

# Stakeholder Participation and Comment Summary

Office of Health Care Quality

September 30, 2016

## Introduction

The Office of Health Care Quality (OHCQ) within the Maryland Department of Health and Mental Hygiene (DHMH) extends its gratitude for all of the comments and recommendations suggested by our valued stakeholders. Due to your efforts we have been able to revise and update COMAR 10.07.14 Assisted Living Programs. A public comment period was held May 2015 through December 2015 to collect input on the draft regulations.

This document summarizes OHCQ's regulatory comment process and includes a summary of the public comments received as of December 2015. During the public comment period, the draft regulations were posted on the Office of Health Care Quality's website and distributed to the public through emails and stakeholder meetings. Individuals and groups had the opportunity to submit comments through an electronic public comment form and in-person meetings. Four public stakeholder meetings were held on site at the OHCQ. Following the public meetings, OHCQ analyzed and reviewed all comments submitted.

## Stakeholders

Stakeholders were provided the opportunity to provide multiple comments throughout the regulatory review process. A total of 63 individuals and organizations submitted approximately 600 comments on the proposed Assisted Living regulations. The commenter's were representative of various sectors and included: Providers; Advocacy and Professional Associations; Training and Education Providers; State and Local Government; OHCQ Surveyors; and Private Citizens. The Other category includes stakeholders who did not identify their profession or professional association. \*OHCQ Surveyors participated as private citizens and used the same comment submission platform to participate. Figure 1 illustrates the distribution of stakeholders by their profession or professional association.

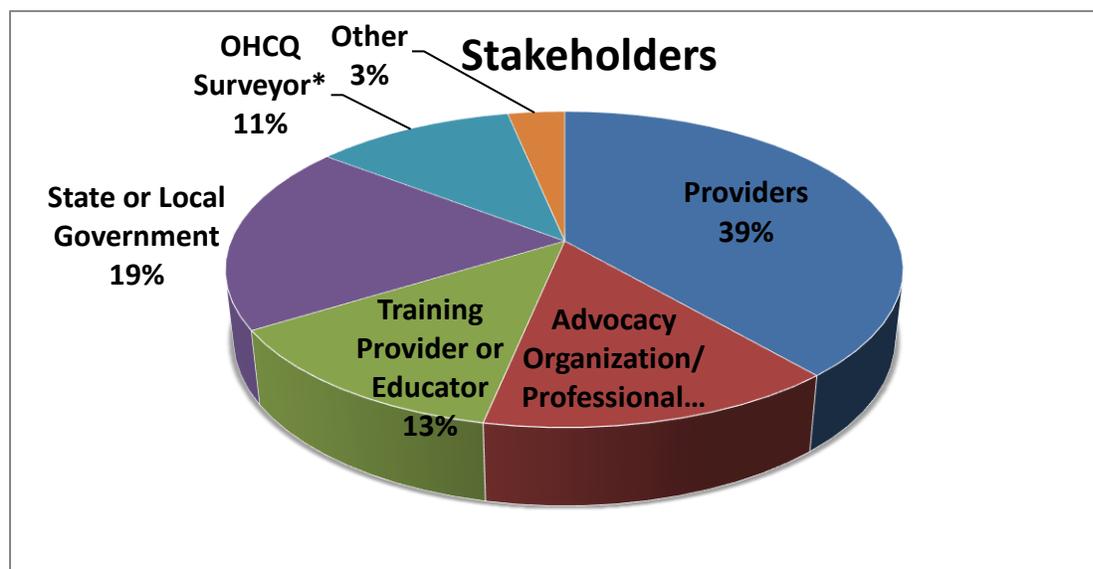
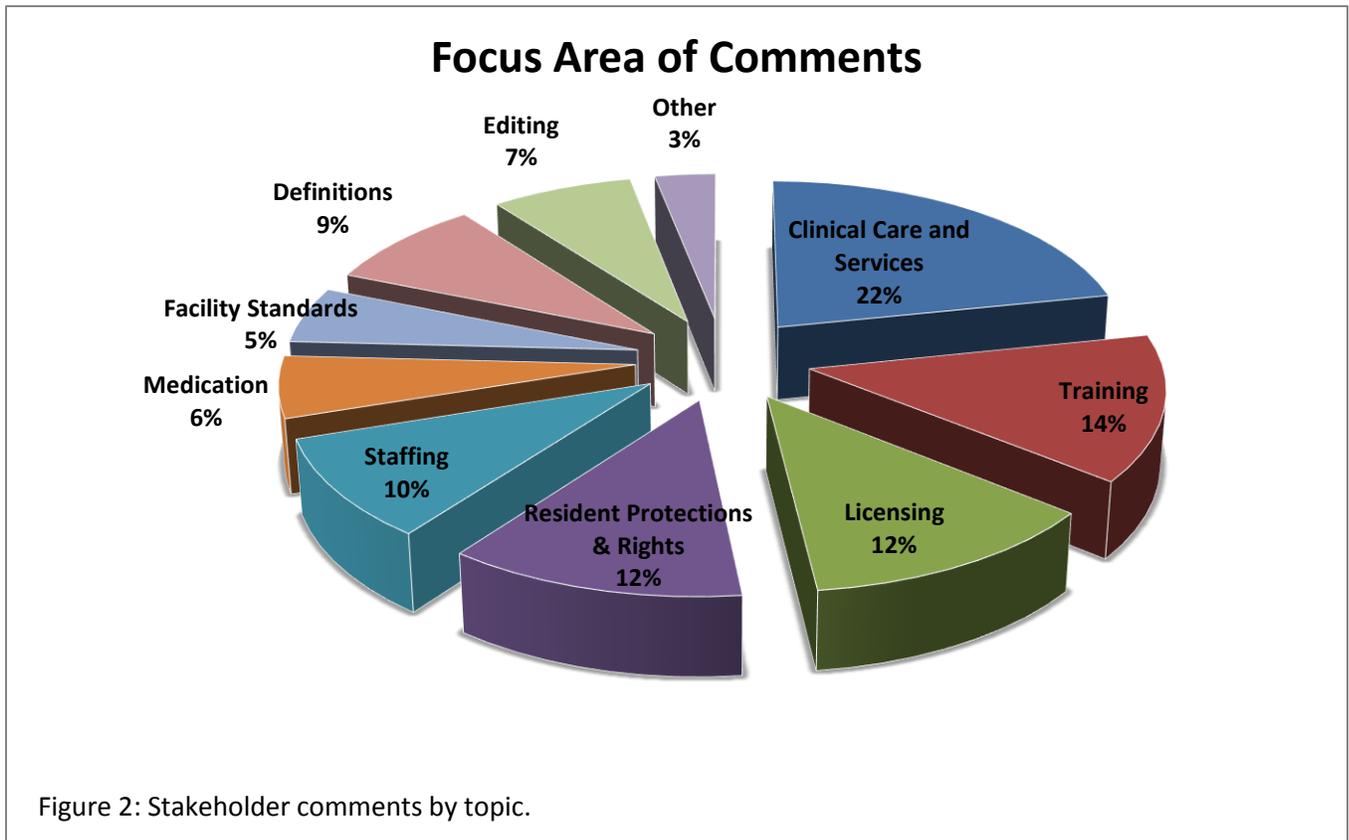


Figure 1: Stakeholder participation by profession or professional association.

### Focus Areas

OHCQ organized the comments received into similar categories to determine the regulations and topics that were of the most concern to stakeholders. The nearly 600 comments were organized into 10 categories. Clinical Care and Services represented the highest percentage of comments (22%), specifically resident care documentation practices. Training had the second highest percentage of comments (14%). Figure 2 illustrates the distribution of comments by topic.



### Clinical Care and Service

OHCQ received a diverse range of comments that both opposed and advocated for revisions to the clinical care and service provisions in the regulations. This category consists of comments regarding the following provisions: Alzheimer’s and dementia special care units; resident assessment; weekly care notes; nutrition and diet; delegating nurse; and service plans. A sample of the comments received that represent this category are included below.

#### Resident Assessment

- Regulation .17 and Regulation .18 now require BOTH a nursing assessment and the resident assessment tool be completed within 48 hours of a significant change of condition, which is a tighter timeframe than current regulation and potentially requires more paperwork than what is currently

needed now. Rather than streamlining, the process has now become more cumbersome. As a reminder, the revised RAT incorporates a nursing assessment into the tool, which was done to alleviate the nurse from having to complete two separate documents.

- Allow the RAT to be completed thirty (30) days prior or within 48 hours following admission to match the timeframes in .18 3a. It is often very hard to get a full RAT done prior to move in day especially if a resident is coming from out of state.

#### *Weekly Care Notes*

- Delete weekly care notes and make it monthly care notes similar to other industries. In addition, the list that triggers a more frequent care note is too expansive and should not include “non-routine leaves of absences (what is that?) or when seen in home by any health care provider. The provider performing the service is already required to leave a note.
- Ensuring accurate and consistent documentation throughout the record should be part of their oversight. Delegating nurses’ documentation is almost across-the-board horrible. Stuff is missing, it’s inaccurate, etc...

#### *Service Plan*

- Recommend that the plan be reviewed more often than six months, and the resident and/or resident representative should be involved in the service plan development process. This will help ensure more individualized and a more current plan of care. The service plan is the foundation for determining the resident’s preferences and needs.
- The acuity of health care conditions and the high utilization of medications in the current AL population requires greater oversight than just a 6 month review.

#### *Delegating Nurse Responsibilities*

- While the language of .17G(2) allows for more frequent visits, we are worried that this will create a source of friction between the delegating nurse and the provider. It seems that many delegating nurses will see a need to visit more than once every 90 days, but that will cost the provider additional money so the provider will press the delegating nurse to only visit every 90th day. That is all the regulations will require. It would be better to state this new standard in the converse, i.e., “if all staff are licensed, the delegating nurse may lengthen the period of the nurse’s periodic onsite review from 45 days up to a period as long as 90 days, if the delegating nurse determines more frequent reviews are not necessary.” This formulation may put more pressure on the nurse’s malpractice premiums.

#### *Nutrition and Diet*

- MDoA does not believe that the requirement for keeping menus on hand should be reduced from two months to one month. Likewise, we do not believe that the requirement that there be “documentation by a licensed dietician or nutritionist that the menus are nutritionally adequate” should be eliminated. Without this requirement, how will we know residents are receiving

nutritionally adequate meals? The training providers receive is not equivalent to that of a licensed dietician/nutritionist. Removing this requirement will serve only those providers who refuse to observe nutritional requirements. Many of these providers are repeat offenders and require continuous monitoring and investigation due to complaints. While obtaining approval from a licensed dietician or nutritionist costs money, we have seen so many problems with food that we believe this regulation remains necessary.

#### *Alzheimer's/Dementia and Special Care Unit*

- Individuals with dementia have specialized needs, and the environment, staff training, and overall care should be looked at closely to ensure the best quality of care.
- [This Alzheimer's and dementia special care unit] requires additional services...For example, there are increased staffing and training requirements. These increased requirements may cause increased financial and logistical consequences. Additionally, if the facility cannot provide the required services, they will not be able to admit individuals with dementia, thus limiting placement options.

#### **Training & Education**

The Manager and Assistant Manager qualifications, particularly related to experience and to whether an individual needed a bachelor's degree, were addressed in multiple comments. These comments illustrated that the regulation as written was confusing. Another focal point of comments in training and education was the refresher requirements for Managers and Assistant Managers.

Many of the comments on training also provided feedback on the training requirements for cognitive impairment. While many of the comments recommended increasing the training requirements, others recommended a decrease in training requirements.

The timing of training for general staff was also addressed. Many stakeholders felt that the requirement that staff be trained in Alzheimer and Dementia Units prior to providing care was cost prohibitive, and that staff learned better on the job training. Others noted that training prior to providing resident care was critical to ensuring resident safety.

#### *Manager and Assistant Manager Qualifications*

- I am unclear how a college degree will impact one's ability to effectively manage an assisted living facility. What seems more relative and appropriate is experience in the field as well as taking the 80 hour Manager's training Course through the Beacon Institute. I have no degree and have served as both an alternate and manager for fifteen years. I understand there are facilities being managed inadequately however if a manager has had the proper training and held the position for a period of time without incident a college degree does not seem necessary.
- The requirement to limit the position of Assisted Living Manager and that of Alternative Assistant Living Manager to an individual having a 4 year, college level degree is discriminatory. It prevents those who lack the college degree, but have the experience training and knowledge from applying

for these positions. It prevents RN's who may not have a 4 yr college degree from applying for this position.

#### *Assistant Living Manager and Assistant Manager Continuing Education*

- The Recommendation to require ALM Refresher every four years is too long. After completing the 80 hour program, students are often unable to start their business or work in the field immediately, and there can be considerable lag time. At least at the two-year interval, they can maintain proficiency, but with four-year interval, they would need to be retrained. Additionally, the two-year interval provides the opportunity for timelier updates. Establishing a four- year interval without receiving updates is untimely and potentially hazardous for the patient. Changing the interval still does not address repercussions for noncompliance. A rule without enforcement should not be a rule and says to the ALM, the patient's family, and the patient that this is not really important, and continuing education is not a priority, until something serious happens.

#### *Training and Education Requirements for All Staff*

- We recommend increasing the amount of initial minimum training set forth in .14I(1) from 5 hours to 8 hours and the amount of ongoing training for personal care staff under .14I(3)(a) from 2 hours to 5 hours and under 14I(3)(b) from 1 hour to 3 hours. It is estimated that up to 80% of residents have Alzheimer's disease or some other type of dementia. Other residents have mental illness that impacts their functioning and communication. Adequate training, therefore, is essential to the provision of care. In fact, discharges and resident/resident and resident/staff behavioral problems could be minimized through interactive training strategies that help staff understand that behaviors are oftentimes due to illness and disease, and that appropriate interventions can be used rather than inappropriate medications.
- Requiring the additional 20 hours of initial training for staff on the care of residents with Alzheimer's prior to providing direct resident care is unreasonable and most likely will be ineffective. Staff are bombarded with information in the first days of orientation. Some of that time is already focused on Alzheimer's care. 20 hours is excessive and costly.

#### *Timing of Training for General Staff*

- The best way to learn is to combine instruction with interaction with residents. 20 hours prior to giving care is an incredible training burden that is too much overload of information at one time.
- The eight (8) hours of dementia training is fine but the additional twenty hours means new co-workers will not be able to start providing care for two weeks. This presents both cost and care challenges for providers.
- All persons giving direct care and support should be trained prior to giving services and anyone with the job description that involves service to the resident need to be train in advance NOT AS YOU GO. We are talking about the quality of life for persons, it is difficult enough with the tools needed to address the challenges of caring for persons with a diversity of problems, illnesses, and issues. To minimize the ability to provide the best quality of care by being untrained going into it is not smart.

## **Licensing Requirements and Enforcement**

A topic that received a large amount of discussion was the removal versus the retention of the Level of Care provision. It was a polarized topic with stakeholders either in strong opposition or strong support for retaining the Level of Care provisions. Enforcement of the regulations was another common theme. In addition, issues concerning coordination between Ombudsmen programs and OHCQ were raised.

### *Access to Residents by Ombudsmen*

- Add that an ALF cannot deny access to the Department and any agency designated by the Department. This will reinforce the role to investigate resident driven complaints.
- Add that an assisted living cannot deny access to OHCQ, APS or the ombudsman program. This should also be added to .11 Compliance monitoring and .31 Resident's Rights. Timely access is critical for each agency to perform their mandate. Ombudsman Program access is not just a resident right, but a requirement of the Older American's Act.

### *Licensing Application, Licensing Renewal, and Unlicensed Facilities*

- Please keep the current text of "At least 30 days before the expiration of its current license." This is for office purposes. A turn-around time of 14 days is not very feasible for a unit that licenses over 1400 facilities.
- An ALF should not provide services beyond its licensed capacity.

### *Level of Care*

- This regulation is an important aspect of the regulation and needs to stay. Not only does it address significant conditions that affect a resident as their need for support increase, but more importantly it describes the skills and capability needed by the staff providing the care and lays an excellent premise for recognizing if your facility is the appropriate setting.
- LifeSpan strongly supports the removal of the levels of care. LifeSpan diligently worked with OHCQ to revise the assessment and scoring tool based on the removal of level of care. As members will discuss, removing the level of care (given that the majority of providers are licensed for level 3) provides for a better service plan more focused on quality.

## **Resident Protections & Rights**

Discharge protections were highlighted by advocacy groups, representatives of government agencies, and from private citizens.

Other resident protections and rights that were highlighted by stakeholders included the appropriate use of restraints, and the financial protections of residents. In response to the comments, OHCQ changed the language to make clear that chemical restraints could only be used for the protection of the resident. OHCQ also added language to ensure residents had the rights to leisure activity, and to participate in community activities.

### *Discharge Protections*

- The regulations do not sufficiently provide for discharge protections for residents. There is a lack of sufficient safeguards to ensure resident rights and safety as provided for in appropriate discharge planning.
- Discharge protections is Maryland Legal Aid's main focus. This is the most common problem that clients ask about and where we see the most frequent abuse. In the midst of the regulatory review, CMS issued the final HCBS Community settings Rule in 2014, which requires full State compliance by 2019. The Rule requires, among other things that any assisted living provider accepting HCBS funds must sign a lease with the same protections that tenants throughout the State have against eviction. This means that all assisted living residents that pay their provider using the Medicaid Waiver or other HCBS program will have eviction rights. For several reasons we must seize this opportunity and extend the same discharge rights to all assisted living residents.

### *Reporting Requirements*

- Incidents should include an assault on a resident whether an injury results or not. This would allow for investigation by OHCQ, and allow for advocacy by the Ombudsman Program.

### *Other Resident Protections and Rights*

- We would like to see language added to the provisions on restraints that makes clear that drugs (and/or chemicals) may not to be used for the convenience of the staff or to discipline residents.
- Recommended new language... It is important to support residents to participate in activities in the greater community as often recreational activities if offered at all, are limited to the facility or in adult medical day care centers. Choice of social and leisure activities should reflect what is meaningful and enjoyable to the resident as opposed to what is decided by staff.

### **Staffing Levels & Job Requirements**

Stakeholders responded to the staffing ratio required in dementia units, and the more general requirements for adequate staffing. While some stakeholders felt that the staffing ratio for dementia units was arbitrary, other stakeholders felt that “adequate staffing” was not clear enough to be enforceable.

Stakeholders also drew attention to confusion regarding the interpretation of the “universal worker” prohibition. Under the current regulation, staff who provide resident care are allowed to provide occasional housekeeping or laundry assistance. However, any staff who is providing resident care must have their *primary* assigned duty be resident care.

Finally, multiple individuals were concerned with the vaccination requirements. Stakeholders advocated for self-report of vaccination status, to keep costs down. Other stakeholders felt that assisted living facilities should be required to provide the vaccination at no cost to the employee due to the high risk of the flu for older residents.

### *Staffing Level and Ratios*

- Clarify what “on site staff sufficient in number means”. This is impossible to prove.
- Appropriate staffing is determined by the organization providing the services. This determination is made by careful evaluation of the resident's needs, type of staffing provided and possibility of requiring private duty care givers in situations where appropriate. Too many details go into making this determination and cannot be successfully determined by OHCQ by making a blanket statement for all facilities.

### *Universal Workers*

- Recommendation is to add wording that allows this practice if the provider is working toward a universal worker approach or is moving toward a “culture change” model to allow for a greater number of staff to help a resident. Also within a decentralized dining approach, everyone helps with everything sometimes. Providers offer a variety of approaches to activities and meals and direct care staff are often part of the process.
- Direct care staff needs to be able to provide occasional housekeeping and laundry assistance to residents. The universal worker is an effective care model in many communities.

### *Vaccination Requirements*

- Influenza vaccines should be offered to all staff free of charge since it is a highly contagious disease and often more deadly for older individuals and individuals with chronic health conditions

## **Medication**

Stakeholders’ brought a myriad of medication related concerns to the attention of the OHCQ staff. Many comments focused on the utility of interim medication storage boxes. A number of other comments discussed the frequency of pharmacy reviews, the labeling of medication, and the use of the MAR. Some of these comments supported increased requirements, whereas others presented concerns about the increase cost of more strict requirements.

### *Interim Medication Box*

- Not having an interim box provided by the pharmacy could result in a significant delay in care to residents.

### *Pharmacy Reviews and Requirements*

- There were several comments on increasing frequency of pharmacy review and requiring programs to contract with dietician services. Again, this is examples of increased regulations than can unduly burden programs and increase costs. If a specified program has significant issues in these and any other areas, it should be addressed individually by OHCQ through its enforcement powers.
- We recommend changing the review requirement from every 6 months to every 3 months for any resident receiving 9 or more medications. Medication issues are a primary driver of ED visits for older adults as well as the consequences of delirium e.g., falls, weight loss, apathy, somnolence

and more. Given the high number of medications and the high risk for drug / drug interactions, residents deserve this level of oversight. Most states require medication reviews every 3 months – despite the number of medications.

### **Facility Standards**

Input regarding the facility standards was very detailed and helpful in strengthening patient protections.

- All staff should be informed about the emergency plan since emergencies can happen at any time. Emergency plans should be reviewed to see if the plan is viable and current.
- Add wording to state that an assist rail for a toilet cannot be mounted behind the toilet; the rail has to actually be usable! The majority of elderly residents need assistance lowering themselves to the toilet, as well as raising themselves up from a toilet. If you mount an assist rail on a wall behind the toilet, it's impossible to use it for its intended purpose because nobody can reach it!

### **Definitions**

Definitions provide important context for the regulations, and are helpful for clarifying the intention of the regulation. Many stakeholders provided comments on the definitions used and definitions that may be missing from the regulations.

### **Editing**

Many stakeholders assisted in finding typos, grammatical errors, and pointing out unclear sections. Thank you for your help!

### **Other**

Other comments highlighted some more broad goals of assisted living. The staff at OHCQ agrees that assisted living services are important for many members of the community, and that assisted livings should have enough requirements to protect resident safety.

Special thanks to Grace Mandel, PHASE Intern for her contributions to this report.
--