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Centers for Medicare and Medicaid Services (CMS) Proposed Rules to Reform Requirements for Long-Term Care Facilities (MCS-3260-P)

Comments Submitted by PHI
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PHI Comments in Response to Proposed Rules to Reform Requirements for Long-Term Care Facilities (MCS-3260-P)

PHI (Paraprofessional Healthcare Institute) works to transform eldercare and disability services. We foster dignity, respect, and independence—for all who receive care and all who provide it. As the nation's leading authority on the direct-care workforce, PHI promotes quality direct-care jobs as the foundation for quality care. Since 1991, PHI has helped organizations, advocates, and policymakers across the U.S. to improve the quality of long-term services and supports (LTSS) through workforce and curriculum development, coaching and consulting services, policy advocacy, and research.

We applaud the Centers for Medicare and Medicaid Services (CMS) for its efforts to modernize and improve nursing home regulations. The following comments aim to ensure that nursing home residents receive quality, person-centered services and supports. PHI's expertise on the direct-care workforce routinely shows that this goal can only be accomplished by ensuring a well-trained and adequately supported workforce sufficient in size to meet demand.

However, a confluence of factors complicate creating a sufficiently-sized workforce of nursing assistants. Between 2015 and 2050, the population of people 65 and older will grow by 60 percent.[1] Compared to people who receive long-term services and supports in the community, residents in nursing homes are 65 percent more likely to be 65 or older. Moreover, nursing home residents are 61 percent more likely to require hands-on assistance with three or more activities of daily living (ADLs) than people who receive LTSS in the community.[2]

Because nursing assistants provide more hands-on assistance to residents than any other facility staff, the Bureau of Labor Statistics (BLS) projects a need of more than 300,000 new nursing assistants from 2012 to 2022.[3,4] BLS also projects that the primary labor pool from which nursing assistants are drawn— women, ages 25-54—will decline over the same time period.[5] Worse, the nationwide nursing assistant turnover rate and job vacancy rate are persistently high and could lead to inconsistent care.[6,7] The following comments offer suggestions for improving the quality of nursing assistant jobs through the proposed regulations. In turn, better jobs will help to retain a larger number of the current national workforce of nursing assistants *and* attract future generations to this essential occupation.

PHI's expertise on these issues is rooted in decades of working with eldercare and disability providers, as well as our original research and policy analysis on the direct-care workforce. Our comments specifically draw on our vast experience providing coaching and consulting services to long-term care facilities across the country. This work affords us a 360-degrees perspective into the realities of nursing home care—achieved through focus groups, one-on-one interviews, multi-day trainings, and in-depth ongoing interaction with all levels of nursing home staff. Additionally, PHI staff members bring decades of experience working in all aspects of the aging and LTSS fields.

§483.5 Definitions

Nurse Aide

We fully support including contract nurse aides in the "nurse aide" definition. Further, while feeding assistants should not be included in the "nurse aide" definition, we do not support the term "feeding assistant." The term "feeding assistant" does not adequately capture the scope of skills required for this role. Furthermore, our experience with nursing homes and various culture change experts argues that referring to meal time activities as "feeding" can diminish the sense of empowerment residents need to thrive in facilities. Throughout these proposed regulations, we suggest CMS change this job title to "dining assistant."

Resident Representative

We appreciate CMS' equal treatment of same-sex couples in the proposed "resident representative" definition. However, the language in this section should reflect the legal context following the 2014 Supreme Court decision in *Obergefell v. Hodges* by removing "…if the marriage was valid in the jurisdiction in which it was celebrated."[8] Additionally, CMS should require that all nursing home staff members be trained in lesbian, gay, bisexual, and transgender cultural competence to ensure the unique needs and legal rights of LGBT residents are upheld. In 2010, PHI developed the LGBT cultural competence curriculum for SAGE's National Resource Center on LGBT Aging—a key resource.

Sexual Abuse

We fully support the inclusion of "sexual abuse" as a form of abuse. While the law must protect residents from sexual abuse, it should also equip managers and direct-care workers with the skills to identify abuse while respecting a resident's ability to engage in consensual sexual activity. Our experience around the country—as well as some recent, well-publicized cases[1]—has surfaced the concern that distinguishing abuse from consensual sexual activity can in some instances be complicated, especially with residents dealing with dementia. This issue can have large-scale implications, given that 78 percent of sexual abuse in nursing homes is committed by other residents; and 40 percent of perpetrators have a cognitive impairment of some form, and 60 to 67 percent of victims have dementia.[9]

As rates of dementia grow and elder abuse increases, direct-care staff and managers need clear guidance on differentiating abuse from consent in these situations.[10] Currently, staff must choose between reporting the incident as abuse (which could infringe on the rights and dignity of residents) and not reporting the incident (which could threaten their employment).

To address these concerns, CMS should study the prevalence of these situations and offer guidance to staffers on properly identifying and reporting sexual abuse in the context of dementia. Additionally, we recommend all nursing home staff and surveyors receive training on sexual abuse and resident rights, including sexual abuse involving residents with dementia.

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[1] See "Boomer Sex With Dementia Foreshadowed in Nursing Home" and "Can a Wife With Dementia Say Yes to Sex?" from *Bloomberg Business*. These stories raise questions about the prevalence of this issue, and whether enough legal guidance exists to distinguish sexual abuse from consent among residents with dementia.

Direct Care/Direct Access Staff

All mentions of "direct care/direct access staff" should be clearly defined. We recommend that this definition follow the §6703 of the Affordable Care Act: "the term 'direct care' means care by an employee or contractor who provides assistance or long-term care services to a recipient.."[11]

§483.10 Resident Rights

§483.10(a)(3)(i) Resident Representatives

We commend CMS for guaranteeing a resident's right to a representative. However, as CMS notes in the summary of provisions for these proposed regulations, a resident representative can take many forms. While we support the inclusive definition of "resident representatives," staffers and residents might be confused about issues of decision-making authority. CMS should require that staff be trained and knowledgeable on differences in rights between resident representatives and residents, thereby reducing instances of staff deferring to the incorrect party for decisions.

§483.10(a)(5) Visitation Rights

We fully support the proposed regulations affording residents greater control over visitation. We also acknowledge overnight stays can be critically important to visitors, especially with residents at the end of life.

In regards to visitation rights, we are witnessing an emerging concern through our work in nursing homes around the country. Staff members are reporting their struggles in effectively dealing with residents' homeless adult children who take up residence in the nursing home for multiple days or longer. These staff members express concerns that nursing homes become de facto shelters in such cases, potentially overcrowding the facility and sparking other concerns about safety, shared space and limited resources.

CMS should explore this issue and assess its prevalence. It should also offer guidance to facilities on how to address these concerns, drawing on best practices from the field.

§483.10(f)(3) HIPAA Rights

We support the array of resident rights under HIPAA, as noted in the regulations. Additionally, CMS should add a provision allowing medical information to be shared with family members with the resident's prior consent—a recommendation aligned with HHS guidance.[12] Research shows that family members are interested in informing and supporting their loved one's supports, and this involvement can be beneficial to the resident [13] Moreover, conflict between staff and resident families is common, leading to staff burnout and turnover, and affecting both the financial stability of nursing home staffers and the care of residents.[14,15] These regulations should include provisions facilitating cooperation and communication among residents, family members, and staff.

§483.10(h) Technology and Abuse

We support the new provisions regarding technology and abuse. We recommend all staff be trained on how to prevent technology-related abuse in facilities.

§483.11 Facility Responsibilities

§483.11(d)(3) Privacy

We support the new privacy-related provisions. However, CMS should strengthen these provisions by clarifying the definition of a "private space," which if left undefined, might not ensure a basic understanding of privacy. We believe an ideal "private space" is a private room available to residents that would allow them to carry out the activities listed in proposed §483.11(f)(ii).

Further, the communication training discussed in the proposed regulations in §483.95(a) should include strategies to communicate with residents in a manner that respects their privacy, especially when imparting sensitive information.

§483.11(e)(9) Resident Representatives

As noted earlier, we suggest an additional provision requiring facilities to educate residents on the roles and responsibilities of a resident representative. If a resident has a family member or close friend with intimate knowledge of their needs, strengths, goals, and preferences, the resident should understand they can involve this person directly in the delivery and planning of their supports and services.

This provision would be especially beneficial for residents who received supports and services primarily from family members or friends prior to facility admission. Given that unpaid caregivers provide 90 percent of LTSS to older people, it's highly likely that most nursing home residents relied on family or friends for LTSS prior to admission.[16] By involving informal caregivers directly in the care planning process, nursing assistants and others would develop a better understanding of how best to serve the resident.[17]

481.11(h)(3)(ii) Issuing Grievance Decisions

We believe that grievance decisions should be distributed to residents as well as representatives –and interested family members should receive a copy of the decision with the resident's prior consent. By helping interested family members stay involved through the grievance process, it will maintain positive relationships among residents, family members, and facility staff. As stated in our comments on §483.10(f)(3), this approach can also have positive effects on workforce retention and care quality.

§483.11(h)(3)(i) Providing Residents with Contacts to Submit Grievances

We support the requirement that residents receive contact information for every available channel to submit and resolve grievances. CMS should also offer guidance related to concerns that might surface when residents are not informed about differing jurisdictions and the potential remedies related to each grievance.

Some states have more than one process for submitting grievances, depending on the nature of the grievance. These requirements will be especially important in states where nursing homes are reimbursed by managed care systems with their own grievance procedures.

§483.12 Freedom from Abuse, Neglect, and Exploitation

483.12(b)(5)(i)(A) Reporting Abuse to Law Enforcement

While we support requirements that law enforcement agencies be notified of potential crimes, this requirement can at times lead to unintended problems. Our experience shows that law enforcement agencies vary in their response rates to reports from nursing homes related to abuse. Moreover, investigations performed by state agencies might experience severe delays. Both scenarios can be partially explained by the high volume of cases being reported and the limited capacity to respond. However, when aides are not exonerated, or are exonerated long after the incident took place, the suspicion of abuse can linger among aides, residents, families, and supervisors. Poor relationships between aides and these individuals can ultimately contribute to aide turnover.[18,19] In cases when the aide is guilty of wrongdoing, such investigation delays could put more residents at risk of abuse.

We request CMS investigate this issue further and offer guidance for reporting potential crimes.

483.12(b)(5)(iii) Anti-Retaliation Policy and Anonymity

We strongly support the explicit mention of anti-retaliation policies and encourage that facility staff be trained on effectively implementing these policies.

§483.15 Transitions of Care

§483.15(b)(2) Transfer of Resident Information

We agree with the new requirements for information that must accompany residents upon transfer from the nursing home. However, without a required timeframe, this provision could spur adverse events upon transfer. We recommend requiring records be immediately transferred with the resident unless the transfer occurs in an emergency situation. In an emergency, we recommend a 24-hour window to transfer records. Resident information is invaluable for direct-care workers and other health professionals to properly provide supports and services on the other end of the transfer.

§483.15(b)(2)(iii)(B) Required Information for Transfer

We support including the resident representative's contact information in the required information for transfer. No matter where the resident lives, staff should have access to the representative's expertise.

If a resident does not select a representative during or prior to care planning, they should be asked whether they want to include the name and contact information for a family member or friend in the transfer documentation. Residents should be properly informed that staff will consult with this selected representative regarding their needs, strengths, goals, and preferences.

§483.20 Resident Assessments

§483.20(b)(1)(xvii) Nurse Aide Participation in the Resident Assessment Process

We fully support new provisions requiring nurse aide participation in the resident assessment process. Nursing assistants provide valuable insights into the care planning process, which is informed by their

regular, hands-on supports and services to residents. Additionally, including nursing assistants in the care planning process can reduce staff turnover by offering aides more responsibility and communication with other members of the care team.[20]

However, CMS should ensure meaningful nurse aide participation by requiring assessment coordinators to obtain input directly from nursing assistant staff. Turnover is lower and retention is great in facilities where members of the care team informally include aides in the care planning process.[21] Facilities will need to ensure adequate staffing to account for nursing assistant participation in the resident assessment meetings. Additionally, nurse aides should be trained on the assessment process, how to effectively offer their input into the assessment, and how that input will be used.

§483.21: Comprehensive Resident-Centered Care Plans

§483.21(a)(2)(i) Care Plan within 48 Hours

We support the newly required immediacy of resident-centered care planning. Producing a care plan within 48 hours will ensure that direct-care and other staff are properly informed on how to meet the needs, strengths, goals, and preferences of the resident.

§483.21(b)(2)(ii) Nurse Aide Participation in the Interdisciplinary Team

We support required nurse aide participation in the interdisciplinary team (IDT) for the same reasons we support their participation in the resident assessment process. Including aides in care planning reduces turnover by offering them more responsibility and opportunities to coordinate with other members of the care team.

However, the participation of nurse aides in the IDT must be substantive. Other staff should not be allowed to use informal conversations with nurse aides to replace in-person aide participation. Aides should be required and given the time to attend care planning meetings in person, and facilities will need to account for nurse aide participation in facility staffing. Again, including aides directly in the care planning process has a greater impact on aide retention than informal representation. [22]

To ensure nursing assistants are effective members of the IDT, they should be trained on the IDT process, how to effectively offer their input during IDT meetings, and how that input should be used.

Finally, IDT meeting coordinators should reasonably accommodate the schedules of all IDT participants-- including resident representatives. Participants should receive written advance notice of meeting dates and times.

§483.21(a)(3)(i) Trauma-Informed Care

We support the proposed requirements that care be "trauma informed." We recommend staff receive specialized training on how to deliver this care. This training should also take into consideration the various sources of trauma, which might necessitate different interventions (e.g. the care considerations for a person who was traumatized by staff abuse are likely different than for a survivor of war).

§483.21(c)(1)(iv) Caregiver Assessment

We fully support requiring facilities to assess residents and caregivers for their abilities and willingness to provide supports and services post-discharge. The facility should also assess resident or caregiver training needs as a component of their "capacity and capability to perform required care." In the same way that aides in nursing homes are trained according to the resident's care plan, those providing LTSS outside of the facility should also receive guidance on necessary skills.

Without these provisions, residents might go without needed supports and services, which could re-direct them to hospitals or nursing homes. An ineffective transition that cycles the resident through nursing homes, personal homes and hospitals can place them at risk of preventable injuries, illnesses, accidents, and other adverse events.

§483.21(c)(1)(vii)(A) Resident Interest in Community Transition

We support requiring nursing homes to document referrals to entities with expertise in transitions to home and community-based care. Because expertise on community living options varies by facility, we also recommend nursing homes provide residents with information (including contact information) on those entities if the resident expresses interest in returning to the community, and if such organizations are available in the local community.

§483.25 Quality of Care and Quality of Life

§483.25(a)(2) Support for Activities of Daily Living

We support explicit requirements regarding activities of daily living. Aspects of care such as good nutrition, grooming, and personal and oral hygiene are essential to a resident's quality of care and quality of life. Similar to other aspects of the proposed regulations, these issues are inseparably linked to staffing levels and training. If nurses and nursing assistants are time-constrained due to inadequate staffing, or if they are not offered proper training, they cannot deliver these services safely or in accordance with the resident's care plan.

§483.30 Physician Services

§483.30(e) In-Person Evaluations by Physicians

While we support reducing hospitalizations to the furthest extent possible, the proposed in-person evaluation carries potential concerns that should be further explored.

In many health emergencies, a resident cannot afford to wait for an in-person physician evaluation before receiving medical care. Because most nursing homes do not have in-house, 24-hour physicians or nurse practitioners, this requirement could pose unnecessary delays. FWe are concerned that staff will be reticent about foregoing the physician for fear of reprimand when emergency circumstances warrant immediate action. We recommend that staff be trained to accurately distinguish emergency situations, and to engage physicians and nurse practitioners in effective, time-sensitive ways. CMS could also explore how emerging telehealth and tele-monitoring technologies might allow physicians to remotely monitor resident status.

§483.35 Nursing Services

We appreciate the acknowledgement of staffing as a critical issue. Research shows that staffing is a strong determinate of resident care quality.[23] Inadequate staffing is also related to staff injury.[24] In fact, due in part to inadequate staffing, nurse aides are more likely to be injured on the job than any other occupation, including construction workers, police officers, and fire fighters.[25] When nursing assistants are not able to work due to injury, staffing issues are exacerbated, and the quality of care is further compromised.

As CMS acknowledges in the provision summary document, many facilities largely base staffing on facility assessments, formally and informally. However, we are concerned the facility assessment might not fully address staffing needs, since it relies on approximate figures and subjective interpretations from staff members.

We recommend CMS develop a formula for a facility-specific staffing ratio based on the facility's case mix. In this approach, residents with higher acuity (as determined by facility census data) would have more staff hours devoted to their care. Staffing levels will also need to account for staff absences, whether long-term (e.g. staff departure) or short-term (e.g. meeting participation or injury). Finally, staffing ratios should account for emergency preparedness regulations, ensuring an adequate number of staff to carry out emergency procedures in accordance with §483.70(e)(3).

This staffing ratio formula will allow state and federal regulators to adequately assess whether staffing levels are meeting residents' needs, strengths, goals, and preferences. Further, by setting a staffing requirement that can serve as a measureable baseline for ongoing monitoring, state policymakers will be better equipped to set reimbursement rates in accordance with facility staffing needs in the years ahead.

Moreover, surveyors should continue assessing staffing adequacy based on their direct observations (e.g. incontinence due to long weight times for toileting assistance). If these types of violations continue in high volume, CMS should consider adjusting staff-ratio formulas.

This case-mixed, facility-specific staffing ratio should be rooted in reliable, auditable data in order to effectively address staffing-related quality issues. PHI and other stakeholders will be better positioned to inform a case-mix adjusted staffing ratio formula once a sufficient pool of public Payroll-Based Journal (PBJ) data is analyzed and published. Therefore, CMS should reopen the comment period on staffing ratios after a sizeable sample of staffing data is made available. In the meantime, proposed staffing requirements based on the facility assessment should be strictly enforced.

In addition to a required staff ratio, we also recommend a 24-hour registered nurse staffing requirement. An insufficient ratio of aides to nurses is a determinant of staff turnover, which affects the quality of care.[26]

Finally, we recommend facilities be required to ensure every nursing assistant has a supervisor on duty who can be accessed for support. Such a requirement would help reduce aide turnover; supportive supervision can minimize nursing assistants' intent to leave.[27]

§483.40 Behavioral Health Services

§483.40(a) Residents with Behavioral Health Issues

We support the inclusion of additional standards to serve residents with behavioral health issues. We also support including behavioral health in the proposed training requirements. In addition to direct-care staff, all staff members and volunteers who interface with residents should be trained in effectively assisting people with behavioral health problems.

§483.45 Pharmacy Services

§483.45(c)(4) Medication Review

We support requiring pharmacists to periodically review resident medications. In addition, we believe that serious or potentially harmful medication irregularities should be shared with the resident their designated representative, and their family if the resident consents. We request CMS develop a definition of serious or potentially harmful irregularities. This definition could draw on characteristics listed in §483.45(d).

§483.60 Food and Nutrition Services

§483.60(i) Food Safety Requirements

We support the new food and nutrition provisions, which reflect person-centered nutrition practices that PHI identified in our *One Vision* project in Michigan, as well as the recommendations featured in the Pioneer Network's *New Dining Practice Standards*.[28,29] These resources were developed by resident advocates, government agencies, provider associations, employee organizations, and culture change champions.

§483.60(a) Staffing

As with many other provisions in the proposed rules, the new food and nutrition regulations are inextricably linked to staffing and training. Without adequate training for staff, residents will not receive the dining assistance they need. Without adequate staffing levels, staff will not be able to devote adequate time to preparing and delivering meals in accordance with resident preferences.

§483.70 Administration

§483.70(e) Facility Assessments

We strongly support the facility assessment provisions. Our comments on §483.70(e) primarily focus on staffing. In our comments on §483.35, we recommend CMS develop a required staffing formula once PBJ data is available. In the interim, we recommend CMS proceed with the proposed regulations that require facilities base staffing on facility assessments. The provisions we suggest in this section will ensure facilities have all the necessary staffing information to inform their staffing strategies before and after implementation of a ratio formula.

In line with our comments on §483.35, monitoring staff turnover should be a required component of the facility assessment. Facilities should collect exit interview data from staff in order to determine the reasons for voluntary separations. Facilities need to understand the frequency and reasons staff depart in order to ensure an adequately sized and sufficiently competent staff to effectively serve residents.

Assessments should also record short-term absences by staff for the sake of determining appropriate staffing levels. Short-term absences should include leave due to injury; participation in resident care planning (including the IDT and resident assessment); in-service training; and paid leave for reasons other than injury.

We also suggest that facilities be required to assess their capacity to provide staff trainings, which are essential to the needs and preferences of residents. It has become increasingly common for facilities to train employees offsite.[30] Facilities should be required to assess the training capacity of these outside entities as well.

§483.75 Quality Assurance and Performance Improvement

§483.75(c)(1) Aide Participation in the Quality Assurance and Performance Improvement Program

We support requirements for including feedback from nurse aides in the quality assurance and performance improvement (QAPI) programs. Similar to participation in the IDT and in the resident assessment process, nursing assistants should receive training on the purpose of the program, as well as how to participate in the QAPI process, including submitting anonymous feedback.

§483.75(f) Workforce Protections

Oftentimes, nursing assistants and other staff run the risk of retaliation for offering suggestions and reports on quality improvement. We suggest staff have the option to submit feedback anonymously through an individual designated for staff input—or another comparable approach. We request language similar to that of §483.85(c)(1), which requires facility ethics programs to include "an alternate method of reporting suspected violations anonymously without fear of retribution."

§483.75(e)(3) Performance Improvement Projects

We support proposals regarding performance improvement projects (PIPs), though we encourage better enforcement mechanisms. While the proposed regulatory language includes provisions on quality of life, we can foresee PIPs becoming too focused on clinical approaches and outcomes, at the expense of the full range of person-centered services and supports. We urge CMS to provide examples of PIPs that balance their focus on both quality of life and clinical outcomes; one notable example is PHI's *One Vision* project.[31]

§483.85 Compliance and Ethics Program

§483.85(c)(1) Required Components for All Facilities

We understand that allowing staff to maintain anonymity might in some cases protect them against retaliation. Such is the basis for our comments on §483.75(c)(1). However, reporting abuse anonymously in some instances can be problematic for nursing assistants. In particular, it introduces the risk that staff

will face reprimand for neglecting to report abuse. PHI's *Training to Prevent Adult Abuse and Neglect (TPAAN)* curriculum instructs trainees to report abuse openly as open reporting can be the best protection against retaliation. We recommend CMS staff training on abuse include similar instruction.

§483.90 Physical Environment

§483.90(d)(2) Resident Beds

We strongly encourage the use of electric beds in all facilities. Manual crank beds are cumbersome and difficult to maneuver for residents, family members, and staff. Through our experience working with nursing homes, we hear stories of nursing staff who fear and sometimes sustain injuries from the physical strain involved in repositioning manual crank beds. In contrast, electric beds are easier and safer for staff members and allow residents the independence to direct their own comfort. An electric bed requirement for all new facilities could greatly reduce injury rates among nurse aides and enhance the delivery of care.

§483.90(f) Staff Alarm System

We recommend all new facilities be built with call bell systems that page staff directly, instead of standard hallway bells, which contribute to high noise pollution in facilities. While there is limited research on noise in nursing homes, the negative effects of noise pollution in healthcare settings on residents, patients and staff are well documented.[32]

§483.90(i) Room Occupancy

We commend the recognition in these proposed regulations that a four-person room contains too many residents. At the same time, we also believe that the two-person requirement is not sufficient and recommend a requirement that all newly constructed nursing homes be built with private rooms for residents. Studies have shown single-occupancy rooms in hospitals improve a patient's quality of life (including satisfaction, sleep, and privacy), as well as improve infection control, which supports the full facility of staff and residents.[33] Moreover, we believe that a single-occupancy room fulfills CMS's commitment to providing residents with a homelike environment.

§483.95 Training Requirements

We have suggested additional training requirements throughout these comments. Additionally, we summarized those comments below and included a chart (*Appendix A*) with those suggested additions.

§483.95(a) Communication

Similar to requirements for compliance and ethics training in §483.85(c)(5), we believe all staff and volunteers should be trained in effective communication. The benefits of this training on the entire facility are diminished if only certain staff are trained.

As stated in our comments related to the in-person physician evaluation in §483.30(e), we believe communication training should include how to effectively communicate resident status between staff and physicians.

Additionally, all staff should be trained on how to communicate in a way that preserves patient privacy. This is reflective of our comments on patient privacy in §483.11(d)(3).

§483.95(b) Resident's Rights and Facility Responsibilities

As stated in our comments on §483.10(a)(3)(i), staff need training to identify and work with different types of resident representatives, or they might wrongfully defer to the wrong decision-maker.

Staff also need training on new visitation policies and how to address visitors who stay for extended periods of time. For clarification of the importance of this training, see our comments on §483.10(a)(5).

Reflective of our comments on §483.21(h), we believe staff should be trained on providing trauma-informed care, including different forms of trauma.

We also suggest additional training requirements for nursing assistants regarding the resident assessment process and the interdisciplinary team, as noted in our comments on §483.20(b)(1)(xvii) and §483.21(a)(2)(ii)(B).

§483.95(c) Abuse, Neglect, and Exploitation

Once CMS clarifies how to effectively identify sexual abuse among residents dealing with dementia and cognitive impairments, this guidance should be included in all abuse training.

Reflective of our comments on §483.10(h), we believe staff should be trained on recognizing and preventing abuse related to technology.

Finally, similar to communication training and compliance training, we believe all staff and volunteers should be trained in abuse reporting and prevention. As an example of its effectiveness, the Michigan Department of Community Health piloted abuse prevention training and found that 60 percent of training participants used techniques learned during training. Among those who used the techniques, 96 percent reported successfully preventing an abusive situation.[34]

§483.95(d) Quality Assurance and Performance Improvement

As stated previously, nurse aides need training on how to substantively provide input into QAPI programs, including education on providing input anonymously.

§483.95(f) Compliance and Ethics

As stated in our comments on anonymous reporting of compliance and ethics violations in §483.85(c)(1), we recommend training include the potential benefits and risks of reporting abuse anonymously.

§483.95(g) Required In-Service Training for Nurse Aides

We believe regulations should further detail the importance of training on dealing with dementia among residents. We suggest that these additions reflect the "Comfort Matters" approach to dementia training,[35] which includes methods for calming residents, and addressing the prevalence of "sundowning" and other symptoms of the disease.

§483.95(i) Behavioral Health

We recommend all staff and volunteers receive training on behavioral health.

Training Hours

Given the many additional training requirements in these proposed regulations, as well as our own recommendations for training, we believe the number of minimum required training hours should be increased. Seventy-five hours is not an adequate amount of time to cover all new and existing requirements. Furthermore, adding new dementia training to continuing education necessitates an increase in continuing education hours. Increasing the number of mandatory training hours allows for more content, improves job satisfaction, and decreases turnover.[36] We support the Institute of Medicine's recommendation that certified nursing assistants receive a minimum 120 hours pre-employment training.[37] We encourage CMS to work with PHI and other workforce training experts to review the impact of these regulations on training for certified nurse assistants and recommend a new minimum training standard.

<u>**Conclusion**</u>

We appreciate the opportunity to comment on the proposed regulations for long-term care facilities. We look forward to participating in future discussions on these regulations. If you have any questions or would like to further discuss these comments, please contact Robert Espinoza, Vice President of Policy, PHI at respinoza@PHINational.org or (718) 928-2085.

Appendix A: Additional Training Requirements

§483.95(a) Communication	• Communicating resident condition to physicians • Preserving privacy
§483.95(b) Resident's Rights and Facility Responsibilities	• Different types of resident representation • Visitation policies • Trauma-informed care • Resident assessment • Interdisciplinary team
§483.95(c) Abuse, Neglect, and Exploitation	• Sexual consent • Prevention technology-related abuse • Abuse prevention • Abuse reporting
§483.95(d) Quality Assurance and Performance Improvement	• QAPI programs
§483.95(f) Compliance and Ethics	• Anonymous ethics and abuse reporting • Anti-retaliation policies
§483.95(g) Required In-Service Training for Nurse Aides.	• Address dementia
§483.95(i) Behavioral Health	• Behavioral health training

[1] U.S. Census Bureau. (2015, March). Projections of the Size and Composition of the U.S. Population: 2014 to 2060 (USCB Publication No. P25-1143) Washington, D.C.: Colby, S., & Ortman, J. Retrieved from: http://www.census.gov/population/projections/

[2] Kaye, H. S., Harrington, C., & LaPlante, M.P. (2010, January) Long-Term Care: Who Gets It, Who Provides It, Who Pays, And How Much? *Health Affairs, 29*(1), 11-21. doi:10.1377/hlthaff.2009.0535

[3] American Health Care Association. (2014). 2014 Quality Report. Washington, D.C. Retrieved from: http://www.ahcancal.org/qualityreport/

[4] U.S. Department of Labor, Bureau of Labor Statistics, Employment Projections Program (2013, December 19). National Employment Matrix, 2012-2022. Retrieved from: http://www.bls.gov/emp/

[5] U.S. Department of Labor, Bureau of Labor Statistics, Labor Force Projections (2013, December 19). Labor Force Participation Rates, 2012-2022. Retrieved from: http://www.bls.gov/emp/ep_data_labor_force.htm

[6] American Health Care Association. (2012). 2012 Staffing Report. Washington, D.C. Retrieved from: http://www.ahcancal.org/research_data/staffing/Documents/2012_Staffing_Report.pdf

[7] Castle, N.G., Engberg, J., & Men, A. (2007). Nursing home staff turnover: impact on nursing home compare quality measures. *Gerontologist, 47*(5), 650-661. ISSN:0016-9013

[8] Obergefell et al. V. Hodges, Director, Ohio Department Of Health, et al. 576 U. S. ____ (2015). Retrieved from: http://www.supremecourt.gov/

[9] Rosen, T., Lachs, M.S., & Pillemer, K. (2010). Sexual aggression between residents in nursing homes: literature synthesis of an under recognized problem. *Journal of the American Geriatrics Society, 58*(10), 1970-1979. doi:10.1111/j.1532-5415.2010.03064.x

[10] Alzheimer's Association. (2015). 2015 Alzheimer 's Disease Facts and Figures. Retrieved from www.alz.org

[11] Compilation of Patient Protection and Affordable Care Act, H.B. 3590, 42 U.S.C. §1397j (2009).

[12] U.S. Department of Health and Human Services, Office for Civil Rights. Sharing Health Information with Family Members and Friends. Retrieved from: http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/sharing-family-friends.pdf

[13] Hertzberg, A., & Ekman, S. (2000). 'We, not them and us?' Views on the relationship and interactions between staff and relatives of older people permanently living in nursing homes. *Journal of Advanced Nursing, 31*(3), 614-622. 10.1046/j.1365-2648.2000.01317.x

[14] Bauer, M., & Nay, R. (2003) Family and staff partnerships in long-term care: a review of the literature. *Journal of Gerontological Nursing, 29*(10), 46-53. PMID:14558235

[15] Abrahamson, K., Suitor, J.; Pillemer, K. (2009). Conflict Between Nursing Home Staff and Residents' Families: Does it Increase Staff Burnout? *Journal of Aging and Health, 21*(6), 895-912. doi:10.1177/0898264309340695

[16] Kaye, H. S., Harrington, C., & LaPlante, M.P. (2010, January) Long-Term Care: Who Gets It, Who Provides It, Who Pays, And How Much? *Health Affairs, 29*(1), 11-21. doi:10.1377/hlthaff.2009.0535

[17] Utley-Smith, Q., Colón-Emeric, C.S., Lekan-Rutledge, D., Ammarell, N., Bailey, D., Corazzini, K., Piven, M.L., & Anderson, R.A. (2009). Staff perceptions of staff-family interactions in nursing homes. *Journal of Aging Studies, 23*(3), 168-177. doi:10.1016/j.jaging.2007.11.003

[18] Abrahamson, K., Suitor, J.; Pillemer, K. (2009). Conflict Between Nursing Home Staff and Residents' Families: Does it Increase Staff Burnout? *Journal of Aging and Health, 21*(6), 895-912. doi:10.1177/0898264309340695

[19] Decker, F.H., Harris-Kojetin, L.D., & Bercovitz, A. (2009). Intrinsic job satisfaction, overall satisfaction, and intention to leave the job among nursing assistants in nursing homes. *Gerontologist, 49*(5), 596-610. doi: 10.1093/geront/gnp051ratio

[20] Banaszak-Holl, J., & Hines, M.A. (1996). Factors associated with nursing home staff turnover. *Gerontologist, 36*(4), 512-517. doi:10.1093/geront/36.4.512

[21] Banaszak-Holl, J., & Hines, M.A. (1996). Factors associated with nursing home staff turnover. *Gerontologist, 36*(4), 512-517. doi:10.1093/geront/36.4.512

[22] Banaszak-Holl, J., & Hines, M.A. (1996). Factors associated with nursing home staff turnover. *Gerontologist, 36*(4), 512-517. doi:10.1093/geront/36.4.512

[23] Castle, N.G. (2008, August). Nursing home caregiver staffing levels and quality of care: a literature review. *Journal of Applied Gerontology, 27*(4), 375-405. doi:10.1177/0733464808321596

[24] Trinkoff, A.M., Johantgen, M., Muntaner, C., & Le, R. (2005, July). Staffing and Worker Injury in Nursing Homes. *American Journal of Public Health, 95*(7), 1220–1225. doi: 10.2105/AJPH.2004.045070

[25] U.S. Department of Labor, Bureau of Labor Statistics, Injuries, Illnesses, and Fatalities Program (2014, December 16). Nonfatal occupational injuries and illnesses requiring days away from work, 2013. Retrieved from: http://www.bls.gov/iif/

[26] Castle, N.G., Engberg, J. (2006). Organizational characteristics associated with staff turnover in nursing homes. *Gerontologist, 46*(1), 62-73. ISSN:0016-9013

[27] Choi, J., & Johantgen, M. (2012). The importance of supervision in retention of CNAs. *Research in Nursing & Health, 35*(2), 187-199. doi:10.1002/nur.21461

[28] PHI, One Vision: Moving Forward. Person-Centered Clarification: Potlucks, Homemade Food, and Garden-Raised Foods Served to Residents. Retrieved from: www.phinational.org/onevision

[29] Pioneer Network Food and Dining Clinical Standards Task Force. (2011, August). New Dining Practice Standards. Retrieved from: https://www.pioneernetwork.net/Providers/DiningPracticeStandards/

[30] Robertson, E.M., Higgins, L., Rozmus, C., & Robinson, J.P. (1999). Association between continuing education and job satisfaction of nurses employed in long-term care facilities. *Journal of Continuing Education in Nursing, 30*(3), 108-113. PMID:10640068

[31] PHI, One Vision: Moving Forward. Retrieved from: www.phinational.org/onevision

[32] HermanMiller Healthcare. (2006.) Sound Practices: Noise Control in the Healthcare Environment. Retrieved from: http://www.hermanmiller.com/MarketFacingTech/hmc/research_summaries/pdfs/wp_Sound_Practices.pdf

[33] Van de Glinda, I., De Roodeb, S., & Goossensena, A. (2007). Do patients in hospitals benefit from single rooms? A literature review. *Health Policy, 84*(2), 153-161. doi:10.1016/j.healthpol.2007.06.002

[34] College of Human Medicine, Michigan State University. (2007, December). Michigan's Adult Abuse and Neglect Prevention Training Program. Retrieved from: http://www.michigan.gov/documents/miseniors/AANPFinal_Report_288338_7.pdf

[35] Levine, L., & Wyatt, A. (2014, December 9). National Partnership to Improve Dementia Care in Nursing Homes. [PowerPoint Presentation]. Retrieved from: https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2014-12-09-Dementia-Presentation.pdf

[36] Han, K., Trinkoff, A., Storr, C., Lerner, N., Johantgen, M., & Gartrell, K. (2014). Associations between state regulations, training length, perceived quality and job satisfaction among certified nursing assistants: Cross-sectional secondary data analysis. *International Journal of Nursing Studies, 51*(8), 1135-1141. doi:10.1016/j.ijnurstu.2013.12.008

[37] Institute of Medicine. (2008). Retooling for an Aging America: Building the Health Care Workforce. Retrieved from http://iom.nationalacademies.org/en/Reports/2008/Retooling-for-an-Aging-America-Building-the-Health-Care-Workforce.aspx