



Missouri Coalition for Quality Care

P. O. Box 7165

Jefferson City, Missouri 65102

September 14, 2019

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3347-P
P.O. Box 8010
Baltimore, Maryland 21244

**Re: Medicare and Medicaid Programs; Requirements for Long-Term
Care Facilities
CMS-3347-P**

Submitted electronically: <http://www.regulations.gov>

Dear Administrator Verma:

The Missouri Coalition for Quality Care (MCQC) is a statewide 501(c)(3) corporation dedicated to the improvement of the quality of care and life for elderly and disabled Missouri residents. We believe that older and disabled persons should be able to live out their lives with dignity and kind, attentive care so that they can be as emotionally and physically healthy as possible, particularly nursing facility residents and in-home care clients in Missouri. We provide education and advocacy on these issues. We also help Missourians make informed choices about long-term care and provide support for individuals and families experiencing problems in that area. MCQC is funded solely by membership fees and contributions.

We appreciate the opportunity to comment on the proposed changes to the federal nursing facility regulations. As explained in more detail below, we object to several of the proposed changes, and offer suggestions that we feel would improve quality of care and quality of life for America's nursing facility residents.

We are concerned that an undue focus on "provider burden" could harm nursing facility residents. Nursing facility operators already have significant flexibility in how they provide care.

Furthermore, residents need the protections in the current regulations more than ever before. Over the years, residents have become frailer and more dependent, and the

majority have dementia. Increased physical and cognitive impairments mean residents need more care and are more vulnerable to abuse and neglect. Any revisions to the regulations should only be made if they improve resident protections, not reduce them.

Our detailed recommendations are presented below.

PROVIDING RESIDENT WITH CONTACT INFORMATION FOR PHYSICIANS (Section 483.10(d))

We recommend retaining most current requirements.

We believe residents should always have up-to-date contact information regarding their attending physician and that the regulations should retain a resident's right to have the same access to contact information for "other" professionals (e.g. psychiatrists, therapists, etc.). This allows residents to contact their providers when they wish, without having to request and then possibly wait to obtain this information.

Because the term "remains informed" has some ambiguity, we agree with the greater specificity provided by a requirement that information must be provided at admission, at a change, and upon a resident's request. The conjunction "and" should be used rather than "or" to make sure that the facility has an obligation in each of these situations.

GRIEVANCES (Section 483.10(j))

We recommend that

- **Complaints be treated as grievances when they are unresolved,**
- **Residents be protected from retaliation whether or not a complaint is treated as a grievance,**
- **Residents be notified of which facility employees to contact regarding grievances,**
- **The regulations retain the specified duties for grievance processing and the specified components of a written grievance decision, and**
- **The regulations maintain the requirement that facilities retain grievance decisions for three years.**

Treating Complaints as Grievances When They Are Unresolved

We are concerned about how CMS proposes to distinguish between a grievance and "general feedback." We understand that not every complaint expressed by a resident should be subject to a full grievance process, but disagree with CMS's proposal to give a facility great discretion to decide not to treat a complaint as a grievance. Under CMS's proposal, many significant resident concerns inevitably would be improperly classified as "general feedback."

For distinguishing between feedback and a grievance, we propose using the comparable standards in CMS's hospital guidance. Under that guidance, a "complaint" is classified

as a “grievance” if it “cannot be resolved at the time of the complaint by staff present, is postponed for later resolution, requires investigation, and/or requires further actions for resolution.”¹ Notably, this standard is consistent with CMS’s preamble statement accompanying the proposed regulations, “that general feedback or complaints stem from general issues that can typically be resolved by staff present at the time a concern is voiced, while grievances are more serious and generally require investigation into allegations regarding the quality of care.”²

Preventing Retaliation

CMS’s proposed language would prohibit a facility from retaliating against a resident who voices a grievance, but would not prohibit retaliation against a resident expressing “general feedback.” The regulation should be written to prohibit retaliation whether or not a complaint is treated as a grievance.

Contact Information for Accessing Grievance Process

CMS proposes to eliminate the “Grievance Official” requirement, so that grievance-related duties can be shared by facility staff, with one individual responsible for overseeing the grievance process. If that change is made, we recommend revising the regulations to require a facility to notify residents of how to contact the facility employees responsible for the grievance process. The current regulations have a comparable requirement, but that requirement is lost in the proposed regulatory language and its deletion of the “Grievance Official” position.

Specifying Duties of Grievance Process

We oppose CMS’s proposal to eliminate the specified duties of the staff members handling grievances. Even if a facility does not have one specified Grievance Official, the duties remain necessary. The duties specified in the current regulation are basic, reasonable, and necessary components of complaint investigation and resolution. They are also broad – leaving adequate flexibility to facilities.

Specifying Contents of Written Grievance Decision

We support maintaining the requirement to provide residents with a written decision regarding their grievance. We object, however, to CMS’s proposal to remove most of the language detailing what must be included in the written decision. CMS states in its discussion of the proposed regulations that it “expects” that facilities will choose to include certain important information in the decisions, but our experience has long been that, in general, if it is not required, it is not done. Unless the specific contents of the notice are mandated, many facilities will provide only the bare minimum called for in the

¹ CMS State Operations Manual, Appendix A (Survey Protocol, Regulations and Interpretive Guidelines for Hospitals (Interpretive Guidance for 42 C.F.R. § 482.13(a)(2))).

²84 Federal Register at page 34,741.

proposed regulations. The grievance regulations should continue to specify the information as required by the current regulations.

Retaining Evidence of Grievance Results for Three Years

We disagree with CMS's position that maintaining evidence related to grievances for three years is burdensome. Any documents concerning grievances will almost certainly be electronic. If not, handwritten documents can be scanned and become electronic. CMS proposes an 18-month requirement; retaining records for an additional 18 months (for a total of three years) would require little to no effort or cost.

Grievance results can indicate the types of problems the facility has had in the past, what was done to address those problems, and if those efforts were successful. This information can be used by both facilities and surveyors to identify problems or potential problems.

NOTICE OF TRANSFER/DISCHARGE WHEN RESIDENT IS HOSPITALIZED (Section 483.15(c))

We support focusing on notices to Ombudsman programs in situations where a resident is not being allowed to return from a hospitalization, but object to use of the terms “involuntary” or “facility-initiated” in the regulations.

We agree with CMS that notice to Ombudsman programs of transfer/discharge related to hospitalization (or other temporary absence) should be focused on situations where the facility is not allowing a resident to return, rather than on all instances when a resident is hospitalized. The scenario where a resident is sent to the hospital, treated, and then not permitted to return to their nursing facility continues to be a widespread problem. In a recent Consumer Voice transfer-discharge questionnaire, approximately 61% of State Ombudsmen indicated that they have observed a trend of nursing facilities refusing to allow residents to return from hospitalizations.

Any revision of the regulations, however, should not use the terms “involuntary” or “facility-initiated.” Those terms currently are used in the guidance but not in the regulations. Inserting any of those terms into one line of the regulations would raise questions about how to interpret “transfer” or “discharge” in other areas of the regulations where those words are not modified by “involuntary” or “facility-initiated.” Any revision also should consider whether changes are necessary in the regulations or the guidance, or both. To a great extent, the issue addressed by CMS's proposed change has been raised by the current requirement in the Surveyor's Guidelines that Ombudsman programs be sent notices regarding “emergency transfers” on a monthly basis.

NURSE STAFFING DATA (Section 483.35)

We support retaining the current requirement that facilities maintain daily nurse staffing data for at least 18 months.

Currently, nursing facilities must retain daily nurse staffing data for at least 18 months, but CMS proposes to reduce this minimum time to 15 months.

We recommend that CMS retain the current 18-month minimum. Since surveys by law may be separated by as much as 15 months, 18 months provides leeway if a survey is late. Also, nursing facilities face no significant difficulty in retaining information for an additional three months, particularly because the information likely is kept electronically.

We know that higher levels of staffing lead to better care. In Missouri, every day nursing home residents aren't getting the care they need because there aren't enough aides and nurses. Insufficient staffing is the most frequent complaint MCQC hears from the family members who call us for help.

PSYCHOTROPIC DRUGS (Section 483.45(e))

We recommend retaining current limitations on as-needed administration of anti-psychotic drugs, along with adding a requirement that all psychotropic medications only be administered with informed consent.

Current regulations allow anti-psychotic drugs to be prescribed on a PRN (as-needed) basis only for 14 days, unless the physician "evaluates the resident for the appropriateness of that medication." CMS now is saying that this requirement is too limiting on facilities, and proposes to allow anti-psychotics to be prescribed for an indefinite time period, if the physician documents the rationale for a specified extended duration, and the extended time is consistent with facility policy and with new regulations that set standards for such facility policies.

We disagree with CMS's proposed changes: use of anti-psychotic drugs should not be made easier. These drugs generally come with "black box" warnings stating that they increase the risk of death in older adults with dementia. Inappropriate use of these drugs continues to be widespread and serious.

To address the consistent overuse of anti-psychotics, we recommend a regulation requiring informed consent by a resident or resident representative prior to administration of any psychotropic medication (including anti-psychotics). Such a requirement is consistent with the well-recognized legal principle that any health care requires consent from the patient or patient representative.

FOOD AND NUTRITION (Section 483.60(a)(2))

We recommend that current standards be retained, but with the grandfathering of current directors of food and nutrition services.

We support the current standards for directors of food and nutrition services and believe that CMS's proposed standards are much too weak. We point particularly to CMS's proposal to require no more than a vaguely described "course of study."

According to CMS, facilities have complained about their current directors of food and nutrition services not qualifying under the regulations. This perceived problem could be dealt with by grandfathering in the current employees. However, any concerns about current employees should not affect the application of the current standards to new hires.

FACILITY ASSESSMENTS (Section 483.70(e))

We recommend that CMS continue to require annual facility assessments.

The facility assessment is critically important because it can help address the number one problem voiced by residents – lack of adequate numbers of well-trained and competent staff, particularly nursing staff. In an assessment, the facility follows a formal process to determine its staffing needs.

CMS proposes to reduce assessment frequency from annually to every-other-year. But because a facility's resident population is not static and staff turnover is high, reviewing and updating the facility assessment at least annually is essential. Otherwise, too much time will elapse between reviews and the staffing levels may not reflect a change in the acuity level, types of diseases, conditions, and physical and cognitive disabilities of a facility's residents.

In Missouri, people can report an incident of abuse or neglect in a facility by calling the Missouri Adult Abuse/Neglect Hotline, which is maintained by the Missouri Department of Health and Senior Services. Unfortunately, the hotline shuts down every night and not all of the calls are answered. Last year, the agency reported that it answered only half of the 92,000 calls to the hotline. Every year there are efforts in the Missouri Legislature to reduce the agency's budget. MCQC is concerned that reduction in staff at the agency has resulted in a decrease in the investigation of complaints of abuse and neglect received by the hotline. Reducing assessment frequency would only exacerbate the lack of oversight of facilities.

Thank you for your consideration of our comments.

Sincerely,

Dave Damico, President
Missouri Coalition for Quality Care