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Respondent Type: Normal Response

Collector: New Link (Web Link)

Custom Value: empty

IP Address: 68.14.252.70

Response Started: Friday, February 22, 2013 4:08:21 PM

Response Modified: Friday, February 22, 2013 4:08:40 PM

1. What parts of the draft rules do you believe are effective?

No Response

2. How can the draft rules be improved?

Proposed Rules for Nursing Care Institutions Title 9, Chapter 10, Article 4 While Sun Valley Lodge has submitted comments yesterday on the most recent version (February) we wish to add additional comments today 1 Pg 15 R9-10-406 A 11 a, b, c, d, e, f & g; #1-3 and #14 We are opposed to any record requirements for volunteers who are not providing care to residents These are still costly requirements which would have a negative impact on volunteerism We are not opposed to record requirements for those volunteers who provide care to residents It is labor intensive to create and ongoing maintenance of files for volunteers who come once a week to call bingo is nonsensical It is also contrary to HB 2634 2. Pg 20 R9-10-409 A 2 a-f All are burdensome, labor intensive, costly They are contrary to HB 2634 3 Pg 21, 22 & 23 R9-10-409 B 1 & 2 C 1, 2 & 3 All are costly, burdensome and labor intensive and are additional unnecessary regulations They are also contrary to HB 2634 4. We are opposed to any rules or regs related to volunteers who do not provide actual care to residents This is very costly and burdensome and an additional regulations since you have proposed a change to the definition of the term "volunteer". Respectfully submitted by Sun Valley Lodge 2/22/13

3. Has anything been left out that should be in the rules?

No Response

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Respondent Type: Normal Response**Collector:** New Link (Web Link)**Custom Value:** empty**IP Address:** 68 14 252 70**Response Started:** Thursday, February 21 2013 1:30:28 PM**Response Modified:** Thursday, February 21, 2013 1:31:11 PM**1. What parts of the draft rules do you believe are effective?****No Response****2. How can the draft rules be improved?**

Sun Valley Lodge is submitting the following comments related to the proposed most recent revisions to the Nursing Care Institutions requirements as outlined in the 2/2013 document for Title 9 Chapter 10, Article 4: 1) Page 9 R9-10-403 A. 2 We are not for profit. It is not practical or reasonable to have our voluntary Board of Directors approve all of our policies. Volunteer Board of Directors would exit not for profit facilities if this requirement is kept as written. Please re-insert the words "or designate an individual to approve." 2) Page 16 Item(s) R9-10-406 A. ii, f & g. Pertaining to meeting screening requirements. It is recommended that the term if applicable be added to item g. 3) Page 16 R9-10-406 11 f. & g. We are opposed to requiring all employees to be fingerprinted. This is the exact opposite of the legislature's mandate to DHS to reduce regulations and costs. This would be a terrific financial burden to us. We can't afford this. Not only the one time huge cost but at every employee turnover. Hopefully, we are misunderstanding your intent. Please clarify your intent on this issue. 4) Page 16 Item R9-10-406 A. h. i. Regarding feeding assistant requirements. There is a typo. The statement should read Completion of the nutrition. . 5) Page 20 R9-10-409 A. 1. a, b, c, d. & g. All are costly burdensome and significant additional regulations which run counter to the legislature's directive to DHS. Letter e and f are ok. 6) Page 21 R9-10-409 B. Why are these rules here? I would believe that NCI's are sending facilities only. Please clarify. 7) Page 22 R9-10-409 C. 1. b and d. We are opposed to the RN requirement. The word nurse is sufficient and less costly to the facility. Please change this like you did for the transport section. 8) Page 27 R9-10-411 C. 13 e. i. & ii. The requirement for an assessment of the patient before a psychotropic medication is administered and the effect of the medication administered to be documented each time the medication is administered for a chronic condition is burdensome and duplicative. The effectiveness and need for the medication is addressed in the Care Plan and Care Conference process and always immediately when a patient's behavior or condition has changed. The Care Plan process is designed to evaluate and trial decreasing or removing psychotropic medications in relation to the resident's behavior over time which is documented in other areas of the medical record including nursing notes, physician progress notes, and behavior records. The requirement should be reworded to apply to a newly ordered/administered medication only. This requirement should be imposed only for medications offered on a PRN basis to assess if the PRN intervention was effective and appropriate. 9) Page 28 R9-10-412. B. 1. The need to establish a document that specifies the types and numbers of nursing personnel necessary to provide nursing services to residents based on the residents' comprehensive assessment is extremely burdensome, unnecessary and costly. The facility is already obligated and required by rule to have "sufficient" nursing staff to appropriately care for the residents. The number of nurses needed is a judgment of the Director of Nursing based on not only resident assessment(s) but on the resources of the facility, admissions, transfers and discharges, length of stay, and any other contributing factors that can impact the workload and responsibility of a nurse. Setting a policy has the potential to have a negative impact on our residents based on an arbitrary number assigned that does not consider other factors that also contribute to workload and ability to provide safe, quality resident care. 10) Page 33 R9-10-415. 5. b. & c. In the event of an emergency medical condition b) a registered nurse in the resident's assigned unit or the nursing care institution's administrator will be contacted. Again, the requirement that it be a registered nurse should be revised to a nurse. It is not unusual for an LPN to be on duty for the evening or night shift without an RN on site. Also, the administrator should be removed from the list of who to contact. The administrator is non-clinical and should not be responsible for appropriately responding to clinical information without understanding the urgency of the information or the clinical significance of the information to the resident. Also, can you please respond as to when the most recent revisions to Title 9, Chapter 10, Article 1 General will be available for review and comment. Respectfully submitted, Michael Fahey, Administrator Sun Valley Lodge February 21, 2013

3. Has anything been left out that should be in the rules?**No Response**

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Collector: New Link (Web Link)

Custom Value: empty

IP Address: 24 249 167 201

Response Started: Thursday, February 14, 2013 8:32:06 AM

Response Modified: Thursday, February 14, 2013 8:33:52 AM

1. What parts of the draft rules do you believe are effective?

No Response

2 How can the draft rules be improved?

Draft rules for freezer temperature of zero, pork cooking temperatures of 160 F, and hot holding temperatures of 140 F are in conflict with the food code 9 A.A C 8, Article 1 and are not evidenced based They are also in conflict with the 2009 FDA food code. <http://www.fda.gov/food/foodsafety/retailfoodprotection/foodcode/foodcode2009/> It is recommended that "frozen foods shall be frozen," that ground pork be cooked to 155 F for 15 seconds, that whole pork like steaks, roasts, and chops be cooked to 145 F for 15 seconds and that hot holding temperatures be set at 135 F This is from the FDA 2009 model food code which is current and evidenced based.

3. Has anything been left out that should be in the rules?

Following is a summary of food temperature recommendations from Chapter 3 of the 2009 FDA Food Code Temperatures for Holding Food that Needs Time and Temperature Control for Safety (TCS)* Store TCS hot food at 135 degrees F or higher• Store TCS cold food at 41 degrees F or lower• Store frozen food at temperatures that keep it frozen * TCS foods most likely to become unsafe are milk, dairy products, meat (beef, pork, and lamb), fish, baked potatoes, tofu and soy protein, sliced melons, cut tomatoes, cut leafy greens, shell eggs (except those treated to eliminate Salmonella spp), poultry, shellfish, crustaceans, heat treated plant food such as cooked rice, beans, and vegetables, sprouts, sprout seeds, and untreated garlic-and-oil mixtures

Cooking Requirements for Specific Types of Food Minimum Internal Temperature Type of Food 165 degrees F for 15 seconds • Poultry – including whole or ground chicken, turkey, or duck• Stuffing made with fish, meat, or poultry• Stuffed meat, seafood, poultry, or pasta• Dishes (leftovers+) that include previously cooked TCS ingredients (raw ingredients should be cooked to their minimum internal temperatures) 155 degrees F for 15 seconds • Ground meat – including beef, pork, and other meat• Injected meat – including brined ham and flavor-injected roasts• Mechanically tenderized meat• Ratities - including ostrich and emu• Ground seafood – including chopped or minced seafood• Shell eggs that will be held for service 145 degrees F for 15 seconds • Seafood – including fish, shellfish, and crustaceans• Steaks/chops of pork, beef, veal, and lamb• Commercially raised game• Shell eggs that will be served immediately 145 degrees F for 4 minutes • Roasts of pork, beef, veal, and lamb• Roasts may be cooked to these alternate cooking times and temperatures depending on the type of roast and oven used: 130 degrees F 112 minutes 131 degrees F 89 minutes 133 degrees F 56 minutes 135 degrees F 36 minutes 136 degrees F 28 minutes 138 degrees F 18 minutes 140 degrees F 12 minutes 142 degrees F 8 minutes 144 degrees F 5 minutes 135 degrees F • Fruit, vegetables, grains (rice, pasta), and legumes (beans, refried beans) that will be hot-held for service

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Respondent Type: Normal Response**Collector:** New Link (Web Link)**Custom Value:** *empty***IP Address:** 24 251 234 146**Response Started:** Tuesday, February 12, 2013 2:53:25 PM**Response Modified:** Tuesday, February 12, 2013 2:56:16 PM**1. What parts of the draft rules do you believe are effective?****No Response**

2. How can the draft rules be improved?

Reviewed food service regulations. If it is changed to meeting the DRIs allow dietitians to continue to use a pattern and do not require complete nutritional analysis of the menu by computer. This change will require an excessive amount of fiber which will decrease intakes of protein and could lead to malnutrition. Allow a range in meeting these requirements in the elderly

3. Has anything been left out that should be in the rules?**No Response**

4
Answers NCI

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Respondent Type: Normal Response

Collector: Health Care Institution Licensing
Rulemaking (Web Link)

Custom Value: empty

IP Address: 24 248 4 100

Response Started: Monday, February 4, 2013 10:37:34 AM

Response Modified: Monday, February 4, 2013 10:38:15 AM

1. If you have any comments or concerns about the rulemaking process or general comments about the rules, please provide your comments or concerns below:

Request: Allowance of an RN to serve as both administrator and DON for a facility 60 beds or less Rationale: Smaller facilities that are licensed for 60 beds or less typically run less than 60 as a yearly census average. The costs involved with maintaining both roles for smaller places is a tremendous financial burden and often having two individuals in smaller places does not necessarily ensure higher quality care, actually the opposite may occur. The code allows for an Administrator to manage two locations up to 25 miles apart, this seems in reality far more concerning, understanding the Administrator is not providing oversight to each place on a daily basis in a meaningful way, than allowing an RN who may possess a license to manage one small facility. A more streamlined organization of authority and decision making works best in smaller facilities. If allowed, organizations would need to apply and the state could implement safeguards to monitor situations via waiver approval process. Possible Suggestions: A facility may allow an RN to serve as both the Administrator and DON in facility with 60 beds or less provided: 1. An RN may serve as both the Administrator and DON provided the RN does not work the floor as a nurse or under another CMS waiver, the RN possesses a current Administrator's license, and 2. The facility apply for a waiver to allow the process 3. The governing body provide oversight to ensure proper management 4. Waivers are applied for yearly and are based on survey results, complaints and citations. Meaning, if an organization is mismanaged, it should turn up in the survey and complaint process. A waiver could be denied if the state feels the facility has too many issues in management area to be effectively and safely operated, thereby enforcing an Administrator and a DON to be appointed. Waiver criteria would not need to be complex or provide more of an administrative oversight burden to the state if based on current licensure and survey practices. Another possible addition if the issue of daily management is a question or concern. The facility appoints an ADON during the time the RN is serving in both capacities. 5. Or all of the above if the state believes safeguards are warranted

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[Go »](#)**Respondent Type:** Normal Response**Collector:** New Link (Web Link)**Custom Value:** empty**IP Address:** 68 14 252 70**Response Started:** Saturday, January 26, 2013 1:58:02 PM**Response Modified:** Saturday, January 26, 2013 2:00:11 PM**1. What parts of the draft rules do you believe are effective?****No Response**

2. How can the draft rules be improved?

Sun Valley Lodge is submitting our comments regarding the proposed rule changes that DHS is considering for nursing care institutions. We are submitting comments on Title 9, Chapter 10, Article 4 Nursing Care Institutions, and we are also submitting comments on Title 9, Chapter 10, Article 1, General. Here are our comments on the proposed rule changes for Article 4 Nursing Care Institutions: 1. R9-10-406 Pg. 15 #9 a & b The read date and the Dr note for T B. requirements in not consistent with Article 1 General pg 26 which says before or after anniversary date. 2. R9-10-409 Pg 19, 20 & 21 A 1 a, b, c all burdensome, costly and unnecessary. For letter c it also mentions R N. What if an R N. is not on duty? A 1 d & e are Ok; A 1 f is not reasonable at all and again R N. is mentioned. All of #2 is burdensome and unnecessary. B 1 a, b & c is burdensome and unnecessary; c mentions R N.; d & e are ok; #2 on Pg 21 all is burdensome and unnecessary and mentions R.N.; Pg 22 2 b i is not practical. 3. R9-10-411 C Pg 26 1 c, d & e are not necessary. 4. R9-10-415 Pg 31 #5 What is an R.N. is not on duty? 5. The word volunteer is used throughout this article. The proposed definition is not acceptable. We are not opposed to using the term throughout this article as long as it only applies to individuals who are providing care for no compensation. Respectfully, Michael Fahey, Administrator, Sun Valley Lodge

3. Has anything been left out that should be in the rules?**No Response**

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Respondent Type: Normal Response

Collector: New Link (Web Link)

Custom Value: empty

IP Address: 70 166 177 162

Response Started: Friday, January 25, 2013 12:16:07 PM

Response Modified: Friday, January 25, 2013 12:17:37 PM

1. What parts of the draft rules do you believe are effective?

As a SNF provider of care in Arizona I am pleased to see our state moving to an "integrated rule" that will finally acknowledge those of us who provide behavioral care or behavioral health (the definition remains murky) based in current rule. We do have concerns but believe that the collaborative nature of our work will allow us to work the details out.

2. How can the draft rules be improved?

As an overview statement that pertains to Maravilla Care Center specifically is that the proposed rule doesn't take our community into full view. The community truly serves the SMI population and has been defined as a go to place for the true SMI's that may not need to next level of care – acute psych. As I have spent more time with the draft rule and the specific language throughout I am concerned that the intent of an integrated model is coming across more piecemeal than integrated (I speak to these issues in the body of this response) Definition of what constitutes "behavioral health" versus "behavioral care" is critical as it truly is at the crux of this integration of rule. The idea that admitting a resident under a Court Order for Treatment may be a broad brush stroke as many facilities in AZ admit COT, not just those that advocate for the behavioral health of the resident. This definition also needs to be in line with what the AHCCCS system see's as a payer for the services. In this light the players become even broader, an example will be Maricopa County and its search for a new Regional Behavioral Health Authority (RBHA) and how they will fit into any final form of the integrated rule. With this integration the question also becomes (emphatically), "who will be in charge?" As a SNF under the current rule we answer to CMS and 42 CFR; as well as the state rules As I read between the lines I read that the survey process would be conflicted, especially in the domain of "residents rights" (more specifics contained below) With a potential change to "behavioral" who will this fall to as according to the mandate we will be "licensed to the highest level of care provided." We also know that CMS does not address the specific needs of the behavioral population – we have done a darn good job in fitting these special folks into the system that does not have accommodation But I beg the question of does the draft rule as written understand the population we serve Define better the role of what a "behavioral tech" is versus a C.N.A who has received appropriate education to meet the needs of the behavioral resident In our community we utilize The Mandt System as our core philosophy treating people with respect and dignity I can not stress enough how strongly I believe that we must have integration that ensures that those living with mental illness receive the continuity of care, have a true medical home and not have to be "turfed" between players in their lives. I need to know that this integration is a benefit for my company; Maravilla Care Center alone employs 298 associates In all there must be a place for people to live a high quality of life while they deal with their mental and physical health.

3. Has anything been left out that should be in the rules?

The sections of the draft that deal specifically with the transport; transfer, clinical lab, radiology, respiratory and rehabilitation are currently written in a very prescriptive format with many "shalls;" this level of prescriptiveness is not reflected in other areas of the draft. As I understand we are moving to these integrated rules to establish another level of efficiencies and provide a more effective way to meet the needs of our Arizona citizens.

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Respondent Type: Normal Response

Collector: New Link (Web Link)

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IP Address: 63 151 254 142

Response Started: Thursday, January 24, 2013 3:18:51 PM

Response Modified: Thursday, January 24, 2013 3:21:05 PM

1. What parts of the draft rules do you believe are effective?

~~~~~ 1) What Parts of the SNF Draft Rules do you feel are Effective? The Arizona Health Care Association represents the vast majority of licensed skilled nursing facilities in the state, and I appreciate the opportunity to weigh in. It is our belief that the intent of the rule revision to create an integrated licensure is a positive effort. The "devil is in the details" as they say, and we have some real concerns about the details. That said, we are committed to collaboration and cooperation at every level and pledge our full support to implementation of all rule and law.

## 2. How can the draft rules be improved?

2) How Can the SNF Draft Rules be Improved? • Further review, analysis and stakeholder dialogue related to the behavioral health component. We are deeply concerned that there is a lack of understanding in the draft about the current environment of behavioral care provided in the SNF setting and whether or not this is currently "behavioral health" care. In some cases it meets the definitions in other situations, it is not the case. We have been driven to this model through the role managed care plays in directing such patients to the SNF setting. Since over 90% of patient care is reimbursed by CMS and AHCCCS. In reading through the current draft there seems to be a disconnect about the differences between the two levels of care (specialty behavioral care which often involves geriatric- psych patients) and behavioral health. We also believe that the principles of licensure and the survey process for SNF at the federal level, and the state behavioral health rules portray a vastly different picture of guiding principles in such areas as resident rights. The CMS survey process "trumps" all others, and how could we be held accountable for conflicting behavioral health rules? We feel there is a lack of clarity in this realm and that there has been insufficient dialogue at a stakeholder level, as well as between the managed care health plans and AHCCCS. Though we have participated in the behavioral health rule workgroups, it is as though the current complexities of the SNF environment are not yet reflected in this draft. I am quite uncertain that facilities would know whether or not to participate in an integrated licensure format for behavioral health. They are currently reimbursed for behavioral care by the Plans and there are no indications that the Plans would be willing to pay behavioral health rates. The administrative burden of additional requirements that may be contrary to SNF rules is an added disincentive. I feel strongly this discussion should be continued. • The massive detail added in sections R-10-409 and 415-418 should be reduced or eliminated. Though we recognize that the sections on TRANSPORT, CLINICAL LAB, RADIOLOGY, RESPIRATORY and REHABILITATION were added for uniformity, I am shocked by the degree of detail that is included. If I may say, this all feels very contrary to Director Humble's recognized leadership philosophy of common sense and flexibility -with clear focus on outcomes. These sections read like best practices rather than minimum standards, and will be crippling, time consuming and costly to survey in an inspection process. They are neither inclusive of all the services we provide (dialysis for example) or reflective of innovations that may be around the corner to streamline efficiency and effectiveness. This is not an improvement in the rule. If there is a need for greater accountability, I am supportive of that, but there should be a reasoned approach with rule that will not require constant, costly revision in the years ahead. Other Specific Concerns: R9-10-402 Regarding the application requirements: this list of services is not accurate or exhaustive, should we also cite behavioral care, hospice, dialysis, behavioral health if not secured? Clarification needed. R9-10-403 Administration- would appreciate clarification on A 5 regarding the absence of and administrator for 30 days. A 9 is also unclear regarding who approves contracted services. This is currently in the scope of service of the administrator. E.7 references incident reporting and we all agreed that this needs further clarification or perhaps just policy direction from DHS. R9-10-406 Personnel and Staffing #2. Leaves direct care in, and # 4 takes it out. Please clarify. The definition of a volunteer in # 8 was identified as an issue. We ask for as much flexibility to maintain community support and involvement without additional administrative requirements. This is also referenced in #10. R9-10-410- 2 e References the choice of the resident's physician. Though we do not disagree in principle, in reality the majority of patients receive an assignment of a physician by their managed care plan. There is effectively no "choice" except for the private pay patient, a very small disappearing minority of the population served by most skilled nursing facilities. #2 O discusses the medical record- is there a required time frame? R9-10-414 Behavioral Health. This speaks directly to some of our confusion about the behavioral health component and whether CNA's will be behavioral health technicians - and if this will be in behavioral care sections of a facility or only licensed behavioral health sections. How will these two sets of services coexist in the same facilities, and will facilities currently providing behavioral care will be forced to license as behavioral health. R9-10-419 Medication Services B 5 references a 3 month review of a residents medications. This does not take into account the growing population of short term transitional care patients we serve, many who are in our facilities for less than 2 weeks. R9-10-420 Food Services section C d ii References only a common area for feeding assistance. We would recommend that there be a revision stating "within the direct supervision of a nurse" rather than referencing an actual space such as a 'common area". This is in keeping with the culture change espoused by CMS that has evolved since the passage of this legislation in 2005 and protects the dignity of resident and patient safety by ensuring the necessary clinical supervision and support is at hand. Also, under NUTRITION FEEDING ASSISTANT TRAINING PROGRAMS We understand from our questions at the meeting that a facility can be designated an "agency" and apply for training but this is unclear in the reading of the draft. Also, RN is left off the list of trainers under I #2. R9-10-422 Environmental Standards #3 needs to address Arizona law indicating no smoking is allowed indoors. R910-423 Safety Standards A 2 regarding oxygen signs, we ask that this be corrected in accordance with life safety NFPA standards.

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**3. Has anything been left out that should be in the rules?**

3) Has Anything Been Left Out of the SNF Draft Rules? R9-10-410 1 A We are uncertain why the section stating that "a resident is treated with consideration dignity and respect" was struck This is a guiding principle of SNF licensure and we believe it is important and should remain in rule R9-10-412 14 and 15 We are uncertain why the reference to medication errors and unnecessary drugs was struck This is a continued focus of every SNF and part of our quality management and the inspection process. Kathleen Collins Pagels, Arizona Health Care Association kcpagels@azhca.org

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Better clarification in the definitions, removing the chest x-ray option from the documentation options for showing freedom from infectious pulmonary Tb,

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**2. How can the draft rules be improved?**

Further clarification if the governing authority can be the person as the one who holds the administrator position (R9-10-403 D.1), Resident Rights regarding R9-10-410 2 e striking the resident responsible for the costs associated with services provided by medical services of the attending physician or designee, does this imply that the facility would be responsible for the costs, even if the facility is an all private pay, not medicare certified,

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**3. Has anything been left out that should be in the rules?**

No Response

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IP Address: 69 242 224 235

Response Started: Tuesday, January 15, 2013 7:29:40 PM

Response Modified: Tuesday, January 15, 2013 8:20:24 PM

**1. What parts of the draft rules do you believe are effective?**

No Response

**2. How can the draft rules be improved?**

R9-10-406: Please review the rules for "volunteers" To put all volunteers through orientation to the nursing care institution policies and procedures seems excessive Especially if their volunteer duties are very limited, such as our lady who comes in to give communion to Catholic residents once a week R9-10-406-A4: Retain the descriptive phrase "who provides direct care" in the definition of personnel who must attend 12 hours of in-service every 12 months R9-10-409 Transport/Transfer - needs to include medical emergency exception (911 calls) This section is much too detailed and proscriptive to be put forward as a minimum standard for health care services It needs to be more broadly defined to address the issues that DHS is experiencing, e.g., patients being dropped off outside or lack of communication between transferring and receiving facilities R9-19-415/416/417/418 The sections on lab/radiology/respiratory/rehab are far too proscriptive in their detail for rules that are supposed to provide a minimum baseline for health care services All Skilled Nursing facilities provide these services (except for professional respiratory services, which are commonly provided under the nursing scope of practice).

**3. Has anything been left out that should be in the rules?**

R9-10-403-A 2 : Consider retaining the language: "or designate an individual to approve" the nursing care institution policies and procedures to allow Administrators to continue to function as local representatives of the governing authority, similar to A9 which states that such a "designated individual" can approve contracted services This would provide consistency in this section. R9-10-415 Add CLIA waiver information R9-10-422-3: Add Tobacco smoking only permitted 20 feet outside. R9-10-423-2: Consider allowing signs at entrance to facility that states oxygen is in use in this facility, rather than requiring individual room signs This complies with current NFPA code. R9-10-424-5 Consider revising to clarify that hand-washing/disinfectant is necessary only after actual resident "contact", i.e., if passing medications and nurse does not actually touch resident there would be no need for hand-washing, etc