September 12, 2019

Seema Verma, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-3347-P
P.O. Box 8010
Baltimore, MD 21244-1850

Submitted electronically to http://www.regulations.gov

Attention: CMS–3347-P – Medicare and Medicaid Programs; Requirements for Long-Term Care Facilities: Regulatory Provisions to Promote Efficiency and Transparency

Dear Administrator Verma:

We are writing on behalf of California Advocates for Nursing Home Reform (CANHR) to comment on the proposed regulations to roll back the Requirements of Participation for Long-Term Care Facilities that were published in the Federal Register on July 18, 2019. CANHR is a statewide, nonprofit advocacy organization dedicated to improving the choices, care and quality of life for California’s long-term care consumers, their families and loved ones.

CANHR strongly urges CMS to withdraw the proposed regulations. The proposed changes have no merit and most of them will degrade care of nursing home residents, exposing many of them to further suffering and harm in nursing facilities throughout the nation.

The Proposed Regulations Will Harm Residents

Now is not the time to weaken core safety standards and rights. Instead, CMS should respond to the disturbing trends discussed below by strengthening standards, enforcement and the screening of owners.

The preamble to the proposed regulations states that CMS’s objectives are “regulatory relief” and reducing the regulatory “burden” on providers. Yet CMS cites no evidence to justify its plan to roll back nursing home requirements. Rather, throughout the preamble, it repeatedly describes instigation and lobbying by the nursing home industry as the basis for its action. The transparent subservience to the nursing home industry is beyond troubling.

Caring for our nation’s most vulnerable elders is not a burden, it is an honor for which nursing homes are collectively paid well over $100 billion annually through the Medicare and Medicaid programs. It is not too much to ask the operators who are being enriched by these programs to treat resident grievances seriously, protect residents from abuse and dangerous drugs, notify the
ombudsman about resident transfers, employ qualified dietary service managers, and improve the tracking and treating of deadly infections.

The proposed regulations do not identify any benefits to residents from the rollbacks. Indeed, there are no benefits to residents, who will be harmed by the weakening of core safety standards and their rights.

Nursing home operators, however, will be richly rewarded. CMS estimates the cutbacks will save operators over $600 million annually, which they will be allowed to pocket because CMS is not requiring operators to reinvest savings into staffing and resident care.

At a time when the quality of nursing home care has never been worse, rolling back the regulations sends exactly the wrong message to the nursing home industry. CMS is directly telling nursing home operators that it will protect their interests at the expense of the residents it is supposed to serve.

This message must be reversed. CMS should withdraw the proposed regulations and take strong actions to enforce the current requirements.

**Nursing Home Residents in Crisis Due to Abuse and Neglect**

As you know, the proposed cutbacks to our nation’s nursing home standards come at a time when evidence is piling up that the quality of nursing home care has never been worse and that many residents are at constant risk of serious abuse and neglect.

**Steep Rise in Abuse**

In June 2019 the U.S. Government Accountability Office issued a report – *Nursing Homes: Improved Oversight Needed to Better Protect Residents from Abuse* – stating that abuse deficiencies more than doubled in recent years, with the largest increase in severe cases.1 The sharp increase in deficiencies took place despite the fact that most nursing home abuse is never reported, investigated or acted upon. Another June 2019 report, this by the HHS Office of Inspector General (OIG) – *Incidents of Potential Abuse and Neglect at Skilled Nursing Facilities Were Not Always Reported and Investigated* (A-01-16-00509) – revealed that skilled nursing facilities failed to report 84 percent of cases of suspected abuse involving high risk emergency hospitalizations of residents.2 OIG’s report followed an alarming public warning it issued on August 24, 2017 that evidence of sexual assaults and other serious crimes are often ignored by nursing homes and officials charged with protecting residents from abuse.3

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2 OIG, Incidents of Potential Abuse and Neglect at Skilled Nursing Facilities Were Not Always Reported and Investigated, A-01-16-00509, June 2019. Available at: [https://oig.hhs.gov/oas/reports/region1/11600509.pdf](https://oig.hhs.gov/oas/reports/region1/11600509.pdf)
3 OIG, Early Alert: The Centers for Medicare & Medicaid Services Has Inadequate Procedures To Ensure That Incidents of Potential Abuse or Neglect at Skilled Nursing Facilities Are Identified and Reported in Accordance With Applicable Requirements, A-01-17-00504, August 24, 2017. Available at: [https://oig.hhs.gov/oas/reports/region1/11700504.pdf](https://oig.hhs.gov/oas/reports/region1/11700504.pdf)
At a March 6, 2019 Senate Finance Committee hearing – *Not Forgotten: Protecting Americans from Abuse and Neglect in Nursing Homes* – the daughters of two elder abuse victims put faces on these tragic crimes, with Maya Fischer testifying about the brutal rape of her mother in a Minnesota nursing facility and Patricia Blank describing the extreme dehydration, neglect and subsequent death of her mother in an Iowa nursing home.  

In California, nursing home residents are abused with frightening frequency. For example, San Francisco’s mayor and other officials held a press conference on June 28, 2019, to discuss a horrific abuse scandal at Laguna Honda, one of the nation’s largest skilled nursing homes, where a group of six employees abused 23 residents over a period of years, subjecting them to verbal and physical abuse, sexual harassment, drugging, humiliation, neglect and other despicable acts.

### Rampant Understaffing

A July 2019 study published in Health Affairs reports that new Payroll-Based Journal (PBJ) data from nursing homes show that few of them ever have enough registered nurse (RN) staffing to meet resident needs, weekend staffing is low, and there are large fluctuations in daily staffing levels. One of the study’s authors described the finding on RN staffing as “staggering.”

We hear daily from California nursing home residents and their family members about the misery, neglect, harm and sometimes death they endure due to understaffing. When it comes to staffing, nursing homes have been fairly described as ghost towns.

### Unscrupulous Nursing Home Chains Endangering Residents

Incredibly, the nation has no system to screen out unfit and dangerous nursing home operators. Virtually anyone or any company can acquire nursing homes and receive federal funding to operate them, no matter how terrible their track record, incompetent, or financially unqualified they may be.

The complete failure to vet nursing home owners poses grave dangers to residents. Nothing illustrates this better than the collapse of Skyline Healthcare last year, a small chain that acquired

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over 100 nursing homes in at least ten states seemingly overnight. Extraordinary chaos ensued after Skyline stopped paying its bills and abandoned many of the facilities. Thousands of desperate residents were neglected and many hundreds of them forced to move to distant facilities. Several states sought emergency receiverships over scores of facilities that Skyline abandoned.9

Turmoil also reigns in California. For example, California’s largest nursing home operator has had three nursing homes terminated from Medicare or Medi-Cal due to the deadly neglect of their residents. Yet he is operating 24 nursing homes he acquired in 2014 without ever having obtained a license to operate them. The Department of Public Health denied licensure applications for six of these facilities years ago but he continues to operate them.10

The unchecked buying and selling of nursing homes has caused a national crisis that needs immediate attention from CMS. Yet instead of seeking much-needed solutions, CMS is retreating from its quality of care regulations.

**Increasing Neglect Due to Profiteering**

California nursing home chains routinely engage in self-dealing scams to pad and hide profits. In May 2018, the California State Auditor reported that residents are increasingly subjected to severe neglect while profits for nursing home chains engaged in self-dealing are soaring. Between 2006 and 2015, nursing home deficiencies that caused, or were likely to cause, serious injury, harm, impairment, or death to residents increased by 35 percent. Meanwhile, nursing home payments to related parties grew by 66 percent and now exceed $1 billion annually.11

**Huge Increase in Complaints**

Complaints against California nursing homes are exploding. According to publicly reported data by the California Department of Public Health, the public filed 10,021 complaints against nursing homes in 2017-18, up 54% from just four years ago (6,517 in 2013-14). Currently, the

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10 On July 8, 2016, the California Department of Public Health denied applications by Shlomo Rechnitz to operate five nursing homes: Windsor Healthcare Center of Oakland, located at 2919 Fruitvale Avenue in Oakland; Windsor Chico Care Center, located at 188 Cohasset Road in Chico; Windsor Chico Creek Care and Rehabilitation Center, located at 587 Rio Lindo Avenue in Chico; Windsor Redding Care Center, located at 2490 Court Street in Redding; and Windsor Gardens Convalescent Center of Anaheim, located at 3415 W. Ball Road in Anaheim. The denial letters are available at: [http://canhr.org/newsroom/newdev_archive/2016/DPH-denies-ownership-applications-by-CA-largest-nursing-home-operator.html](http://canhr.org/newsroom/newdev_archive/2016/DPH-denies-ownership-applications-by-CA-largest-nursing-home-operator.html). On September 16, 2014, the CDPH denied Rechnitz’s licensure application to operate the Riverside Convalescent Hospital located at 375 Cohasset Rd. in Chico.

California Department of Public Health has a backlog of 17,325 open complaints and facility reported incidents involving long-term health care facilities.\textsuperscript{12}

Neglected and abused nursing home residents in California often die before complaints on their mistreatment are investigated.

**Comments on Specific Changes**

Our comments on the specific changes CMS has proposed are set forth below.

**Right to Information on Physicians, Section 483.10(d)**

CMS proposes to weaken the residents’ right to be kept informed of the name and contact information of their attending physician and to eliminate a facility’s duty to keep residents informed of other primary care professionals responsible for their care. This proposal seems designed to keep residents out of their own health care decision-making process.

It is not unreasonable to require nursing homes to keep residents informed of the names of their doctors and how to contact them. The attending physicians and specialists serving residents are usually well known to the nursing home and very unfamiliar to the residents, who are often forced to change doctors when they enter a nursing home. Keeping residents well informed about and connected to their doctors is an important part of person-centered care.

**Resident Grievances, Section 483.10(j)**

The proposed regulations would critically weaken a resident’s right to file a grievance, giving nursing homes almost total discretion to decide what is a grievance, eliminating the position of grievance official and greatly reducing the information that must be included in written grievance decisions. CMS estimates these changes alone will save nursing homes about $78 million a year in lower staff costs for responding to grievances.

We are under no illusion that nursing homes are responsive to resident grievances. The point of the regulation that CMS adopted in 2016 was to change that reality. In finalizing the existing requirements, CMS stated: “The purpose of requiring the facility to have a grievance official is to ensure that there is an individual who has both the responsibility and authority for ensuring, through direct action or coordination with others, that grievances are appropriately managed and resolved.”\textsuperscript{13}

Reversing this expectation will not only harm residents, it will shift large costs to state survey agencies, who will face increased burdens in responding to nursing home complaints that are preventable with effective grievance procedures.

\textsuperscript{12} CDPH online performance metrics dashboards. CDPH complaint investigation data available at: https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/FieldOperationsComplaints_ERIs.aspx

\textsuperscript{13} Medicare and Medicaid Programs: Reform of Requirements for Long-Term Care Facilities, 81 FR at 68724, October 4, 2016.
Transfer and Discharge Notices, Section 483.15

CMS is proposing to narrow the requirement that nursing facilities send transfer or discharge notices to the ombudsman programs by limiting ombudsman notification to only “facility-initiated involuntary transfers or discharges.” This broad and ambiguous exclusion will eviscerate the ombudsman notification requirement, squelch ombudsman protections against inappropriate discharges, and inflame the discharge crisis that is harming residents nationwide.

Inappropriate discharge is one of the biggest ongoing problems in nursing home care. Problem discharges are the most frequent complaint made to ombudsman programs over each of the past five years. CMS recognized the ongoing crisis in its S&C Memo #18-08-NH meant to address discharges that violate federal regulations and cause trauma and safety concerns for the aggrieved residents. Problematic discharges include 1) a massive increase in facilities sending residents to motels, homeless shelters, or unlicensed group homes; 2) illegally refusing to readmit residents following their hospital stays; and 3) unrelenting pressure from facilities to send residents home at the end of their Medicare-covered days, regardless of their need for additional care.

By adding Section 483.15(c)(3)(i)’s requirement to notify the ombudsman of transfers and discharges, CMS gave residents and resident advocates a powerful tool that places only a marginal burden on facilities - which are already statutorily required by law to give notice to residents and their representatives. In just a few years as recipients of notice, ombudsman staff and volunteers have intervened and helped improve the discharge transition for thousands of residents they may have otherwise missed. Ombudsman programs have assisted these residents to stop inappropriate discharges and advocate for good, safe discharge planning.

Providing a copy of transfer and discharge notices to the ombudsman has proven critical for many reasons. The provision of notice has proven invaluable for assisting residents to oppose, and often informally resolve, inappropriate discharges, protecting residents’ health, safety, and rights. Additionally, robust notice requirements give ombudsman programs the ability to identify and address facility-wide deficient practices, such as defective notices or incomplete discharge planning. These efforts, in turn, inform ombudsman of nursing home chain or statewide discharge problems and troublesome trends that are harming residents.

Under CMS’s proposal, facilities will only need to give ombudsman programs a copy of a transfer or discharge notice if the transfer or discharge is “involuntary” and “facility-initiated.” We urge you to avoid these ambiguous terms that nursing homes often use to hide or excuse poorly planned, dangerous evictions. Over the past five years, our office has handled hundreds of complaints about nursing home discharges. Facilities often regard all discharges as “voluntary” so long as the resident is not kicking and screaming in opposition on the way out. What most facilities deem “voluntary” is considered quite the opposite by residents who invariably express feelings of having no choice in the matter of a transfer or discharge. When those residents relent and “go along” with a transfer or discharge, facilities call it “voluntary.”

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14 Source: https://ltcombudsman.org/omb_support/nors/nors-data
We also strongly recommend against using the term “facility-initiated,” which is only a variation of “involuntary” and would lead to more confusion and costly, unsafe discharges. The term “facility-initiated” is not used anywhere else in the regulations and does not appear in the Nursing Home Reform Act. Its use here in the ombudsman notification requirements would simply confuse providers and regulators, in addition to inviting harm to residents when facilities use the term’s ambiguity to conceal poorly planned, unsafe discharges from ombudsman programs.

The preamble definition of these terms is particularly objectionable. It states that a facility-initiated involuntary transfer or discharge is “a transfer or discharge that the resident objects to, did not originate through a resident’s verbal or written request, and/or is not in alignment with the resident’s stated goals for care and preferences.”

Requiring vulnerable elders to “object” to transfers or discharges that they might not even know are planned would turn all of the transfer and discharge protections on their head and render them meaningless. The same is true for discharges being in “alignment with the resident’s stated goals for care and preferences.” Allowing nursing homes to decide if resident discharges are so aligned would subvert residents’ unqualified statutory right to advance written notification of their transfer and discharge rights.

Notice to the ombudsman serves a vital function in ensuring transfers and discharges are safe and appropriate. In order to combat the endless pressure residents face to leave nursing homes without proper placement or planning, CMS needs to strike the proposed change to section 483.15 and maintain the rule that requires copies of transfer and discharge notices be sent to long-term care ombudsman programs. Do not take the backward step of diminishing the rule so that ombudsman are mostly left out of the transfer and discharge process. In this time of massive nursing home eviction problems, the ombudsman notice rule is our best hope for resolution.

**Bed Rails, Section 483.25**

In spite of the accumulation of evidence that nursing home residents who have dementia, immobilizing diseases or temporary confusion are at critical risk of becoming entrapped and seriously injured, asphyxiated or suffocated on bed rails — and that no bed rail prevents falls or is safe for this population — residents continue to be harmed and die from these devices because CMS has not proscribed their use. Changing the word “installation” to “use” may alleviate “several” providers and surveyors’ concerns but does not address the danger of entrapment, asphyxiation and injury that can occur if rails are removed and reinstalled; installed on a bed frame with which they are not compatible; are incompatible with the mattress in use, including its width, depth and type, or are installed by staff who are unfamiliar with the procedure and the product and unable to identify entrapment zones and other hazards. Installation is even more dangerous if the device is an unregulated portable bed rail designed to be affixed to any bed using unstable arms or straps under the mattress.

A state health inspection every 9 to 15 months — or less if Congress were to enact CMS’s proposal to reduce surveys to as infrequently as every 36 months for presumed “high-performing” facilities — will not protect residents who are wrongly provided a bed rail or a bed

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15 84 Fed Reg. at 34,742.
rail with entrapment hazards, including hazards created by improper installation, between surveys.

We continue to support the prohibition of bed rail use for residents with vulnerabilities to entrapment, asphyxiation and injury, and we are concerned that after decades of education on bed rail hazards, many providers continue to purchase beds that incorporate them. For the purposes of this proposed regulation, however, we strongly recommend adding the following language to 483.25(n):

- Use only bed rails and related devices that are affixed permanently and safely to the bed or that can be affixed tightly and securely to the bed frame so that the rail cannot move or become detached from the frame to create an entrapment or fall hazard. Portable bed rails designed to be fixed by the user to a bed should not be permitted by CMS to be used in a nursing facility because of their greater potential to cause injury or death.

- If beds are installed with the bed manufacturers’ bed rails, ensure that when lowered they are locked so that they cannot be raised except by authorized staff and are recessed so that they do not create a fall or other injury hazard.

**Nursing Staffing Data, Section 483.35**

We oppose CMS’s proposal to allow nursing homes to discard daily nurse staffing reports after 15 months. The staffing data is useful to many parties, including complaint and fraud investigators. CMS should maximize the availability of these records.

As noted earlier, the California Department of Public Health currently has a staggering backlog of 17,325 open nursing home complaints and facility reported incidents, some of which have been pending for years and many of them involving poor care caused by understaffing. CMS should not allow operators to destroy evidence that is material to these investigations. It costs nursing homes nothing to keep records for 18 months or more.

**Behavioral Health, Section 483.40**

The proposed regulations would delete requirements on competencies for the staff who serve residents with behavioral health needs and on rehabilitation services for residents with such needs. CMS states the deleted language is duplicative of requirements in other sections.

There is some duplication with other requirements. However, it is valuable in the context of this section to repeat or reference the other requirements, especially the core standard that staff must have the appropriate competencies and skills 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.

Of greater concern, the proposed deletions would further hollow out the very underdeveloped requirements on behavioral health in section 483.40. This section’s overly broad requirements
give little meaningful direction to facilities, surveyors, residents or the public on how residents’ behavioral health needs are to be met. We are attaching our September 9, 2015 comment letter to CMS on the dementia care aspects of this regulation, which contains detailed recommendations on how to improve these standards.

**Liberalizing Use of Antipsychotic Drugs, Section 483.45**

The most objectionable change CMS is proposing would allow nursing facilities to give residents antipsychotic drugs on a PRN basis for an unlimited period of time if a resident’s physician or prescriber authorizes it. CMS would eliminate the requirement that the attending physician or prescriber evaluate a resident to determine the appropriateness of the antipsychotic drug before extending PRN orders beyond 14 days.

This proposal is a terrible mistake on many levels.

PRN use of antipsychotics should be banned, not encouraged. The use of standing orders for antipsychotic drugs is a recipe for abuse. This practice, almost by definition, negates fundamental residents’ rights under the Nursing Home Reform Law. Not only is nursing home staff unqualified to make case-by-case determinations about antipsychotic use; but there is also no medical justification for treating these drugs as if they were the equivalent of a mild pain reliever or other over-the-counter medication.

To much fanfare seven years ago, CMS launched an initiative to improve dementia care and reduce the unnecessary use of antipsychotics in nursing homes. For the first few years of the initiative, antipsychotic use declined – from 26% of all residents in 2011 to 20% in 2016. Since that time, use has barely budged and remains stuck at 20% into 2019.16 There continues to be epidemic levels of antipsychotic misuse in nursing homes today with over 200,000 nursing home residents with dementia being given antipsychotics on a daily basis. This is the time to redouble our efforts to reduce misuse of antipsychotics, not to loosen the rules to permit more chemical restraints via fax or phone order.

Antipsychotic drugs have black box warnings for a reason; they often kill people who have dementia, the target population for PRN antipsychotic use in nursing homes. These drugs also cause mental anguish and devastating cognitive loss that dull the spirits, sap the personalities and crush the spirits of their victims.

We are curious why CMS cited the landmark February 2018 report by Human Rights Watch – “They Want Docile,” How Nursing Homes in the United States Overmedicate People with Dementia – in the preamble while ignoring its findings and recommendations. Its top recommendation was to “End the inappropriate use of antipsychotic drugs in older people with dementia in nursing facilities.”

Siding with providers who want freedom to drug residents without restraint would amount to a final surrender of CMS’s fading Partnership to Improve Dementia Care in Nursing Homes. CMS

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cannot improve dementia care in nursing homes while giving operators the green light to use antipsychotic drugs to sedate and subdue residents who have dementia.

Misuse of antipsychotics and other psychotropic drugs continues to be one of the most pernicious problems in nursing homes and deserves a real campaign marked by enforcement of our laws and improvement of our care standards.

The concerns of “commenters” that limiting PRN orders for psychotropic drugs would interrupt patient care is not supported by MDS data. The percentage of residents receiving an antipsychotic drug between one and six days a week (presumably a PRN order) has held steady between 1.65 and 1.80 for the years before and after the new PRN regulations were adopted in 2016. MDS data also undermine the claim that “prescribers would write routine orders that would result in residents receiving more of the drug more often,” i.e., more residents would receive psychotropic drugs seven days a week. That has not happened at all: routine prescriptions for anti-anxiety drugs has held steady from 2016 through 2018 at about 15.5% while prescriptions for antipsychotics has slightly decreased from 19% to 18%.

CMS is seeking comments on whether its proposed modifications provide sufficient protection for residents. No, they do not. The proposal only protects providers who are misusing antipsychotic drugs.

There are many actions CMS could and should take to protect residents from antipsychotic drugging, the most important of which is to require written informed consent prior to their use. Drugging would decline sharply if residents and their representatives were properly warned about the dangers associated with antipsychotic use and their lack of efficacy in treating dementia. Our attached September 9, 2015 comment letter includes model language for an informed consent requirement.

**Qualifications of Dietary Service Managers, Section 483.60**

CMS is proposing to eliminate the requirement that a director of food and nutrition service be a certified dietary manager, a certified food services manager or have similar credentials when a nursing home does not employ a full-time dietitian.

We strongly agree with the hundreds of commenters who oppose the proposed gutting of these basic educational requirements. As CMS states in the preamble, dietary standards for residents are critical to both their quality of care and quality of life. This being so, their dietary needs should not be managed by underpaid staff with little or no training or education on nutritional care for this vulnerable population.

Allowing nursing homes to continue to employ unqualified persons to manage dietary services will expose residents to malnutrition and discontent about their meals. This proposal is especially unwise given the increasingly poor health status of residents and the ever more common need for special dietary interventions.
In 2016, CMS gave nursing homes five years to help existing dietary service managers obtain the required training and certification, which is inexpensive and widely available. There is no excuse for turning back on this requirement.

**Facility Assessments, Section 483.70**

The proposed regulation would reduce the required frequency of facility assessments from once a year to once every two years.

In dismissing recommendations for minimum staffing requirements when it finalized the 2016 rule, CMS contended that the facility assessment was a better way to determine the resources a facility would need to care for its residents competently. Due to its direct connection to facility staffing decisions, CMS stated then that an assessment is needed at least annually to ensure that there have not been any substantial changes in residents’ needs or a facility’s resources to meet those needs.\(^\text{17}\)

What has changed since 2016 when this requirement was adopted?

We continue to believe that federal minimum staffing requirements are a necessity to prevent the neglect of residents. However, in the absence of such standards, it is profoundly unwise to allow nursing homes to go two years between assessments of their staffing needs. The facility self-assessments are foundational to meeting the needs of the facility residents, serving as the primary tool for discerning resident acuity, staff competency, and staff sufficiency. Given the constant turnover of residents and staff in nursing homes, anything other than an annual assessment risks a significant gap between resident needs and staffing assistance.

**Quality Assurance and Performance Improvement (QAPI), Section 483.75**

CMS proposes to eliminate many process requirements for QAPI, resulting in halving estimated facility costs for this function.

We are not proponents of QAPI or any of the many other quality assurance programs that providers have promoted through the years as sure-fire methods to improve the quality of care in nursing homes. Nursing homes should choose their own management improvement tools and be judged by the results.

Nonetheless, QAPI is mandated by law, and so it is worrisome that CMS would wound it in this fashion while still leaving it in place and devoting resources to it. If CMS wants to give nursing homes more flexibility on quality assurance, it should consider seeking repeal of QAPI rather than rendering it useless.

\(^\text{17}\) 81 Fed. Reg. at 68787.
Infection Control, Section 483.80

By changing the requirement that the infection preventionist (IP) work at least “part-time” at the facility to one where the IP must have “sufficient time” at the facility, CMS would be replacing one vague standard with another.

The vagueness of either standard will essentially leave nursing homes on the honor system for the IP position, which is hardly appropriate given the finding CMS cited in the preamble about the millions of infections nursing home resident suffer each year and hundreds of thousands of resident deaths annually due to infections. The tragic suffering and deaths of such enormous numbers of residents due to nursing homes’ rampant failures to track and treat deadly infections deserves urgent attention from CMS, not the unconscionable retreat it has proposed.

The deadly nature of nursing home infections and how poor care and low staffing are turning nursing homes into breeding grounds for drug-resistant germs is the subject of an alarming New York Times article this week, Nursing Homes Are a Breeding Ground for a Fatal Fungus. It includes scathing comments from various public health officials on highly unacceptable conditions in nursing homes that are causing the increasing prevalence of dangerous infections, including a statement describing nursing homes as “the dark underbelly of drug-resistant infection” by the doctor who heads the fungal division at the Centers for Disease Control and Prevention.

We recommend the regulations establish a presumption that a facility lacks a qualified IP with sufficient time for these duties whenever violations of infection control are identified. In addition to other appropriate remedies, such a finding should trigger a directed plan of correction to require full-time presence of a qualified IP immediately. This approach would encourage nursing facilities to take infection control standards and deficiencies seriously, something that is generally not the case now.

Downgrading Compliance and Ethics Programs, Section 483.85

CMS proposes to save nursing home owners over $123 million each year by eliminating requirements for dedicated compliance officers and compliance liaisons, along with other changes that send a message that ethics and compliance of nursing home operators are no longer a priority for CMS.

The symbolism of this message will not be lost on those nursing home operators who are the cause of the unrelenting neglect and abuse that are occurring in so many of the nation’s nursing homes. They no longer need to even fake an interest in ethics or compliance.

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Exemptions from Life Safety Code Requirements, 483.90

This proposal would allow certain nursing homes to revert to outdated fire safety standards, exempting them from meeting the Fire Safety Equivalency System (FSES) in the 2012 Life Safety Code. In the name of protecting an estimated 50 nursing homes nationwide from having to upgrade to the current fire safety standards, CMS would endanger many thousands of nursing home residents by lowering fire safety standards that were intended to keep them safe. This misguided change is completely unacceptable.

Resident Rooms and Bathrooms, Section 483.90

The proposed rules state they will “reduce punitive facility construction requirements that will save in excess of $325 million” annually by exempting certain facilities first certified after November 28, 2016 from requirements that bedrooms accommodate no more than two residents and that each resident room have its own bathroom.19

There is nothing punitive about requiring nursing homes to make residents’ living environments less inhumane.

According to the preamble, the facilities that CMS would spare from these requirements are previously certified facilities that were terminated from Medicare and hundreds of facilities that change ownership each year without the transfer of a Medicare Identification Number and provider agreement.20

Every aspect of this proposal is troubling but nothing more so than CMS’s assumption that there are 150 skilled nursing facilities that are terminated from Medicare each year, “which we will assume come back into the program eventually under the same ownership with a new Medicare Identification Number.”21 It is appalling that CMS expects that every nursing home that has been forced out of the Medicare program due to terrible care will be readmitted to Medicare under the same ownership. This inexplicable tolerance of unfit owners helps explain why most troubled nursing homes rarely improve.

Why is CMS trying to spare terminated providers the expense of making their facilities livable?

CMS states that industry stakeholders claim the room and bathroom requirements discourage building, remodeling, upgrading and the purchase of facilities. Just the opposite is true. The requirements set a standard that encourages remodeling and upgrading of facilities to provide a more livable environment in nursing homes. Operators who are not prepared to invest in upgrading aged nursing homes with unlivable accommodations should not be allowed to acquire them or obtain certification if they do so.

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19 84 Fed Reg. at 34,739.
20 84 Fed Reg. at 34,760.
21 84 Fed Reg. at 34,760.
Occupancy tends to be lower after a termination or a sale, making them an opportune time to upgrade a nursing home’s accommodations for residents.

We note that CMS acknowledges that “more than two residents to a room not only infringes on a resident’s privacy and dignity, but also creates issues related to infection control and safety” and “that rooms without bathrooms increase risks related to falls, quality of care, and infection control.” There are no better reasons for withdrawing this ill-advised proposal.

**Delaying Implementation of Phase 3 Requirements**

We object to the proposal to delay implementation of the Phase 3 QAPI and compliance and ethics requirements. As CMS notes, statutes required these provisions to be implemented years ago. Moreover, CMS gave nursing homes three years to implement these requirements in the final 2016 rule.

CMS cites “confusion for the nursing home community” as a reason for delay, but there would be no confusion if not for CMS’s current efforts to roll back these requirements.

**Informal Dispute Resolution, Sections 488.331 and 488.431**

There is a clear double standard in these rules. Requirements that help protect residents are considered a burden and too prescriptive. But no amount of prescriptiveness is too much for requirements that solely benefit nursing home operators, such as the proposed modifications to the IDR and IDDR requirements.

CMS should repeal the IDR and IDDR procedures. Due process protections for nursing home operators are excessive and should be scaled back. Doing so would save mountains of paperwork for state survey agencies.

**Waiving Civil Money Penalties, Section 488.436**

This proposal would create a constructive waiver process of the right to appeal civil money penalties, allowing nursing home operators to automatically receive a 35 percent reduction of fines imposed for neglect without even asking for it.

CMS estimates this provision will save nursing homes $1,108,226 annually. It is outrageous that CMS is seeking to help the nursing homes that have mistreated and neglected their residents by reducing their fines and related costs.

Where is the concern for the residents who were harmed by their neglect?
We strongly urge CMS to withdraw the proposed regulations. It is highly inappropriate to sacrifice the rights and safety of residents in order to enrich nursing home operators.

Sincerely,

Michael Connors
Advocate

Anthony Chicotel
Staff Attorney

Patricia L. McGinnis
Executive Director