licensed staff that provide direct care.

In addition, there is an insufficient supply of workers. Our facility is facing the most significant staffing challenges we have ever experienced.

The amount of Medicaid resources that state made available for compliance with DPH increased minimum staffing rule is significantly inadequate.

In conclusion, therefore we are requesting the proposed DPH regulation to substantially revised to address these concerns.

Sincerely,

Penni Martin
Administrator

1 Abrahms Boulevard, West Hartford, CT 06117 | 860.523.3800 | www.HebrewCenterRehab.com

Hebrew Center
for Health and Rehabilitation

August 3, 2023

Comments on DPH Proposed Regulation (PR2022-32)

To the Department of Public Health:

My name is Carlene Green, and I am the Assistant Administrator for Hebrew Center for Health & Rehabilitation Center, a 257-bed skilled nursing facility located in West Hartford. I have been in the nursing home industry for over 20 years. I have recently taken on the position of Assistant Administration at the facility and will be sitting the state exam to become an Administrator.
Hebrew has over 200 employees. We are affiliated with National Heath Care Associates. We are active Connecticut Association of Health Care Facilities (CAHCF) members.

I am asking you to make significant changes to this proposed regulation. We do not oppose increasing Connecticut's direct care staffing minimum from 1.9 to 3.0. Still, we are vehemently opposed to how specifically DPH has interpreted the state legislative requirement in the proposed regulations and how DPH is currently implementing the requirement.

The proposed regulation reverses the public Health code rule that counted direct care licensed staff and CNA staff toward meeting the minimum staffing standard. It won't lead to better care and will likely worsen the situation by writing this rule. The rule should also include direct care provided by licensed staff that provide direct care.

In addition, there is an insufficient supply of workers. Our facility is facing the most significant staffing challenges we have ever experienced.

The amount of Medicaid resources the state made available for compliance with the DPH increased minimum staffing rule is significantly inadequate.

In conclusion, therefore, we request that the proposed DPH regulation be substantially revised to address these concerns.

Sincerely,

Carlene Green
Assistant Administrator

Water's Edge
Center for Health & Rehabilitation

July 31, 2023

Comments on DPH Proposed Regulation (PR2022-32)

To the Department of Public Health:

My name is Richard DeMio and I am the Administrator of Water's Edge Center for Health and Rehabilitation located in Middletown Connecticut. Water's Edge has been providing nursing home care in our community for 30 years. We are 150 bed nursing home with 180 employees that are working at our facility.

Although we are not opposed to the increased direct care staffing minimum from 1.9 to 3.0, we are strongly opposed to how specifically DPH has interpreted this state legislative requirement in the proposed regulations and how DPH is currently implementing the requirement. The proposed regulation reversed the public health code rule that appropriately counted direct care licensed staff and certified nursing assistant staff toward meeting the minimum staffing requirements.

As everyone is aware, since the COVID pandemic, there has been a shortage of health care workers and despite the aggressive recruitment of staff, we still can't fill many open licensed nursing and Certified Nursing Assistant open positions. We have raised their wages and provided free education to help them get licensed, yet we still are very challenged and have multiple openings on all shifts. Therefore, it couldn't be worse timing to not only increase the minimum direct care staffing requirement, but also make it impossible at this time to meet the requirement by separating licensed and CNA staff. We can on most days meet the 3.0 hours of direct care staffing, as long as we can count the aggregate of both licensed and CNA staffing together. Therefore, at this time we hope that you will reconsider this regulation and allow both licensed and CNA staff to be counted in aggregate to meet the new standard.

In addition to the inability to hire enough workers to meet an increase in staffing, there is also the financial burden of an unfunded staffing mandate. In many cases we have to pay the extremely high cost of hiring agency staff that typically doesn't provide the same quality of care as in-house staff. The cost of additional staff, especially agency staff is not sustainable and should be considered at this time as this proposed bill is being considered.

Thank you for the opportunity to share my concerns.

Sincerely,

Richard DeMio
Administrator

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Middletown, CT 6457
P 860 347 7286
F 860 346 5589
watersedgerehab.com

Water's Edge
Center for Health & Rehabilitation

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COMPLETECARE
— GLENDALE —

COMPLETECARE
— GLENDALE —

July 29, 2023

Comments on DPH Proposed Regulation (PR2022-32)

To the Department of Public Health:

My name is Marian Gaudioso. I am the Administrator at Glendale Center in Naugatuck, Connecticut. Glendale has been providing nursing home care in our community for close to 50yrs. We are a 120 bed nursing home, and we have 147 employees working at our center. I have been an Administrator for 25yrs and continue to love what I do.

I am writing to ask you to make major changes to this proposed regulation. While we do not oppose Connecticut's direct care staffing minimum from 1.9 to 3.0, we are strongly opposed to how specifically DPH has interpreted this state legislative requirement in the proposed regulations and how DPH is currently implementing the requirement. DPH's decision to separate the direct care hours and only focusing on the CNAs 1.26 to 2.16 hours per day does not allow centers to show that we exceed in Licensed hours who also provide direct care to our residents. We know that centers everywhere are experiencing this shortage and receiving violations. How can DPH continue to cite centers when there are not enough caregivers to fill current hours never mind the new increased mandated hours. You can help. Require that the staffing mandate of 3.0 includes ALL direct care givers. Licensed nurses are direct care givers.

My team and I meet daily and weekly to review how we can improve to recruit and retain staff. Retaining our staff after 3 years of a pandemic when several of their coworkers either retired or left to seek other opportunities outside the nursing home arena due to burnout and fatigue. Trying to recruit new staff from a smaller pool of availability and still compete against other nursing homes, staffing agencies, hospitals and homecare. Glendale continues to try to think outside the box and partner with colleges and high schools to bring new talent and sponsor our new hires through certification classes to become CNAs. We have increased wages, offered retention, referral and pick up shift bonuses all that go unfunded by reimbursement to try and meet the mandate.

In conclusion I suggest legislators and DPH develop a true collaborative partnership with the nursing home sector to discuss our challenges with operators and staff to develop a roll out of the new staffing minimum requirements. No one is opposing the increase however for centers to be successful we must work together. After 3 years of an historic pandemic that none of us will forget nor do we want to relive we owe it to ourselves, the staff who stayed with us, the new talent who want to thrive in this arena but more importantly we owe it to our residents and their families to work on this together and make it successful.

Thank you for your time and consideration.
Sincerely,
Marian Gaudioso

Marian Gaudioso, LNHA
Complete Care at Glendale

July 27, 2023

Comments on DPH Proposed Regulation (PR2022-32)

To the Department of Public Health:

My name is Angela Perry. I am the Administrator at Complete Care at Harrington Court in Colchester, CT 06415. We have been serving our close knit community for 45 years. We are a 125 licensed bed nursing home, and we have 90 employees working at our facility.

My employees and I are opposed to the increased Connecticut's direct care staffing minimum from 1.9 to 3.0 due to the immense staffing shortages that have been catapulted since the COVID-19 pandemic with slow recovery. This has directly affected the overall culture of the facility, ultimately affecting delivery of care as there has been an increased use of staffing agencies that (a). do not provide consistent care due to the inconsistent individuals that are provided, (b) individuals who may be confirmed for a shift but do not show up that devastates the daily staffing as we are dependent on their attendance, and (c) the extraordinary price gouging that has added an additional financial burden to an already limited reimbursement system and/or limits the willingness for individuals to seek employment in our settings due to the significant rates they are given with the agencies that we are unable to compete with.

The proposed regulation wrongly increases the cna minimums from 1.26 to 2.16 hours per day. In a recent annual health inspection, there were surveyors who shared that 24 out of 26 of their recent inspections resulted in insufficient staffing deficiencies. This should not be overlooked as a lack of due diligence to fill open positions from the facility, but a broader issue that the industry continues to experience. Instead of giving deficiencies there needs to be a collaborative initiative to address the issue in a non-punitive manner.

My team and I meet consistently on a daily basis to identify ways to recruit and retain staff. We share creative approaches and have a plotted timeline on all of our efforts over the past 6 months to meet the demands of the staffing requirement, which was also shared with the surveyors during the inspection. However, the staffing "pool" is small and we are in direct competition with neighboring nursing homes.

In conclusion, this is why we are requesting the proposed DPH regulation be substantially revised to address these concerns. My suggestion is to host a meeting with nursing home employees that is solution focused. Perhaps initiate a staffing initiative cohort with members of nursing homes that are directly impacted and can speak to real life scenarios and ideas that may assist in alleviating this burden we are experiencing. Ultimately, we all have the same goals, quality of care, customer satisfaction, and positive outcomes.

Respectfully,

Angela Perry, PhD, LNHA, FACHA

Administrator
Complete Care at Harrington Court

Leeway

Leaders in AIDS Care

July 28, 2023

Comments on DPH Proposed Regulation (PR2022-32)

To the Department of Public Health:

My name is Jay Katz, the Executive Director at Leeway Inc. in New Haven, Connecticut. Leeway has been providing nursing home care in our community for 28 years. We are a 30 bed nursing home, and we have over 100 full-time, part-time and contracted employees working at our organization.

We are not opposed to the increase of Connecticut's direct care staffing minimum from 1.9 to 3.0, but we are strongly opposed to how specifically DPH has interpreted this state legislative requirement in the proposed regulations, and how DPH is currently implementing the requirement.

There are major problems with how DPH has proposed increasing the direct care minimum staff from the outdated 1.9 hours to 3.0 hours of direct care staff per resident day.

One area of concern for Leeway is the proposed regulation increasing the CNA minimums from 1.26 to 2.16 hours per day.

This one-size fits all approach removes the care team's flexibility in assigning staff to address the care needs of our residents. Leeway's care team has been successful in delivering high quality care, and has consistently operated above the state minimum of 3.0 hours of direct care staff per resident day, since the regulation's implementation. Because of the size of our unit and the conditions of our residents, we have developed routines that are efficient and effective. The ability of our staff to support each other and collectively serve our consumers is a testament to their dedication as caregivers. The comradery developed among our team will be disrupted by these operational changes.

Our organization is not opposed to change, we are comfortable adjusting to the dynamic landscape of the healthcare industry. The industry is currently facing a post pandemic staffing crisis. Our organization has invested considerable resources in the recruitment, development, and retention of staff. Unfortunately, we cannot keep up with the supply shortages, and this regulatory demand is overwhelming.

Another area of concern for our agency is that these staffing increases are not adequately funded.

We thought that the state legislature was making sufficient Medicaid resources available to the Department of Social Services to assure nursing homes had the resources to comply with the anticipated DPH minimum staffing rule, but DPH put out a policy that requires significantly more resources. The

Leeway, Inc. * 40 Albert Street * New Haven, Connecticut 06511
Telephone 203.865.0068 * facsimile 203.401.4541 * email info@leeway.net * website www.leeway.net

THE LUTHERAN HOME SOUTHBURY

990 Main Street North
Southbury, CT 06488

August 14, 2023

Comments on DPH Proposed PR2022-032

To the Department of Public Health:

Thank you for the opportunity to provide comments on DPH Proposed Rule PR2022-032. My name is Michelle Bettigole. I am both a registered nurse and a licensed nursing home administrator in the State of Connecticut. In those capacities, I have served senior citizens of Connecticut for over thirty years. I am currently the Chief Senior Care Officer for Ascentria Care Alliance, responsible for a network of five non-profit nursing homes in New England including Lutheran Home of Southbury (LHS) in Southbury, Connecticut. LHS has been providing nursing and rest home care in our community for over 100 years. Currently we serve more than 285 senior citizens in the State of Connecticut with over 236 employees.

Lutheran Home of Southbury is a member of Ascentria Care Alliance, one of the largest nonprofit, human service organizations in New England. With many locations throughout the region, Ascentria serves children, youth and families; persons with developmental disabilities and mental illness; refugees, including unaccompanied refugee minors; as well as older adults and has done so for over 150 years.

While we are not opposed to an increase to Connecticut's direct care staffing minimum from 1.9 to 3.0, we are concerned about how the Department of Public Health (DPH) has interpreted this state legislative requirement in the proposed regulations and how DPH is currently implementing the requirement.

Our concern stems from one main element in the implementation proposed by DPH:

- Staffing Challenges: There is currently a national shortage of healthcare workers, and this trend is likely to continue for the foreseeable future. DPH's interpretation of the State requirement can only be met by increasing staffing. This is a challenge for LHS and other skilled nursing providers for several reasons. First, the qualified candidates are simply not available for hire as so many healthcare workers have left the workforce. New workers are not entering the healthcare field where pay is low, and the work is hard. Second, both for-profit and non-profit

nursing homes are competing for the same limited supply of candidates, driving wages higher and making recruitment and retention a tremendous challenge. We do not have the resources to fund new staff positions even if they were available to hire.

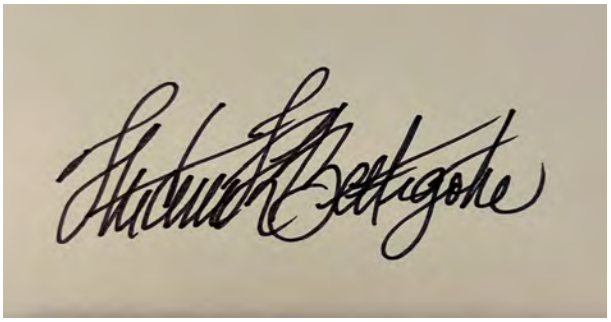
We are proud to say that at Ascentria we are addressing the healthcare workforce crisis with two initiatives:

- CNA Training: In order to meet the ongoing workforce challenge, LHS has been sending staff members for training to become certified nursing assistants at our cost since 2021. We have helped over a dozen candidates become certified nursing assistants, but that total remains a fraction of the caregivers we need.
- Human Development Center: In order to provide pathways for careers advancement for healthcare workers and others at our organization, we are taking the groundbreaking step to create the Human Development Center (HDC) within our organization. Supported by privately raised funds, the HDC will provide a comprehensive set of resources to our employees, many of whom are from under-resourced communities. We will work to understand the challenges our employees face and create a set of wraparound services to mitigate those challenges enabling our employees to thrive professionally and personally.

We want to be clear that we do not oppose a meaningful 3.0 minimum staffing rule. However, we do have serious concerns about the mandated rules for implementation put forth by DPH without a clear pathway to recruit and train the appropriate caregivers. We believe that the intended goal of the state's proposed legislation is to maximize the quality of care received by nursing home residents. DPH's plans for implementation will make it more difficult for skilled nursing centers like Lutheran Home of Southbury to remain focused on meeting the needs of our residents in a manner that has benefited our residents for over 100 years.

We respectfully ask that the Department of Public Health consider revising their proposed regulation to address these concerns. We want to be part of a solution that works for all nursing homes in Connecticut and would welcome the opportunity to join any committee that may materialize in this matter.

Respectfully,



Michelle R. Bettigole, RN, MS/MSN
Chief Senior Care Officer

Touchpoints
Rehab at Manchester

August 7, 2023

To whom it may concern,

My name is Tyina Melendez and I am the current Infection Control Nurse of Touchpoints at Manchester, located in Manchester, CT. I have worked as an IP/ PDC Nurse for about 2 years. I chose this profession because of the strong nurses I have within my family.

Although I haven't been an IP/PDC Nurse for long I have worked in skilled nursing facilities for over 10 years all around Connecticut in many different roles. I do feel as though implementing a direct care minimum staffing requirement would benefit all nursing facilities but, I do disagree with the way this it's being implemented. We are hoping for a well thought out plan on how to go about implementing such a change as there are many different factors that need to be looked at and considered first.

Thank You,
Tyina Melendez, IP/ PDC
Touchpoints at Manchester

Part of the iCare Health Network

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7/31/2023

This letter is being written related to the DPH 3.0 Direct Care minimum staffing regulations, Tracking No. PR2022-032.

My name is Denise Quarles and I am the Regional Director of Operations for Civita care centers. We operate 6 Skilled Nursing facilities in CT, for a total of 745 beds within our facilities.

I am proud to say that I have worked in Long-term care since 1993. I started my career in Social Work at a facility in Torrington. I worked at this SNF until I received my Administrator LT Care certificate in 1999. I have worked in the role of a Nursing Home Administrator in 5 homes throughout the years, until I became a Regional Director in 2020.

I consider my most important role to be a Resident Advocate. I have always focused my attention on offering the very best, compassionate, quality care. Doing our best for each resident we serve allows us to be successful.

I am writing this letter as I don't believe that the proposed regulation is a meaningful solution to improving the quality of care in our homes.

Demanding an increase in C.N.A hours from 1.26 to 2.16 is not the answer. Our increase in open positions and inability to fill all our open positions is where help is needed. The needed staff are simply not out there. We are spending more dollars on advertising, and even more on agency staff that are not reliable and sometimes cost twice the amount of our own staff. These agency staff do not offer the same care that our workers do. Building relationships with residents is critical, and offering consistent care givers is necessary to offer quality care. Education is key, and providing education to agency staff that are not committed to our residents and nursing home is a challenge every day. We are spending thousands of dollars each payroll on OT and bonuses for our own staff. These staff are burnt out! They are tired! Increasing C.N.A staffing levels is only going to force providers to use more agency staff.

Licensed staff continually provide direct care. Management and therapy staff also provide care when needed. Why not consider a mandate that allows us to count others who assist with care?

All the homes staff (3) 8-hour shifts per day. Why would we create a mandate that is written for (2) 12-hour shifts? The public health code should be updated to reflect what is truly happening in our homes. These "2" shifts are only adding to the chaos and staffing concerns.

We all work in LT care because we care about the residents! Please help us to care for them. Provide a mandate that either funds additional staff or help us to recruit needed staff to fill our open positions. This understaffing issue is only going to get worse. CT

needs more C.N.A and Licensed Staff. Giving out violations for not meeting this mandate is not going to help get our residents quality care. We need to work together on real solutions to get the workers we need to provide for this vulnerable population.

Thank you,

Denise Quarles

Regional Director

Civita care centers

Comments related to Proposed Regulation Concerning: Nursing Home Staffing Ratios
Tracking Number:PR2002-032

August 4, 2023

My name is Charmaine Martin-Davis and I am MDS Case Manager LPN of Westside Care Center, a 162-bed skilled nursing facility located in Manchester, CT. Westside Care Center is part of the iCare Health Network, which operates eleven skilled nursing facilities in Connecticut. I have been an MDS Case Manager for over eleven years.

I am writing today to express my deep concern regarding the State of Connecticut, Department of Public Health's (DPH) implementation of the nursing home minimum staffing.

My major concerns lie in the inability to recruit the staff needed, incremental cost of this unfunded mandate, and removal of the combined cap in favor of two distinct, arbitrary caps.

In my Fourteen years of practice in the long-term care nursing facility arena I have never seen a staffing crisis as significant as what currently exists in the nursing industry. While the crisis may have begun with COVID, the after-effects have continued years later.

In closing, increased staffing for nursing homes is an admirable idea, the reality of implanting these goals are in direct conflict with the current reality that the industry is already suffering from a staffing shortage. Even if funding were secured to cover the incremental expense, finding the additional staff would prove to be an insurmountable.

I would be happy to discuss these points in greater detail as you consider the regulation.

Sincerely,

Charmaine Martin-Davis

MDS Case Manager
Westside Care Center

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www.WestsideCareCtr.com

West Haven
CENTER FOR NURSING & REHABILITATION

Testimony in Opposition to Unfunded and Unworkable DPH 3.0 Direct Care Minimum Staffing Regulations
Re: eRegulation No. PR2022-032

To whom it may concern:

I am the administrator at the West Haven Center for Nursing and Rehab. We are a 98-bed facility with a current census of 93. We are also the primary employer of approximately 110 employees. We have been a prime destination for West Haven residents to admit for rehab and nursing. My job is to oversee this operation and the well-being of its residents and staff.

I have been working in nursing homes for 20 years and have been a Licensed Administrator for 8 years. I have always loved working with the elderly and am passionate that they are given the quality care that they have worked so hard for and earned.

Although I agree wholeheartedly with the idea of increased staffing for our nursing home, I strongly disagree with the timing of this. We are on the heels of a pandemic that completely upended the healthcare system, especially Long-term Care. We are still struggling to fill open positions, fighting with our neighboring competition over the same applicants. The current staff is tired; most of them work two jobs as it is. To impose a strict staffing minimum on an exhausted industry at this time is not going to make anything better. If anything, it will burn out and close most facilities at this time.

We currently have open positions on all 3 shifts. I have 3 fulltime 3-11p CNA positions that I can't seem to fill. This continues to inhibit our ability to deliver the best quality care and customer service outcomes.

We almost always meet or exceed 3.0 hours of direct care hours for the day, but this is a combination of CNAs and licensed staff. Penalizing facilities for not meeting the increased staffing level of 2.16 for CNAs is counterproductive and by no means, will it improve quality of care outcomes.

Aside from the CNAs; licensed staff, administration and therapy staff help our residents throughout the day. The real costs associated with increased staffing levels and recruiting a depleted employee pool, and/or contracting with labor companies to meet staffing quotas will be a financial detriment to health centers.

I agree that investing in the long-term care workforce should be a priority but not at the expense of bankrupting facilities. There should be a phase-in if we are going to move in this direction with staffing minimums. DPH should fix their outdated two 12-hour shift health code to be more in line with the 3-shift work day. I am not opposed to a meaningful 3.0 minimum direct care staffing rule but not the one that DPH proposed.

Regards,

Jonah Kraus
LNHA

310 Terrace Avenue, West Haven CT 06516 | Telephone: 203-654-2100