

JANICE K. BREWER

GOVERNOR



ARIZONA STATE VETERAN HOME
4141 NORTH S. HERRERA WAY
PHOENIX, ARIZONA 85012
PHONE (602) 248-1550

ROBERT BARNES

INTERIM DIRECTOR

May 2, 2013

Ms. Kathryn McCanna
Arizona Department of Health Services
Division of Licensing Services
Bureau of Medical Facilities Licensing
150 N 18th Ave , Suite 405
Phoenix, AZ 85007-3248

Dear Ms. McCanna;

I am writing to comment on the proposed draft rules found in Title 9, Chapter 10. My comments are as follows:

1. R9-10-403 Administration Section A. Number 7. Subsection a reads "Expected not to on the nursing care institution's premises for more than 30 calendar days, or"

Suggestion: Fix grammatical error to read "Expected not to be on the nursing care institution's premises for more than 30 calendar days, or"

2. R9-10-403 Administration. Section D. Number 4 reads "develop a written report of the investigation within 48 hours..." Section D. Number 5 reads "Submit a copy of the investigation report to the Department within 48 hours..."

Suggestion: 48 hours does not allow sufficient time to do a thorough investigation into an allegation of abuse, neglect and exploitation. The CMS nursing home regulations allow 5 working days to submit the report to the state. I respectfully request more time to complete a meaningful investigation.

3. R9-10-403 Administration. Section E. Number 1 states "an administrator shall provide written notification to the Department: within one working day after a resident's death".

Suggestion: I respectfully request that such notifications be solely for those residents who die unexpectedly or as a result of an untoward incident such as a fall. My facility has an average of 10 resident deaths each month. This requirement will place a burden on staff time and the associated costs in lost time and resources from competing needs.

Thank you for your consideration of my comments

Sincerely,

A handwritten signature in cursive script that reads "Colleen Rundell".

Colleen Rundell, M S., LNHA

Received
MAY 10 2013
Medical Facilities Licensing

THE NELSON LAW GROUP ★
PLLC
LAW, CONSULTING, & GOVERNMENT SOLUTIONS

May 10, 2013

Mr. Richard Young
Arizona Department of Health Services
Division of Licensing Services
Bureau of Long Term Care Licensing
150 N 18th Avenue, Suite 440
Phoenix, Arizona 85007-3248

Re: Outpatient Services in a Nursing Care Institution

Dear Mr. Young,

We are writing on behalf of Sante Chandler, LLC, Scottsdale OP CO, LLC, Asante of Mesa, LLC, and Asante TRC of Surprise, LLC to provide comments on the proposed rules for nursing care institutions. During past discussions, we requested that the Department allow nursing care institutions to provide outpatient services to recently discharged residents and to patients being discharged from nearby hospitals, as permitted by Medicare and other states. The existing rules do not *prohibit* nursing care institutions from providing outpatient services, but the Department has interpreted its rules to not allow this practice because the rules do not *explicitly* state that nursing care institutions may provide outpatient services. In order to meet community needs and to be consistent with Medicare law on this subject, we request that the Department add language to the proposed rules expressly allowing nursing care institutions to provide outpatient services.

Giving patients the choice to continue receiving services in the same location and from the same professionals who have been providing services during the patients' residency in a nursing care institution greatly benefits the patients. Unfortunately, discharged patients who need to find alternate therapy sources often feel discouraged about starting the therapy process with someone new and elect to do nothing at all. Studies show that patients who are discharged to a home setting have an average decline in function of 10% if they do not continue physical therapy. These declines can result in patients being readmitted to a hospital setting. Medicare recognizes the detriment to patients and the cost to government programs from high readmission rates and is therefore focusing on reducing hospital readmission rates. Being afforded the opportunity to work with therapists a patient already knows increases the likelihood that the patient will continue therapy, thereby aiding the patient's recovery and decreasing hospital readmission rates.

Furthermore, allowing nursing care institutions to provide outpatient therapy provides cost savings to patients and government programs. After relatively short stays in the Sante nursing care institutions, many patients are able to return to their homes so long as they have the opportunity to receive ongoing therapy services. Allowing the patients to obtain the therapy services they need from their existing health care provider in a nearby and familiar setting that is focused on patients with their specific needs gives those

patients the freedom to be discharged as early as possible and saves financial resources that would otherwise be expended on inpatient stays.

Most outpatient treatment centers cover a wide range of therapy needs rather than specializing in one particular area. The Sante nursing care institutions have state-of-the-art therapy gyms with equipment specifically designed and calibrated for the geriatric population and their unique uses. Additionally, the skilled professional staff in the Sante nursing care institutions are trained and educated to work with a geriatric population. Because the Sante nursing care institutions can provide specialized care to a specific patient population, patients in the community ask the facility to provide outpatient services. Unfortunately, these patients are turned away due to the Department's licensing interpretation. Revising the nursing care institution rules to allow these specialized existing resources to be utilized by the surrounding community is a great benefit to patients.

Other states recognize the many benefits of allowing patients to receive outpatient services from licensed nursing care institutions and therefore allow these services to be provided under nursing care institution licenses. Medicare similarly recognizes these benefits and therefore allows skilled nursing facilities to bill for outpatient services under their Medicare provider numbers (without requiring the skilled nursing facilities to obtain a separate provider number for outpatient services). Accordingly, we respectfully request that the Department support patient choice and efficient access to health care, consistent with existing Medicare policy and other states' laws, by allowing licensed nursing care institutions to provide outpatient services.

Please let me know if you have any questions or need further information.

Sincerely,

A handwritten signature in black ink that reads "Mayan Tahan". The signature is written in a cursive, flowing style.

Mayan Tahan

“ NCI ”

Response to Nursing Care Institutions Proposed Rules, April 2013 Draft

In response to the question “Has anything been left out that should be in the rules?”

According to 42 USC § 1395i-3(e)(3) “the State, for transfers and discharges from skilled nursing facilities effected on or after October 1, 1989, must provide for a fair mechanism for hearing appeals on transfers and discharges of residents of such facilities ” Please include rules related to this appeal process in the NCI Rules

Submitted by:

Teresa Teeple, State Long Term Care Ombudsman, Arizona Department of Economic Security

DHS Integrated Rule – Open Comment Forum
Wednesday, April 24, 2013

Having been a member of the Nursing Care Institutions Integration Rulemaking Workgroup my concerns related to the current draft rule are significant.

During the single “workgroup meeting” it was made clear that the Law 2011, Chapter 96 was passed in part to reduce monetary or regulatory costs on persons or individuals and to streamline the regulation process. And The Integration Plan will “provide regulatory consistency for all health care institutions” and “integrate behavioral and physical health services licensing...” It was also mentioned that the goal of DHS was to minimize extraneous reporting to the department → falls reporting, etc.

In reviewing and studying Draft 3 of the rule it appears that the previously mentioned items are not a part of the rule.

The rule was initially discussed with the workgroup as a “voluntary process” and the language reflected this in “Supplemental Application Requirements” and was carried forward through Draft 2. In the current draft it is no longer a voluntary option but compulsory for licensure. Why the change in language?

How will these actions be in compliance with the Law 2011, Chapter 96 related to “streamlining the regulatory process?” I am interpreting that the burden will be greater as the potential that survey has been expanded to include two licensing agencies; if behavioral health is a licensed component of the community’s overall license.

In order to truly integrate behavioral and physical health services, as defined in the rule, the definition between “behavioral health” versus “behavioral care” needs focus. The portion of the overall rule dedicated to “Behavioral Health” **R9-10-414** is the shortest rule, a mere 10 lines.

And the idea of “minimizing extraneous reporting to the department” has been negated in **R9-10-403** with the mandated “death” reporting.

In conclusion, it is my opinion that the current Draft 3 of the integrated rule falls short of what Law 2011, Chapter 96 mandated and actually adds additional cost to the State of Arizona and regulatory burden to the providers in the State of Arizona.

Thank you.


Jeffreys B. Burnett
CEO
Maravilla Care Center

Current and DRAFT Rules:

The current NCI Rules under R9-10-904.D 4. require (as you know) that an administrator shall ensure the nursing care institution's compliance with the fingerprinting requirements in A.R.S. §36-411

The new DRAFT rules under R9-10-406 E 3 c. require that a personnel record for each employee, volunteer. And student contain as applicable, documentation of compliance with the requirements in A.R.S. §36-411

A.R.S. §36-411:

This is the statute that identifies the basics of fingerprinting for NCIs. And as such, sets the basis for individuals getting fingerprinted by their licensing boards, as well as individuals working at the same facility not needing to be fingerprinted again if they remain at the same facility when their card expires.

The Concern:

In a recent survey, the facility is reporting that they are going to be cited based on a memo they were given dated July 9, 2009. The facility is saying that they are being cited because a nurse got her fingerprints back in 2001 at the Board of Nursing, and not the facility was obligated to get her re-fingerprinted because she got her license renewed. The memo is not signed but refers the changes that were made in 2009 regarding the two-tiered level cards and the need for individuals to be re-fingerprinted to get a level 1 card. It also refers to changing 20 days to 7 days for compliance. I was still at ADHS when this was in the process and resulted in Senate Bill 1049. Most of this bill relates to child care licensing. But most importantly, in the very first page of this bill – it lists all the statutes and/or amendments that are affected by SB 1049. A.R.S. §36-411 is not amended by Senate Bill 1049. Therefore the requirements for NCIs regarding fingerprinting are governed by A.R.S. §36-411 which is NOT amended by the Senate Bill 1049 from 2009.

The July 9, 2009 memo also refers the reader to go to www.azdhs.gov/als for further information. This is the main page for licensing and if you go to LTC licensing – the only documents are the substantive policy and frequently asked questions that have been in place since the original fingerprinting rules and statutes were created.

Please review these requirements, and if there is something I am missing, then I would appreciate knowing as soon as possible. I recognize that all of the convoluted rules regarding fingerprinting do not always make the most sense. However, to start citing facilities now in 2013 for a requirement that was created in 2009 that does not even apply to NCIs is just not right.

I appreciate you checking this over, and making sure I am not missing something Richard.

As always, thanks for all you are doing

Sincerely,

Sylvia



CHAPTER 10 – ARTICLE 4

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Respondent Type: Normal Response**Collector:** Web Link (Web Link)**Custom Value:** empty**IP Address:** 24 251 70 186**Response Started:** Sunday, May 5, 2013 7:39:37 PM**Response Modified:** Sunday, May 5, 2013 7:49:22 PM**1. What parts of the draft rules do you believe are effective?**

It's commendable that the rules are being updated and that changes will promote the collaboration among long-term care providers.

2. How can the draft rules be improved?

The draft rules can be improved by emphasizing the vital links between a resident's quality of life, psychosocial care, and medically-related social services that are provided by an MSW prepared social worker. Person-centered care is now the expectation, not the exception, for meeting residents' and patients' individualized needs in long-term care facilities. Achieving person-centered care requires multidisciplinary staff skilled in many areas. The social worker is a core practitioner on any interprofessional team, but currently in Arizona nursing homes, many social work positions are filled by individuals who do not have a social work degree, have not had social work training, and are not being supervised by an experienced, degreed social worker (Bonifas, 2009). According to the current federal guidelines, almost anyone can work as a "social worker" in a long-term care facility. The definition of a qualified social worker does not mandate an actual social worker and, in fact, allows persons from a host of different backgrounds to work in a social work position. Furthermore, the federal regulations for a "qualified social worker" only apply to facilities licensed for greater than 120 beds. This arbitrary delineation based on a random number of beds is ill-advised, unethical and must change. Residents and patients in smaller facilities experience the same challenges, the same emotional pain and suffering and complexities of multimorbidities as residents in larger facilities (NASW, 2004). Just stating that the facility is still required to provide medically-related social services for these smaller facilities has resulted in even more untrained and unqualified social services staff attempting to meet these residents' often complex psychosocial needs. Right now, with these proposed rule changes, Arizona has the opportunity to demonstrate commitment to ensuring that our long-term care residents receive the deserved and outstanding psychosocial care to which they are entitled and to set an example for other states. Currently, the biopsychosocial-spiritual needs of many Arizona residents and patients continue to go unmet. Unfortunately, even in facilities with 120 beds and more, many of the individuals hired to work in a social work capacity do not have a social work degree, do not have social work training, and are not supervised by a qualified, degreed social worker with long-term care experience. A person calling themselves a nurse would never be allowed to even apply for a nursing position. A person licensed as an LPN would never be hired as an RN. By law, it is required that a Director of Nurses be an RN. The time has come that we demand the same attention to qualifications and training for social workers. The psychosocial needs of facility residents and patients require the level of attention and skills equivalent to physical health needs (Simons, Bern-Klug, & An, 2012). Just like a nurse can cause a patient or resident harm, so can social workers and individuals acting in a social work capacity. While it may not be as overt as a drastic medication error or a wrong treatment, social work staff, and especially people providing social work services without a degree and proper training, can cause psychological, emotional and mental harm to patients, residents and families. Here are just a few examples of the situations that are common in nursing homes: a much younger population of residents that requires staff with specialized training and behavioral health skills to address issues like sexuality, substance abuse, thwarted progression of normal developmental stages; family crises such as disagreement regarding the plan of care requiring negotiation and skillfully facilitated discussions; patients with advanced stages of illness such as cancer, Huntington's chorea, dementia, and strokes - all which require skilled social workers with substantive knowledge and skills to address the complex psychosocial needs to achieve constructive outcomes (Simons et al, 2011). It is unthinkable, not to mention against the law in long-term care, for a non-nurse to administer medications, to change a dressing, to hang an IV, or to complete an assessment of systems. Yet, non-social workers, and other individuals with no training in social work, are allowed to complete psychosocial assessments, facilitate family meetings with feuding family members, attempt to counsel individuals suffering with grief stemming from a terminal illness, implement a behavioral plan for a resident with a mental illness, assess for suicidality, and initiate difficult discussions regarding advance care planning. The residents and patients in long-term care deserve more than that! They deserve to have qualified social workers at the MSW-level tending to their complex biopsychosocial-spiritual needs. They deserve the benefit of an MSW-prepared social worker, just like patients in home health, hospice, and hospital settings; the

needs of patients and residents require this level of practitioner. One of my colleagues is a clinical educator and consultant for long-term care facilities, and has worked in many different facilities throughout Arizona: small, large, for profit, non-profit, single facility, multi facility chains, rural and inner city. My colleague has seen recurrent themes and problems that give rise to great concern regarding the quality of psychosocial care being provided to facility residents and patients. While the staff are well-intended and are working their hardest to meet the multitude of regulations, run their facilities in a challenging economic environment, and provide excellent care to residents and patients. However, many situations occur that pose considerable risk to residents' emotional and psychological well-being when unqualified persons are attempting to fill the role of social workers. Below are examples of problems that my colleague has seen in long-term care facilities related to undegreed, untrained, and unqualified individuals who are not social workers, attempting to provide medically-related social services. In each of these cases, I believe the potential for the resident to suffer harm is evident. These are excerpts from many reports written over the past few years. All identifying information has been removed. These are but a few of the many examples that demonstrate the impact of people working in a social work position, who are not social workers, who demonstrate inadequacy of critical thinking skills, as well as lack of knowledge of the essential elements of effective psychosocial care from comprehensive assessment to care planning to provision of services.

Example #1 Resident alleged (per grievance report dated months earlier that was erroneously written instead of an allegation of abuse) that a CNA "moved her too fast, was not friendly and moved her bad arm too much so that it hurt." Dissatisfaction was also expressed for how the CNA dressed the resident and that the resident felt "sloppy." Per facility policy, the social worker is responsible for grievance investigations. The grievance form was incomplete. During an interview with the administrator, she stated that this resident expresses frequent complaints and that she "complains about everyone." This behavior was not care planned nor was the allegation of abuse investigated. Furthermore, the social worker reports receiving instruction by the Director of Nurses to counsel the CNA on her behavior rather than the Director of Nurses doing so, so that the disciplinary action would not result in the CNA's termination. This CNA has been counseled on previous occasions about her abusive behavior, and at the time of the consultant's report, was still employed at the facility. The administrator was not aware of this instruction from the DON, but assured the consultant that appropriate measures would be taken. At no time did the social worker demonstrate the ability to resolve this issue.

----- Example #2 Social Service Progress Notes: • 6/12/12 entry states wife works and patient will be at home alone, they can't afford caregivers and was referred to [Law Firm] to begin ALTCS. • 6/13/12 0900 entry – informed by OT that resident made a comment about wanting to kill himself and then the statement, "Dr. [Name] feels resident would not follow through with it." • 6/13/12 1600 entry from care conference – resident stated, "I was just joking. Forget about it" in reference to the statement about wanting to kill himself. Psych consult ordered. No further discussion of suicidal statement throughout rest of stay. Suicidal ideation/intent was never assessed by the social services person (who is not a social worker), facility staff, or attending physician. No one completed an assessment to include asking the resident why he made the statement, how he would try to kill himself, determine if the means were available, if he has ever made those comments before, had previous attempts, etc. Even if everyone were in agreement that a resident would not try to hurt himself, the assessment and objective documentation is crucial. Even though this resident had "behaviors" it cannot be assumed that a statement of harm is just part of those behaviors. The significant and obvious psychosocial needs of this resident went unmet.

Example #3 Excerpt from a Care Plan: Mood – Altered mood state as evidenced by self isolation and verbal and physical abuse. Goal – Will exhibit signs of socially acceptable behavior. Approaches – Encourage out-of-room activity, explain all treatments and procedures, follow the universal behavioral plan, monitor for signs of depression, and administer medications. • At no time was an assessment completed to determine the nature of the mood and behavioral problems. The social services designee's (who is not a social worker) notes do not contain evidence that any of the following questions were addressed. Why does she "self isolate?" Is it because she does not speak English or has extreme paranoia related to germs? Does she just prefer to be by herself in her room (may not enjoy group activities)? How is the self isolation a problem? How is she verbally and physically abusive? When and why is it a problem? For whom? Is the goal that she learn to demonstrate "socially acceptable behavior" realistic? If so, what does that mean? How does her culture impact this? Her psychiatric diagnosis? Who is responsible for teaching her these new social behaviors? Since it is already known that she doesn't like to be outside of her room, why is there an approach to encourage this? Does it benefit her? Are there out-of-room activities that she does enjoy? Visiting with family? Pets? How does the language barrier impact this? How does staff "explain all treatments" if her English is very limited? Does she get agitated when they approach her? Would a communication board be helpful? What input does the family offer? Does all staff know and implement the "universal behavioral plan?" Is it part of an inservice? Is it posted somewhere accessible to staff? The psychosocial needs of this resident were unmet. In contrast to the examples above in which the psychosocial needs of the residents went unmet, below is an outline of the entries in the medical record and social work actions demonstrating the value and skill set of an MSW prepared social worker. • 69 year old patient admitted to facility following lengthy hospital stay following a stroke, hip fracture and pneumonia. She has co-morbid diagnoses of schizophrenia, chronic obstructive pulmonary disease (COPD) and uses a breathing machine at night. She has moderate expressive aphasia, but is still capable of participating in decisions and can make her needs known using a dry erase board and her limited verbal skills. Her functional status prior to hospitalization was complete independence and now she requires moderate to extensive assistance with activities of daily living and is

dependent for most of her instrumental activities of daily living. She is divorced with two adult children, both of whom live locally. The patient has not completed advance directives. She was living on a limited income from social security, but was having trouble paying for all her monthly expenses. The social worker determined that the patient was receptive to visualization techniques to help address anxiety issues when she was unable to communicate her needs easily. She trained staff from all shifts how to use these interventions. The social worker added approaches to address psychosocial functioning and mood to the care plans for cognitive impairment, psychiatric illness, COPD, pain management and functional limitations, e.g. approach on left side, ensure dry erase board and pen are within reach, use visualization techniques to help relieve anxiety, use simple statements such as, "I can see you are upset. I will wait while you write what you need." The social worker facilitated complex discussions with the patient, family and interdisciplinary team regarding advance care planning and determined that the patient did not want to be a full code as had been indicated upon admission. Throughout the course of these meetings, patient was able to complete powers of attorney and a living will. The social worker assisted the patient's youngest daughter in exploring her resistance to mom's decision to be a do not resuscitate code status. The social worker met with patient many times to help her express her wishes regarding discharge planning, to explore options, to address the issues of grief that had begun to arise as patient realized the full extent of her limitations and the impact on her life and the behavioral manifestations of the psychiatric illness. The social worker helped the patient identify her strengths (the foundation of the social work perspective is a strengths approach) as well as ways to utilize these strengths given her current situation. She also communicated with the entire health care team regarding these strengths and how to help incorporate them into the daily plan of care. She followed up with staff regularly to determine how things were progressing. The social worker provided clear documentation that outlined problems, identified the plan of care, and demonstrated the patient's response to those interventions and subsequent modifications to the plan of care. The social worker demonstrated competence in her role as patient advocate while also balancing the needs and realities of the facility. She was successful in facilitating delicate conversations with the patient related to the behavioral components of her psychiatric illness and the frustration it caused staff, e.g. staff splitting, repetitive complaints. The social worker tracked the PHQ-9 scores (a depression measure) and promptly notified the interdisciplinary team when the symptoms increased and the scores changed. She met with the physician to relate the concerns. All documentation was defensible and accurate. The social worker advocated with the community behavioral case manager to ensure continuity of care and services during patient's stay in the long-term care facility. An MSW who is trained to work in the long-term care setting and demonstrate this level of skill is not only meeting the psychosocial needs of the resident, but also the expectations of the federal regulations. Examples like the one above are, unfortunately, the exception rather than the norm. But yet, this example meets the requirements according to the Federal regulations. So, why is there disconnect, a void between what the regulations clearly mandate and reality? The residents in long-term care deserve the level of expertise like this example. If the above resident were part of your family - your mother, sister, aunt or friend - I would hope she were in the facility with the MSW social worker. References Bonifas, R. P. (2009). Psychosocial care in Arizona skilled nursing facilities. Unpublished research data. Arizona State University School of Social Work. National Association of Social Workers Center for Workforce Studies. (2004). A study of the roles and use of licensed social workers in the United States. Washington, DC: National Association of Social Workers. Simons, K., Bern-Klug, M., An, S. (2012). Envisioning quality psychosocial care in nursing homes: The role of social work. *Journal of the American Medical Directors' Association*, 13, 800-805. Simons, K., Connolly, R., Bonifas, R., Allen, L., Bailey, K., Downes, D., & Galambos, C. (2012). Psychosocial assessment of nursing home residents via MDS 3.0: Recommendations for social service training, staffing, and roles in interdisciplinary care. *Journal of the American Medical Directors' Association*, 13, 190.e9-190.e15; doi:10.1016/j.jamda.2011.07.00

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

Here is what we request be included in the draft rules. Arizona has an opportunity to be a leader in the quality of psychosocial care provided to long-term care residents and patients - an example to which other states can aspire - by incorporating the following recommendations in the draft rules: 1) Mandating that MSW-prepared social workers be hired in all nursing homes. Will this be challenging? Yes, it will. But this should not deter us from putting requirements into effect that will provide residents and patients with an MSW's expertise and to ensure that their biopsychosocial needs will be met. There can be provisions or a waiver allowing facilities to apply for a waiver that can ease the transition while locating and hiring an MSW. Perhaps for smaller facilities the rule can mandate a part-time MSW. Until the rules are written that demand truly qualified social workers, as defined by an MSW degree, to provide the complex biopsychosocial-spiritual services that most individuals require in long-term care, the status quo will go unchanged and residents' psychosocial needs will go unmet. Isn't this the level of care that we would wish for our own loved one in such a situation? 2) Change the quality rating point system to allot 15 points, equal to that of nursing and medical care, for medically-related social services. Utilize the social work competencies as defined by the Council on Social Work Education for use in areas working with older adults. Refer to the information and the Competency Scale at this website: <http://www.cswe.org/Centers/Initiatives/GeroEdCenter/TeachingTools/Competencies.aspx> Also, of critical importance in delineating the role of the social worker is the article titled "Envisioning Quality Psychosocial Care in

Nursing Home: The Role of Social Work" by Kelsey Simons, PhD, MSW; Mercedes Bern-Klug PhD, MSW, MA; Sofia An, MSW This article was printed in the Journal of the American Medical Director's Association in 2012 3) Create a separate section within Article 4 that specifically addresses Social Work, just as almost every other department is listed in the draft rules, e.g. medical records, nursing services, medical services, etc. The Rules must reflect a commitment to an expectation that the social work department will consistently demonstrate professionalism and competency, just like that of Nursing Services and Medical Services. 4) Although not addressed in these comments, it is disappointing that there is not a section addressing the Activities Department in the Arizona Draft Rules. This is another very important department that staffed with qualified, trained and supervised individuals, can significantly and positively impact each resident's quality of life. Nursing homes have made commendable strides in the care and treatment of patients and residents. But, we have much left to accomplish. This starts with raising the bar so that truly qualified social workers, by degree and training, are working in every nursing home in our state. Not only will psychosocial needs be addressed, they will be tended to in a way that will actually save money by preventing avoidable complications, help prevent unnecessary hospitalizations, improve customer satisfaction, make the work place easier for staff and ultimately improve the overall well-being of our nursing homes

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IP Address: 24.251.153.14

Response Started: Sunday, May 5, 2013 1:07:48 PM

Response Modified: Sunday, May 5, 2013 1:08:55 PM

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

Food services REgulations

2. How can the draft rules be improved?

Minor name change- Registered Dietitians are now called Registered Dietitian NUtritionist (RDN)

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

No Response

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Respondent Type: Normal Response**Collector:** Web Link (Web Link)**Custom Value:** *empty***IP Address:** 24 251 153 14**Response Started:** Sunday, May 5, 2013 12:55:34 PM**Response Modified:** Sunday, May 5, 2013 1:07:24 PM**1. What parts of the draft rules do you believe are effective?**

Nutrition and Feeding Assistant Training Programs - good start!

2. How can the draft rules be improved?

I An individual in charge of a nutrition and feeding assistant training program shall ensure that: 1. The materials and coursework for the nutrition and feeding assistant training program demonstrate includes the following topics: a. Feeding techniques, b. Assistance with feeding and hydration, - DELETE ASSISTANCE WITH FEEDING THIS IS ALREADY COVERED UNDER FEEDING TECHNIQUES CHANGE THIS TO "NUTRITION AND HYDRATION" The program is called "nutrition and feeding asst trng prg" but there is no coursework on nutrition. Nutrition is vital to the feeding process, hence the name of the program. Other states have included "nutrition and hydration" as part of the coursework. Also, the addition of the Registered Dietitian as part of the group that provides the training program. RDs have the training to assist with proper feeding and hydration. This program will take a team approach to be successful, with the RD, SLP, OT, RN as key members. Several states who have implemented this have realized the benefits of the RD as part of that team. To name a few - TX, CO, MS, DE, WI, KY, NV, NJ, OK. The 74,000 member strong Academy of Nutrition and Dietetics (formerly the American Dietetic Assoc) thru the Dietetics in Health Care Communities practice group, already has the "Nutrition and Feeding Assistant's Trainer Manual" and corresponding "trainee guide" which is used in numerous states. This was made in collaboration with RDs, SLP, OTs, RNs and MDs.

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

Add RD as part of the team providing the coursework. Add "nutrition" in the coursework. It is the NUTRITION and Feeding training program after all.

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Respondent Type: Normal Response**Collector:** Web Link (Web Link)**Custom Value:** *empty***IP Address:** 24.251.153.14**Response Started:** Sunday, May 5, 2013 12:23:40 PM**Response Modified:** Sunday, May 5, 2013 12:29:23 PM**1. What parts of the draft rules do you believe are effective?**p 50. Feeding Assistant Program

2. How can the draft rules be improved?

Add as approved instructors or part of the instructor team - Registered Dietitian (RD) It takes a team to make this program successful. The RD is part of that vital team to ensure that food is accepted. Various states have included the RD as part of the Feeding Assistant Program team. In fact, the 74,000 member strong Academy of Nutrition and Dietetics - Dietetics in Health Care Communities, already has a Feeding Assistant Program Trainer's Manual and Trainee guide. This manual is widely used in various states.

3. Has anything been left out that should be in the rules?Adding RD to the Feeding Assistant Program. Thank you for the opportunity to voice comments

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Respondent Type: Normal Response**Collector:** Web Link (Web Link)**Custom Value:** empty**IP Address:** 64 88 163 125**Response Started:** Saturday, May 4, 2013 5:01:29 PM**Response Modified:** Saturday, May 4, 2013 5:10:06 PM**1. What parts of the draft rules do you believe are effective?**

My name is Faye Lincoln, Sr. Vice-President, Policy & Government Relations, for Avalon Health Care. I am responding to this section Article 4 - Nursing Care Institutions & Behavioral Health Services related to Nursing Care Institutions: Licensing. Most of my comments specifically relate to the integration of Behavioral Health Services. I can be reached via email at flincoln@avalonhci.com or by cell phone at (801) 518-6565.

2. How can the draft rules be improved?

In reviewing the proposed NCI / SNF regulations, we concur with all the formal comments provided by the Arizona Health Care Association. To avoid being repetitive, we provide the following recommendation: a) Delay the implementation of these proposed regulations and establish a small Sub-Committee of NCI / SNF representatives in the industry to provide clarity and to review the overly burdensome regulations in advance of implementation. Behavioral Health Services: We would like to address the rules in depth related to the Behavioral Health Services integrated under the NCI/SNF license. We refer you to our Survey Monkey response on Definitions as an earlier reference. We will speak to our specific comments related to the 3 types of "behavioral" residents in NCIs/SNFs: a) Individual residents with medical conditions who qualify for a NCI/SNF with underlying behavioral health issues; b) Memory care or dementia units for residents with medical conditions who qualify for a NCI/SNF and who exhibit behavioral health issues related to their dementia; c) Behavioral health units serving residents with medical conditions who qualify for a NCI/SNF with underlying behavioral health conditions which may be organic or non-organic in nature; such behavioral health issues are of a higher clinical level than in (a) or (b) above. Section R9-10-414 refers to regulations under R9-10-1011 (B) for compliance related to "Behavioral Health Services". Given the in-depth nature of the mental disorders and support required under R9-10-1011 (B), we do not believe this level of depth or service requirements are needed for either Level (a) or Level (b) above. We suggest establishing a new definition for Levels (a) and (b) referred to as "behavioral care", separate from "behavioral services". It is unrealistic to expect that the service requirements levels under R9-10-1011(B) are required for an NCI/SNF under Level (a) who serves individual residents with medical conditions and an underlying behavioral issue. SNFs and primary care physicians are experienced in serving this population. Integrating these types of inappropriate guidelines will only serve to unnecessarily and inefficiently increase costs and limit access to care for these residents. Memory Care or dementia units under Level (b) also does not require the depth and support outlined under R9-10-1011(B). We do believe that additional education and training may be appropriate, with special policies and procedures to support this type of population which ensures high quality care. While we would agree that Level (c) units require a more specialized outlined level of services and support, policies and procedures, as well as education of staff, we do not believe that the regulations under R9-10-1011 (B) appropriately address this unique specialized care in SNFs. We believe that R9-10-1011(B) apply to outpatient treatment centers that uniquely provide court-ordered acute mental health services, family counseling, group counseling, etc - services which are not routinely provided in such specialty SNF units. We also believe that R9-10-1011(B) is geared towards treating residents with primary acute and chronic mental health disorders which are non-organic in nature. A SNF with this type of unit must first ensure that residents meet the criteria for entry into a nursing care facility based on medical needs, with the resident then having an underlying behavioral disorder which may be organic or non-organic in nature. This includes advanced dementia, head traumas and brain cancer s as well as more traditional mental health diagnoses. Specialized, high level behavioral health in a SNF is often a missing link in the continuum of care between acute psychiatric or state hospital stays and the lower level residential living support programs / home & community-based programs for behavioral health issues. However, the SNF setting is unique for this level of care and should not be confused with primary care treatment centers or residential living programs serving the primary mental health population. We believe it is this level of care which will also require a specifically negotiated Medicaid or private pay rate add-on. Recommendations: 1) We would suggest that the rules related to integrated behavioral health services be delayed for implementation until greater clarity for this type of service be developed. 2) We recommend that Levels (a) and (b) not be included in the more in-depth behavioral health services and be further differentiated as "behavioral care" with generalized, regulations for Memory Care or secured units at a NCI/SNF. We believe that "behavioral health services" in a NCI/SNF should be limited to a higher level unit with appropriately adopted regulations to serve this unique setting. 3) We recommend that a specialty Sub-Committee work with the Dept. of Licensing in the coming

months to assist in establishing reasonable guidelines for differentiating "behavioral care" from "behavioral health services" which make sense for a NCI/SNF setting 4) We would also recommend that the Dept of Licensing, with the Sub-Committee, look more closely at R9-10-114 for behavioral health technicians and behavioral health paraprofessionals and ensure these groups fit appropriately into the NCI/SNF setting

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

We refer to the breakout of Levels (a) and (b) for "behavioral care", differentiating from "behavioral health services" which maintains a different standard of care. This is noted in Question #2 above

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Respondent Type: Normal Response**Collector:** Web Link (Web Link)**Custom Value:** empty**IP Address:** 70.190.114.13**Response Started:** Saturday, May 4, 2013 12:30:40 PM**Response Modified:** Saturday, May 4, 2013 12:45:16 PM**1 What parts of the draft rules do you believe are effective?****No Response**

2. How can the draft rules be improved?

Nutrition and Feeding Assistant Training Program R9-10-425 An individual providing the training course is: a. A physician, b. A physician assistant, c. A registered nurse practitioner, d. A licensed practical nurse, e. A speech-language pathologist, or f. An occupation therapist; The list is not complete. It should include Registered Dietitian/Nutritionist

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

In #5 Food Service, I number 2 on page 48 "An individual providing the training course is: should also include Registered Dietitian/Nutritionist. The RDN's course of study and practice involve the science of food and nutrition with the techniques/understanding to educate.

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Respondent Type: Normal Response

Collector: Web Link (Web Link)

Custom Value: *empty*

IP Address: 74 39 242 130

Response Started: Thursday, May 2 2013 10:44:15 AM

Response Modified: Thursday, May 2, 2013 10:46:19 AM

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

No Response

2. How can the draft rules be improved?

I believe that the Arizona Health Care Associated has articulated my concerns and recommendations and fully support their position on the proposed rules

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

No Response

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Respondent Type: Normal Response

Collector: Web Link (Web Link)

Custom Value: *empty*

IP Address: 66 210 243 52

Response Started: Wednesday May 1 2013 2:30:48 PM

Response Modified: Wednesday May 1 2013 2:54:13 PM

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

No Response

2. How can the draft rules be improved?

R9-10-403 Administration Section A number 7 a grammatical error. Reads "Expected not to on the nursing care institution's premises for more than 30 days" Should read "Expected not to be on the " Section D, number 4 48 hours is a tight timeframe to execute a thorough investigation of an allegation of abuse, neglect or exploitation. CMS regulations allow 5 working days to submit reports to the state agency. If a thorough report is wanted, the time frame needs to be increased from 48 hours Section D number 5 Same comment as Section D, number 4 Section E number 1 Written notification to the Department within one working day of a resident's death. Suggestion: Resident's unexpected death My facility averages 19 deaths per month This requirement for all deaths will be time consuming and have associated employee costs

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

No Response

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Respondent Type: Normal Response

Collector: Web Link (Web Link)

Custom Value: *empty*

IP Address: 206 82 203 100

Response Started: Tuesday, April 30, 2013 10:19:36 PM

Response Modified: Tuesday, April 30, 2013 10:23:49 PM

1 What parts of the draft rules do you believe are effective?No Response

2. How can the draft rules be improved?

>> R9-10-403. Administration CPR and first aid certification required for all personnel (why??) . This was further referenced in R9-10-406 (E) (3)(g) that requires CPR documentation in every personnel's file (isn't this a waste of resources for those who don't need it i.e. maintenance staff, business office, etc?) Under E 1 2 and 3. – the administrator must provide written notification within 1 working day after a resident's death within 2 working days of a resident's suicide attempt or infliction of self-injury requiring medical attention within 3 working days of a resident's accident, emergency or serious injury that results in the resident needing medical service (DHS discontinued this years ago as it was deemed unnecessary, why restart?) R9-10-404 Quality Management It talks about Quality Assurance activities but under 2. and 3 – it asks for a documented report to be submitted to the governing authority and maintaining the report for 12 months after the date the report is submitted (QA is an INTERNAL privelege and used to improve quality between team members and our policis and procedures)

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

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Respondent Type: Normal Response**Collector:** Web Link (Web Link)**Custom Value:** empty**IP Address:** 98 225 114 140**Response Started:** Monday April 29 2013 1:33:52 PM**Response Modified:** Monday April 29, 2013 8:04:09 PM**1 What parts of the draft rules do you believe are effective?**

To recognize and initiate changes to the rules that will promote the collaboration among all providers in long-term care is to be commended.

2. How can the draft rules be improved?

The draft rules can be improved by emphasizing the vital links between a resident's quality of life, psychosocial care, and medically-related social services that are provided by an MSW prepared social worker. Person-centered care is now the expectation, not the exception for meeting residents' and patients' individualized needs in long-term care facilities. Achieving person-centered care requires multidisciplinary staff skilled in many areas. The social worker is a core practitioner on any interprofessional team, but currently in Arizona nursing homes, many social work positions are filled by individuals who do not have a social work degree, have not had social work training, and are not being supervised by an experienced, degreed social worker (Bonifas 2009). According to the current federal guidelines, almost anyone can work as a "social worker" in a long-term care facility. The definition of a qualified social worker does not mandate an actual social worker and in fact, allows persons from a host of different backgrounds to work in a social work position. Furthermore, the federal regulations for a "qualified social worker" only apply to facilities licensed for greater than 120 beds. This arbitrary delineation based on a random number of beds is ill-advised, unethical and must change. Residents and patients in smaller facilities experience the same challenges, the same emotional pain and suffering and complexities of multimorbidities as residents in larger facilities (NASW, 2004). Just stating that the facility is still required to provide medically-related social services for these smaller facilities has resulted in even more untrained and unqualified social services staff attempting to meet these residents' often complex psychosocial needs. Right now, with these proposed rule changes, Arizona has the opportunity to demonstrate commitment to ensuring that our long-term care residents receive the deserved and outstanding psychosocial care to which they are entitled and to set an example for other states. Currently, the biopsychosocial-spiritual needs of many Arizona residents and patients continue to go unmet. Unfortunately, even in facilities with 120 beds and more, many of the individuals hired to work in a social work capacity do not have a social work degree, do not have social work training, and are not supervised by a qualified, degreed social worker with long-term care experience. A person calling themselves a nurse would never be allowed to even apply for a nursing position. A person licensed as an LPN would never be hired as an RN. By law, it is required that a Director of Nurses be an RN. The time has come that we demand the same attention to qualifications and training for social workers. The psychosocial needs of facility residents and patients require the level of attention and skills equivalent to physical health needs (Simons, Bern-Klug, & An, 2012). Just like a nurse can cause a patient or resident harm, so can social workers and individuals acting in a social work capacity. While it may not be as overt as a drastic medication error or a wrong treatment, social work staff and especially people providing social work services without a degree and proper training, can cause psychological, emotional and mental harm to patients, residents and families. Here are just a few examples of the situations that are common in nursing homes: a much younger population of residents that requires staff with specialized training and behavioral health skills to address issues like sexuality, substance abuse, thwarted progression of normal developmental stages; family crises such as disagreement regarding the plan of care requiring negotiation and skillfully facilitated discussions; patients with advanced stages of illness such as cancer, Huntington's chorea, dementia, and strokes - all which require skilled social workers with substantive knowledge and skills to address the complex psychosocial needs to achieve constructive outcomes (Simons et al, 2011). It is unthinkable, not to mention against the law in long-term care, for a non-nurse to administer medications, to change a dressing, to hang an IV, or to complete an assessment of systems. Yet, non-social workers, and other individuals with no training in social work, are allowed to complete psychosocial assessments, facilitate family meetings with feuding family members, attempt to counsel individuals suffering with grief stemming from a terminal illness, implement a behavioral plan for a resident with a mental illness, assess for suicidality, and initiate difficult discussions regarding advance care planning. The residents and patients in long-term care deserve more than that! They deserve to have qualified social workers at the MSW-level tending to their complex biopsychosocial-spiritual needs. They deserve the benefit of an MSW-prepared social worker, just like patients in home health, hospice, and hospital settings; the needs of patients and residents require this level of practitioner. In my role as a clinical educator and consultant for long-term care facilities, I have had the privilege of working in many different facilities throughout Arizona: small, large, for profit, non-profit, single facility, multi facility chains, rural and inner city. In almost every facility I see recurrent themes and

problems that give rise to great concern regarding the quality of psychosocial care being provided to facility residents and patients. Overall, I believe that staff are well-intended and are working their hardest to meet the multitude of regulations, run their facilities in a challenging economic environment, and provide excellent care to residents and patients. However, I also see situations that pose considerable risk to residents' emotional and psychological well-being when unqualified persons are attempting to fill the role of social workers. Below are examples of problems that I have seen in long-term care facilities related to undegreed, untrained, and unqualified individuals who are not social workers, attempting to provide medically-related social services. In each of these cases, I believe the potential for the resident to suffer harm is evident. I have taken excerpts from many reports that I have written over the past few years. All identifying information has been removed. These are but a few of the many examples that I can provide that demonstrate the impact of people working in a social work position who are not social workers, who demonstrate inadequacy of critical thinking skills as well as lack of knowledge of the essential elements of effective psychosocial care from comprehensive assessment to care planning to provision of services.

Example #1 Resident alleged (per grievance report dated months earlier that was erroneously written instead of an allegation of abuse) that a CNA "moved her too fast, was not friendly and moved her bad arm too much so that it hurt." Dissatisfaction was also expressed for how the CNA dressed the resident and that the resident felt "sloppy." Per facility policy, the social worker is responsible for grievance investigations. The grievance form was incomplete. During an interview with the administrator, she stated that this resident expresses frequent complaints and that she "complains about everyone." This behavior was not care planned nor was the allegation of abuse investigated. Furthermore, the social worker reports receiving instruction by the Director of Nurses to counsel the CNA on her behavior rather than the Director of Nurses doing so, so that the disciplinary action would not result in the CNA's termination. This CNA has been counseled on previous occasions about her abusive behavior, and at the time of the consultant's report, was still employed at the facility. The administrator was not aware of this instruction from the DON, but assured the consultant that appropriate measures would be taken. At no time did the social worker demonstrate the ability to resolve this issue.

----- Example #2 Social Service Progress Notes: • 6/12/12 entry states wife works and patient will be at home alone, they can't afford caregivers and was referred to [Law Firm] to begin ALTCS. • 6/13/12 0900 entry – informed by OT that resident made a comment about wanting to kill himself and then the statement, "Dr. [Name] feels resident would not follow through with it." • 6/13/12 1600 entry from care conference – resident stated, "I was just joking. Forget about it" in reference to the statement about wanting to kill himself. Psych consult ordered. No further discussion of suicidal statement throughout rest of stay. Suicidal ideation/intent was never assessed by the social services person (who is not a social worker), facility staff, or attending physician. No one completed an assessment to include asking the resident why he made the statement, how he would try to kill himself, determine if the means were available, if he has ever made those comments before, had previous attempts, etc. Even if everyone were in agreement that a resident would not try to hurt himself, the assessment and objective documentation is crucial. Even though this resident had "behaviors" it cannot be assumed that a statement of harm is just part of those behaviors. The significant and obvious psychosocial needs of this resident went unmet.

----- Example #3 Excerpt from a Care Plan: Mood – Altered mood state as evidenced by self isolation and verbal and physical abuse. Goal – Will exhibit signs of socially acceptable behavior. Approaches – Encourage out-of-room activity, explain all treatments and procedures, follow the universal behavioral plan, monitor for signs of depression, and administer medications. • At no time was an assessment completed to determine the nature of the mood and behavioral problems. The social services designee's (who is not a social worker) notes do not contain evidence that any of the following questions were addressed: Why does she "self isolate"? Is it because she does not speak English or has extreme paranoia related to germs? Does she just prefer to be by herself in her room (may not enjoy group activities)? How is the self isolation a problem? How is she verbally and physically abusive? When and why is it a problem? For whom? Is the goal that she learn to demonstrate "socially acceptable behavior" realistic? If so, what does that mean? How does her culture impact this? Her psychiatric diagnosis? Who is responsible for teaching her these new social behaviors? Since it is already known that she doesn't like to be outside of her room, why is there an approach to encourage this? Does it benefit her? Are there out-of-room activities that she does enjoy? Visiting with family? Pets? How does the language barrier impact this? How does staff "explain all treatments" if her English is very limited? Does she get agitated when they approach her? Would a communication board be helpful? What input does the family offer? Does all staff know and implement the "universal behavioral plan"? Is it part of an inservice? Is it posted somewhere accessible to staff? The psychosocial needs of this resident were unmet.

--- In contrast to the examples above in which the psychosocial needs of the residents went unmet, below is an outline of the entries in the medical record and social work actions demonstrating the value and skill set of an MSW prepared social worker. • 69 year old patient admitted to facility following lengthy hospital stay following a stroke, hip fracture and pneumonia. She has co-morbid diagnoses of schizophrenia, chronic obstructive pulmonary disease (COPD) and uses a breathing machine at night. She has moderate expressive aphasia, but is still capable of participating in decisions and can make her needs known using a dry erase board and her limited verbal skills. Her functional status prior to hospitalization was complete independence and now she requires moderate to extensive assistance with activities of daily living and is dependent for most of her instrumental activities of daily living. She is divorced with two adult children, both of whom live locally. The patient has not completed advance directives. She was living on a limited income from social security but was having trouble paying for all her monthly expenses. • The social worker determined that the patient was receptive to visualization techniques to help address anxiety issues when she was unable to communicate her needs easily. She trained staff from all shifts how to use these

interventions. • The social worker added approaches to address psychosocial functioning and mood to the care plans for cognitive impairment, psychiatric illness, COPD, pain management and functional limitations, e.g. approach on left side, ensure dry erase board and pen are within reach, use visualization techniques to help relieve anxiety, use simple statements such as, "I can see you are upset. I will wait while you write what you need." • The social worker facilitated complex discussions with the patient, family and interdisciplinary team regarding advance care planning and determined that the patient did not want to be a full code as had been indicated upon admission. Throughout the course of these meetings, patient was able to complete powers of attorney and a living will. The social worker assisted the patient's youngest daughter in exploring her resistance to mom's decision to be a do not resuscitate code status. • The social worker met with patient many times to help her express her wishes regarding discharge planning to explore options, to address the issues of grief that had begun to arise as patient realized the full extent of her limitations and the impact on her life and the behavioral manifestations of the psychiatric illness. • The social worker helped the patient identify her strengths (the foundation of the social work perspective is a strengths approach) as well as ways to utilize these strengths given her current situation. She also communicated with the entire health care team regarding these strengths and how to help incorporate them into the daily plan of care. She followed up with staff regularly to determine how things were progressing. • The social worker provided clear documentation that outlined problems, identified the plan of care, and demonstrated the patient's response to those interventions and subsequent modifications to the plan of care. • The social worker demonstrated competence in her role as patient advocate while also balancing the needs and realities of the facility. She was successful in facilitating delicate conversations with the patient related to the behavioral components of her psychiatric illness and the frustration it caused staff, e.g. staff splitting, repetitive complaints. • The social worker tracked the PHQ-9 scores (a depression measure) and promptly notified the interdisciplinary team when the symptoms increased and the scores changed. She met with the physician to relate the concerns. All documentation was defensible and accurate. • The social worker advocated with the community behavioral case manager to ensure continuity of care and services during patient's stay in the long-term care facility. An MSW who is trained to work in the long-term care setting and demonstrate this level of skill is not only meeting the psychosocial needs of the resident, but also the expectations of the federal regulations. Examples like the one above are, unfortunately, the exception rather than the norm. But yet, this example meets the requirements according to the Federal regulations. So, why is there disconnect, a void between what the regulations clearly mandate and reality? The residents in long-term care deserve the level of expertise like this example. If the above resident were part of your family - your mother, sister, aunt or friend - I would hope she were in the facility with the MSW social worker.

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

Here is what we request be included in the draft rules. Arizona has an opportunity to be a leader in the quality of psychosocial care provided to long-term care residents and patients - an example to which other states can aspire - by incorporating the following recommendations in the draft rules: 1) Mandating that MSW-prepared social workers be hired in all nursing homes. Will this be challenging? Yes, it will. But this should not deter us from putting requirements into effect that will provide residents and patients with an MSW's expertise and to ensure that their biopsychosocial needs will be met. There can be provisions or a waiver allowing facilities to apply for a waiver that can ease the transition while locating and hiring an MSW. Perhaps for smaller facilities the rule can mandate a part-time MSW. Until the rules are written that demand truly qualified social workers - as defined by an MSW degree, to provide the complex biopsychosocial-spiritual services that most individuals require in long-term care, the status quo will go unchanged and residents' psychosocial needs will go unmet. Isn't this the level of care that we would wish for our own loved one in such a situation? 2) Change the quality rating point system to allot 15 points - equal to that of nursing and medical care, for medically-related social services. Utilize the social work competencies as defined by the Council on Social Work Education for use in areas working with older adults. Refer to the information and the Competency Scale at this website: <http://www.cswe.org/CentersInitiatives/GeroEdCenter/TeachingTools/Competencies.aspx>. Also, of critical importance in delineating the role of the social worker is the article titled "Envisioning Quality Psychosocial Care in Nursing Home: The Role of Social Work" by Kelsey Simons, PhD, MSW; Mercedes Bern-Klug PhD, MSW MA; Sofia An, MSW. This article was printed in the Journal of the American Medical Director's Association in 2012. 3) Create a separate section within Article 4 that specifically addresses Social Work, just as almost every other department is listed in the draft rules, e.g. medical records, nursing services, medical services, etc. The Rules must reflect a commitment to an expectation that the social work department will consistently demonstrate professionalism and competency - just like that of Nursing Services and Medical Services. 4) Although not addressed in these comments, it is disappointing that there is not a section addressing the Activities Department in the Arizona Draft Rules. This is another very important department that staffed with qualified, trained and supervised individuals, can significantly and positively impact each resident's quality of life. Nursing homes have made commendable strides in the care and treatment of patients and residents. But, we have much left to accomplish. This starts with raising the bar so that truly qualified social workers, by degree and training, are working in every nursing home in our state. Not only will psychosocial needs be addressed, they will be tended to in a way that will actually save money by preventing avoidable complications, help prevent unnecessary hospitalizations, improve customer satisfaction, make the work place easier for staff and ultimately improve the overall well-being of our nursing homes. References: Bonifas, R. P. (2009). Psychosocial care in Arizona skilled nursing facilities. Unpublished research data. Arizona State University School of Social Work. National Association of Social Workers Center for Workforce Studies. (2004). A study of the

roles and use of licensed social workers in the United States Washington, DC: National Association of Social Workers Simons K Bern-Klug, M , * An, S (2012) Envisioning quality psychosocial care in nursing homes: The role of social work. Journal of the American Medical Directors' Association, 13, 800-805. Simons, K , Connolly, R, Bonifas, R Allen, L Bailey, K *, Downes, D , & Galambos, C (2012) Psychosocial assessment of nursing home residents via MDS 3 0: Recommendations for social service training, staffing, and roles in interdisciplinary care Journal of the American Medical Directors' Association. 13, 190 e9-190e15; doi:10 1016/j jamda 2011 07 00

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

No Response

2. How can the draft rules be improved?

A MSW prepared social worker is the only person educated in the laws, community agencies psychological needs of the patient and her family, and the expertise to coordinate all the information to the benefit of the patient

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

No Response

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Respondent Type: Normal Response

Collector: Web Link (Web Link)

Custom Value: *empty*

IP Address: 206 82 203 100

Response Started: Thursday, April 25, 2013 11:31:12 AM

Response Modified: Thursday, April 25, 2013 11:35:19 AM

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

I don't feel that the draft is very effective. The changes don't add much value

2. How can the draft rules be improved?

R9-10-403 Administration>> 1. CPR and first aid certification required for all personnel (why??) This was further referenced in>> R9-10-406 (E) (3)(g) that requires CPR documentation in every personnel's file. (isn't this a waste of resources for those who don't need it i.e. maintenance staff, business office, etc?)>> 2 Under D 2 - the facility must report abuse, neglect or exploitation of resident immediately >> defined as "without delay" while Fed regs define it as "within 24 hrs." >> Submit written report within 48 hours. (why can't we just follow the Federal guidelines on the reporting requirement and timeframe??)>> 3 Under E 1 2 and 3 – the administrator must provide written notification within 1 working day after a resident's death; seems like this is not necessary to put this extra work on (We already follow mandated guidelines to notify people of a death)>> within 2 working days of a resident's suicide attempt or infliction of self-injury requiring medical attention>> within 3 working days of a resident's accident, emergency or serious injury that results in the resident needing medical service (DHS discontinued this years ago as it was deemed unnecessary, why restart?)>> R9-10-404 Quality Management >> Talks about Quality Assurance activities but under 2 and 3 – it asks for a documented report to be submitted to the governing authority and maintaining the report for 12 months after the date the report is submitted (QA is an internal privilege)

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

No Response

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Respondent Type: Normal Response

Collector: Web Link (Web Link)

Custom Value: empty

IP Address: 70.209.67.227

Response Started: Thursday, April 25, 2013 7:08:24 AM

Response Modified: Thursday, April 25, 2013 7:32:37 AM

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

1 CPR and first aid certification required for all personnel) . This was further referenced in R9-10-406 (E) (3)(g) that requires CPR documentation in every personnel's file (isn't this a waste of resources for those who don't need it i e maintenance staff, business office, etc?) Would we really ever want a business offices after performing CPR on a patient who is coding? 2. Under D 2 - the facility must report abuse, neglect or exploitation of resident immediately defined as "without delay" while Fed regs define it as "within 24 hrs."Submit written report within 48 hours ..(why can't we just follow the Federal guidelines on the reporting requirement and timeframe??) 3 Under E 1 2 and 3 - the administrator must provide written notification within 1 working day after a resident's death, within 2 working days of a resident's suicide attempt or infliction of self-injury requiring medical attention, within 3 working days of a resident's accident, emergency or serious injury that results in the resident needing medical service (DHS discontinued this years ago as it was deemed unnecessary, why restart?) R9-10-404 Quality Management Talks about Quality Assurance activities but under 2 and 3 - it asks for a documented report to be submitted to the ngoverning authority and maintaining the report for 12 months after the date the report is submitted (QA is an internal privelege)

2. How can the draft rules be improved?

No Response

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

No Response

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Respondent Type: Normal Response

Collector: Web Link (Web Link)

Custom Value: empty

IP Address: 70.209.67.227

Response Started: Thursday, April 25, 2013 7:08:24 AM

Response Modified: Thursday, April 25, 2013 7:12:47 AM

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

1. CPR and first aid certification required for all personnel) . This was further referenced in R9-10-406 (E) (3)(g) that requires CPR documentation in every personnel's file. (isn't this a waste of resources for those who don't need it i.e. maintenance staff, business office, etc?). Would we really ever want a business offices after performing CPR on a patient who is coding? 2. Under D 2 - the facility must report abuse, neglect or exploitation of resident immediately defined as "without delay" while Fed regs define it as "within 24 hrs."Submit written report within 48 hours .(why can't we just follow the Federal guidelines on the reporting requirement and timeframe??) 3. Under E 1 2 and 3 – the administrator must provide written notification within 1 working day after a resident's death, within 2 working days of a resident's suicide attempt or infliction of self-injury requiring medical attention, within 3 working days of a resident's accident, emergency or serious injury that results in the resident needing medical service (DHS discontinued this years ago as it was deemed unnecessary, why restart?) R9-10-404 Quality Management Talks about Quality Assurance activities but under 2 and 3 – it asks for a documented report to be submitted to the ngoverning authority and maintaining the report for 12 months after the date the report is submitted. (QA is an internal privelege)

2. How can the draft rules be improved?

No Response

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

No Response

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Respondent Type: Normal Response

Collector: Web Link (Web Link)

Custom Value: *empty*

IP Address: 70 102 49 162

Response Started: Wednesday, April 24, 2013 2:58:12 PM

Response Modified: Wednesday, April 24, 2013 3:15:04 PM

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

No Response

2. How can the draft rules be improved?

No Response

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

How will the new rules be integrated into the QIS process? Under what tasks will the surveyors be looking for compliance with the new regulations that are not obviously documentation related?

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Respondent Type: Normal Response**Collector:** Web Link (Web Link)**Custom Value:** empty**IP Address:** 98 191 125 242**Response Started:** Wednesday, April 24, 2013 11:04:32 AM**Response Modified:** Wednesday April 24, 2013 11:32:36 AM**1. What parts of the draft rules do you believe are effective?****No Response**

2. How can the draft rules be improved?

>> 1 R9-10-403. Administration: why should CPR and first aid certification required for all personnel? Its too much as is having CPR documentation in every employee's file - can be a waste to keep this up to date.>> 2. Under D 2 - the facility must report abuse, neglect or exploitation of resident immediately defined as "without delay" while Fed regs define it as "within 24 hrs " I would like to stay with federal guidelines on this. Having a clear cutoff such as "24 hours" will make it much more clear and definable. >> 3 Under E 1 2 and 3 - the administrator must provide written notification within 1 working day after a resident's death within 2 working days of a resident's suicide attempt or infliction of self-injury requiring medical attention within 3 working days of a resident's accident, emergency or serious injury that results in the resident needing medical service My understanding is this was considered unnecessary a year ago when it was implemented Not sure why should start again?>> R9-10-404 Quality Management. This talks about Quality Assurance activities but under 2 and 3 - it asks for a documented report to be submitted to the governing authority and maintaining the report for 12 months after the date the report is submitted Would like to see Quality Assurance stay as an internal privilege

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

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[Filter Responses](#) [Download Responses](#) [View Summary](#)Displaying 23 of 28 respondents [« Prev](#) [Next »](#) Jump To: 23 [Go »](#)**Respondent Type:** Normal Response**Collector:** Web Link (Web Link)**Custom Value:** *empty***IP Address:** 206 82 203 100**Response Started:** Wednesday, April 24, 2013 11:19:24 AM**Response Modified:** Wednesday April 24, 2013 11:21:34 AM**1 What parts of the draft rules do you believe are effective?****No Response**

2. How can the draft rules be improved?

I am concerned about the CPR requirement for all staff This will be a financial hardship on low income employees For example- Laundry Aide The reporting time frame for an allegation of abuse needs to remain as is I have been an Administrator for 13 years and the process works.

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

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Respondent Type: Normal Response

Collector: Web Link (Web Link)

Custom Value: *empty*

IP Address: 206 82 203 100

Response Started: Tuesday, April 23 2013 1:26:31 PM

Response Modified: Tuesday, April 23 2013 1:27:02 PM

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

No Response

2 How can the draft rules be improved?

R9-10-403 Administration 1 CPR and first aid certification required for all personnel (why??) This was further referenced in R9-10-406 (E) (3)(g) that requires CPR documentation in every personnel s file. (isn't this a waste of resources for those who don't need it i.e. maintenance staff, business office, etc?) 2. Under D 2 - the facility must report abuse, neglect or exploitation of resident immediately defined as "without delay" while Fed regs define it as "within 24 hrs." Submit written report within 48 hours (why can't we just follow the Federal guidelines on the reporting requirement and timeframe??) 3 Under E 1 2 and 3 – the administrator must provide written notification within 1 working day after a resident's death within 2 working days of a resident's suicide attempt or infliction of self-injury requiring medical attention within 3 working days of a resident's accident, emergency or serious injury that results in the resident needing medical service (DHS discontinued this years ago as it was deemed unnecessary, why restart?) R9-10-404 Quality Management Talks about Quality Assurance activities but under 2 and 3 – it asks for a documented report to be submitted to the governing authority and maintaining the report for 12 months after the date the report is submitted (QA is an internal privelege)

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

No Response

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Respondent Type: Normal Response

Collector: Web Link (Web Link)

Custom Value: empty

IP Address: 24 249 185 20

Response Started: Tuesday, April 23, 2013 12:27:23 PM

Response Modified: Tuesday, April 23, 2013 12:38:06 PM

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

I don't believe the changes are effective. Please see my comments below.

2. How can the draft rules be improved?

R9-10-403 Administration 1 CPR and first aid certification required for all personnel (why??) . This was further referenced in R9-10-406 (E) (3)(g) that requires CPR documentation in every personnel's file. (isn't this a waste of resources for those who don't need it i e. maintenance staff, business office, etc?) 2. Under D 2 - the facility must report abuse, neglect or exploitation of resident immediately defined as "without delay" while Fed regs define it as "within 24 hrs." Submit written report within 48 hours .(why can't we just follow the Federal guidelines on the reporting requirement and timeframe??) 3 Under E.1 2 and 3. - the administrator must provide written notification within 1 working day after a resident's death within 2 working days of a resident's suicide attempt or infliction of self-injury requiring medical attention within 3 working days of a resident's accident, emergency or serious injury that results in the resident needing medical service (DHS discontinued this years ago as it was deemed unnecessary, why restart?) R9-10-404 Quality Management Talks about Quality Assurance activities but under 2. and 3 - it asks for a documented report to be submitted to the governing authority and maintaining the report for 12 months after the date the report is submitted (QA is an internal privelege)

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

No Response

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Respondent Type: Normal Response

Collector: Web Link (Web Link)

Custom Value: empty

IP Address: 98 191 114 135

Response Started: Tuesday, April 23, 2013 12:13:29 PM

Response Modified: Tuesday, April 23, 2013 12:27:06 PM

1 What parts of the draft rules do you believe are effective?**No Response**

2 How can the draft rules be improved?

Rules pertaining to Nursing Care Institutions-CPR and first aid certification required for all personnel. This was further referenced in R9-10-406 (E) (3)(g) that requires CPR documentation in every personnel's file. (isn't this a waste of resources for those who don't need it i.e. maintenance staff, business office, hairdresser, housekeeping, etc?) This may be a financial burden for those staff who don't work on the floor on a one on one basis with residents and not a necessity for appropriate care or response. See CPR protocols for BLS from American Heart Association. Adult found down response would be to activate 911 then start CPR. Anyone without a CPR card can call out for assistance, activate 911, etc. Once the person has activated the internal facility response someone that is CPR certified (Nurse, CNA, etc) would respond and start CPR. What is the benefit of the rule? Under D 2 - the facility must report abuse, neglect or exploitation of resident immediately defined as "without delay" while Fed regs define it as "within 24 hrs." Submit written report within 48 hours. (why can't we just follow the Federal guidelines on the reporting requirement and timeframe??) 3. Under E. 1, 2 and 3 - the administrator must provide written notification within 1 working day after a resident's death within 2 working days of a resident's suicide attempt or infliction of self-injury requiring medical attention within 3 working days of a resident's accident, emergency or serious injury that results in the resident needing medical service (DHS discontinued this years ago as it was deemed unnecessary, why restart?) R9-10-404 Quality Management Talks about Quality Assurance activities but under 2. and 3. - it asks for a documented report to be submitted to the governing authority and maintaining the report for 12 months after the date the report is submitted (QA is a facilities internal privilege)

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

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Respondent Type: Normal Response

Collector: Web Link (Web Link)

Custom Value: empty

IP Address: 206.82.203.100

Response Started: Tuesday, April 23, 2013 10:17:47 AM

Response Modified: Tuesday, April 23, 2013 10:28:47 AM

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

I don't believe that any of the draft rules are effective

2. How can the draft rules be improved?

Rp-10-401 Definitions• The definition of "resident" means a patient receiving nursing care institution services. Under the assisted living rules (R9-10-801) definitions – the definition of "resident" means a patient accepted by the assisted living facility. Can the definition of "resident" be different in different rule sets? R9-10-402 Application Requirements• In every meeting and discussion group seeking comment on these draft rules, it was repeatedly asked by multiple providers and interested associations including AHCA, if the integrated model was voluntary. I.e. if a nursing care institution provided services to behavioral residents, could they continue as they currently are, or must they adopt the integrated model? The answer was consistently made that choosing an integrated license was voluntary. These requirements were listed under a supplemental license application and now have been included to the regular license application. The language in this section includes the words "shall include:" and requires the facility to list all the services provided including behavioral health services. If the term "is requesting authorization to provide" is trying to state that these are optional services – it is unclear. (Does this mean authorization from DHS or the appropriate state agency? "Authorization" is a term most commonly used with AHCCCS services)• Under 1. a ii – This section states that the facility must identify whether they have "an area for residents on ventilators." Under b ventilator services are not listed. How do facilities identify their ventilator services if they do not have "an area" but just provide these services on a regular skilled unit or units? How does this address a facility that provides ventilator services just not in a designated area? R9-10-403. Administration• Under C.1 d. – states that policies and procedures are established, documented, and implemented that cover CPR training. This requirement is new and was not included in the earlier drafts reviewed in the provider meetings. This requirement has never been mandatory in NCI rules. Reference is made to R9-10-406(E) (3) (g) that requires documentation in the personnel files of this CPR training and also references first aid training. Neither of these requirements has been discussed with the provider community. Further under the documentation requirement, there is reference made to this being included in every employee's personnel record. Are we to assume that every employee in an NCI is to have first aid and CPR training? (Maintenance, housekeeping, dietary, business office, etc.) It also refers to volunteers and students. Who is intended to have CPR and first aid and why is it included now when these rules are supposed to simplify?• Under D.2. - 4. The requirement now reads that the facility must report abuse, neglect, or exploitation of a resident immediately (that is defined as "without delay" – leaving room for interpretation) and must investigate and send a written report within 48 hours. "Immediately" is defined in federal regulation as 24 hours. It would be most helpful to have the same requirement to avoid confusion. Current rules require immediate reporting but written reports must be submitted within 5 days (mirroring the federal requirement and avoiding confusion between state and federal requirements). Submitting a report within 48 hours would be onerous for facilities and most likely would require additional resources for the SA to process. There is simply no staff presently to process, investigate and enforce what currently exists. Why would the department create additional, more stringent rules? Forty eight hours does not allow the facility to conduct a thorough investigation, leaving the potential for a rush to judgment. • Under E.1, 2 and 3 – The DRAFT rules now require that under E.1 that an administrator must provide written notification within 1 working day after a resident's death. Again, new information, not discussed in any previous rules working meetings, AND entirely outside the philosophy of palliative care, avoiding unnecessary re-hospitalizations, providing comfort care and hospice services to provide dignified deaths to millions of our elders. Much less, the burden on both providers and the department to process this information. Why would the department require such an unnecessary and random piece of information? • Under E.2. a requirement to notify the department within 2 working days of a resident's attempted suicide or infliction of self-injury that results in the resident needing medical services. There is already a requirement to report "incidents" – why would this (again random) bit of information be needed. Requires increased burden on both sides. Never discussed in any previous rules meetings. • Under E.3. now required to report in 3 working days a resident's accident, emergency, or serious injury that results in needing medical services. Again, not discussed previously, new information and this goes back to an archaic practice of reporting all falls with injuries – the department discontinued this many years ago after identifying that it was an exercise in futility and in a specific study, found that none of these reports required further intervention by the department so the department specifically discontinued having facilities report this information. The department cannot keep up with the current workload – why would they inflict these random, burdensome, unnecessary rules on themselves for oversight and on providers? This goes entirely against the statute to simplify these rules. It is hard to believe that anyone from LTC licensing was consulted in creating these requirements. R9-10-404 Quality Management• Under 2. And 3 – the DRAFT rules require a documented report regarding quality assurance activities that

identifies each concern and actions taken by the facility to correct the concern. The reports are to be submitted to the governing authority and kept along with supporting documentation for 12 months. AHCA has no quarrel with this requirement except that we would require a disclaimer that the reports constitute an internal privilege and would not be required to be submitted to the survey agency. This is the requirement federally and it would negate this process if the state agency had access to this information under state rule R9-10-406 Personnel and Staffing. Under A the draft rules identify that behavioral health technicians and behavioral health paraprofessionals must be at least 21 years old. We are questioning consistency again--why this is listed in NCI/SNF rules and not in AL rules? C. This refers to BSWs and MSWs among others having to be under "direct supervision" as defined by the Board of Behavioral Health Examiners. This would be impractical and unnecessary in a skilled nursing facility. The requirements and definitions of social work requiring a BSW have been removed. New definitions for social worker and social work services have been inserted in the definitions both in Article 4 for SNFs but also in Article 1. It is confusing as to what preparation is required for the practice of social work in a SNF. In Article 1 – the reference is to A R S 32-3251 which identifies BSWs, MSWs, and CSWs. We feel strongly that SNFs must at least maintain a BSW level of preparation to coordinate the complex medically-related social services required with the acuity and complexity of our residents. Under D the requirement for providing proof of freedom from infectious tuberculosis has been changed from volunteers to those who have direct interaction with a resident. The sentence should be clarified or rewritten to make it clear that this requirement applies ONLY to volunteers and not to a personnel member or an employee. The current sentence leaves room for an interpretation that only staff or employees that have direct resident contact would need proof of freedom from TB. Under E 3 g – the DRAFT rules now require that individuals have documentation of CPR and first aid training. The applicable individuals are "each employee, volunteer, and student". As mentioned above, this has never been required in NCI/SNF rules. This was not discussed in any previous meetings or input sessions. This was not in previous DRAFT versions. This would pose a financial burden on facilities. Why would the department now require maintenance personnel, housekeepers, dietary personnel, etc to have CPR and first aid training? This is one of many examples where an arbitrary requirement has been ADDED to the current rules without merit or discussion. Under G.4 – the DRAFT rules require the director of nursing to develop, document and implement... this should read the "director of nursing or designee" since many facilities have staff development coordinators or assistant directors of nursing who fulfill this requirement. R9-10-407. Admission. Under 3 The sentence should read: "A resident's needs do not exceed the medical services, nursing services or behavioral services available." behavioral services are omitted under the DRAFT. R9-10-409. Transport; Transfer. Under A and B. These sections refer to the "transport" of a resident to another health care institution as an outpatient, with the intent of receiving the patient back at the sending institution; and to the "transfer" of a resident to another institution as an inpatient without the intent of returning to the sending institution. There is no guidance for discharging home. The description of the policies and procedures is excessively prescriptive and does not begin to compare with other policy and procedure requirements in these rules. For instance, there are one line requirements that describe almost all policies and procedures under R9-10-403. Administration. These rules go into excessive and prescriptive detail regarding residents who are transported and transferred. The rules do not specify if such things as consents are required (2.a) every time a resident goes to say a dialysis appointment. Not well thought out. Just someone's idea of a concern that needed to require a rule. Under A e – is a good example of how prescriptive these rules are. This section says that the policy must "Specify how medical record information for the resident that is not provided at the time of transport but is requested by the receiving health care institution is communicated to the receiving health care institution." One would assume that the sending institution would call it over, send it by fax, email it, etc. Why would we be assuming in the first place that the medical information is not provided? A simple rule that requires all necessary information to assure a safe and appropriate transfer is sent with the resident would suffice. R9-10-414. Behavioral Health Services. This section refers back to the issue of choice. If the department is NOW saying that there is no choice in integrating these requirements for behavioral health services – then there needs to be significant dialogue with AHCCCS plans to assure that the nursing care institutions will be compensated appropriately for providing these services. The requirements here are understated at best. Nine short lines. Compared to 2 ½ pages on transferring and transporting a resident. R9-10-420. Medication Services. Under A 1 c – States that a pharmacist reviews a resident's medications every three months. This is outdated and should be at least monthly, especially with the multiple changes, the increased acuity, etc. Under C 5 – 7. These sections refer to training for personnel members other than medical practitioners or a registered nurse for self administration of medications. First of all, LPNs can also administer meds in a NCI. And other personnel cannot. The only other persons who can administer meds or assist with medication administration in this setting are certified medication assistants – and they must be registered and trained according to the requirements from the State Board of Nursing. It appears that several of the changes in these rules that apply to skilled nursing facilities were made by people who are not familiar with this setting. R9-10-422. Food Services. Under B 10. This requirement reads that water is available and accessible to residents at all times. There is no clarification as to what accessible means. R9-10-423. Emergency and Safety Standards. Under B. Reads that an administrator shall ensure that if applicable, a sign is placed at the entrance to a room or area indicating that oxygen is in use. This should be clarified that this signage is only required when smoking is allowed in a building. (LSC 18 7 4 and 19 7 4) R9-10-424. Environmental Standards. Under A 6. This rule states that heating and cooling systems maintain the nursing care institution at a temperature between 70 degrees F and 85 degrees F at all times. These temperatures currently read 71 degrees to 84 degrees. The new assisted living rules state 70 – 84 degrees. Which temperatures are facilities supposed to adhere to and we were assured that these would all be consistent and uniform to all provider types and be placed in Article 1. There are no rules for water temperatures in these NCI rules – yet the assisted

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

more rules and regulations add unnecessary burden/paperwork and provides for less actual care to the residents and patients of long term care and skilled nursing.

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Respondent Type: Normal Response

Collector: Web Link (Web Link)

Custom Value: *empty*

IP Address: 206 82 203 100

Response Started: Tuesday, April 23, 2013 10:20:26 AM

Response Modified: Tuesday, April 23, 2013 10:23:43 AM

1. What parts of the draft rules do you believe are effective?**No Response**

2. How can the draft rules be improved?

R9-10-403 Administration 1. We don't see the benefit of requiring all personnell to have CPR and first aid certification This was further referenced in R9-10-406 (E) (3)(g) that requires CPR documentation in every personnel's file - This seems like a waste of resources for those who don't need it i e maintenance staff, business office, etc? 2. Under D 2 - the facility must report abuse, neglect or exploitation of resident immediately defined as "without delay" while Fed regs define it as "within 24 hrs " Submit written report within 48 hours (why can't we just follow the Federal guidelines on the reporting requirement and timeframe??) 3 Under E 1 2 and 3. - the administrator must provide written notification within 1 working day after a resident's death within 2 working days of a resident's suicide attempt or infliction of self-injury requiring medical attention within 3 working days of a resident's accident, emergency or serious injury that results in the resident needing medical service (DHS discontinued this years ago as it was deemed unnecessary, why restart?) R9-10-404 Quality Management Talks about Quality Assurance activities but under 2 and 3. - it asks for a documented report to be submitted to the governing authority and maintaining the report for 12 months after the date the report is submitted (QA is an internal privelege)

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

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[Go »](#)**Respondent Type:** Normal Response**Collector:** Web Link (Web Link)**Custom Value:** *empty***IP Address:** 98 191 125 248**Response Started:** Tuesday, April 23, 2013 10:03:16 AM**Response Modified:** Tuesday, April 23, 2013 10:23:29 AM**1. What parts of the draft rules do you believe are effective?****No Response**

2. How can the draft rules be improved?

R9-10-403 Why? R9-10-406 isn't this unnecessary resource for those individuals who don't need it? D 2- Why don't we just follow Federal guidelines on reporting requirements and time frames? Wouldn't it cut back on confusion and unnecessary inquiry calls to the Health Services which don't have the resources to filter the calls E 1 ,2 ,3-why restart something that was deemed unnecessary and discontinued years ago by DHS? R9-10-404;2 ,3 - QA is an internal privilege

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

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Respondent Type: Normal Response

Collector: Web Link (Web Link)

Custom Value: *empty*

IP Address: 68 14 240 251

Response Started: Tuesday, April 23, 2013 9:57:39 AM

Response Modified: Tuesday, April 23, 2013 10:02:19 AM

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

No Response

2 How can the draft rules be improved?

R9-10-403 Administration>> 1. CPR and first aid certification required for all personnel (why all personnel?) . This was further referenced in R9-10-406 (E) (3)(g) that requires CPR documentation in every personnel's file (isn't this a waste of resources for those who don't need it i e maintenance staff, business office, etc? The facility is staffed with RN/LPN and C N A with these credentials) >> 2. Under D 2 - the facility must report abuse, neglect or exploitation of resident immediately defined as "without delay" while Fed regs define it as "within 24 hrs. Submit written report within 48 hours . (why can't we just follow the Federal guidelines on the reporting requirement and timeframe, we often play phone tag and leave multiple messages to get through to someone in the division of LTC, why would the state reg be more restrictive in this area when it is clearly defined by the federal regulation)>> 3. Under E 1 2 and 3 – the administrator must provide written notification within 1 working day after a resident's death, within 2 working days of a resident's suicide attempt or infliction of self-injury requiring medical attention, within 3 working days of a resident's accident, emergency or serious injury that results in the resident needing medical service (DHS discontinued this years ago as it was deemed unnecessary, why restart?)>> R9-10-404 Quality Management >> Talks about Quality Assurance activities but under 2. and 3 – it asks for a documented report to be submitted to the governing authority and maintaining the report for 12 months after the date the report is submitted (QA is an internal privilege and should be treated as such) >> >>

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

Oaind Feeding assistant rules? Federal government placed regs into effect however, we still are without in AZ thus can not enact- would enhance care provided to our residents.

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Respondent Type: Normal Response

Collector: Web Link (Web Link)

Custom Value: empty

IP Address: 70.166.177.162

Response Started: Friday, April 19, 2013 11:06:23 AM

Response Modified: Friday, April 19, 2013 11:09:45 AM

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

No Response

2. How can the draft rules be improved?

R9-10-402 in previous discussions with providers and through both Drafts One and Two the intent of the Rule was to provide SUPPLEMENTAL APPLICATION REQUIREMENTS for an integrated license. Draft Three now reflects a compulsory application requirement to meet the integrated license. From a providers perspective this means that this is no longer a voluntary application process for providers to pursue and removes the intent of the original legislation to "reduce monetary or regulatory costs on persons or individuals and streamline the regulation process." R9-10-403 C 1.d is a new section and relates to CPR and First Aid Training for staff of the provider. As this rule reads this would include all members of the provider's payroll; as well as volunteers and students. This rule does not simplify any processes for the provider and adds another layer of burden. R9-10-403 C 2 - 4 relates to reporting abuse, neglect or exploitation and the timing of reporting. This is a significant change from past rule and draft rule and potentially forces a provider to reach a conclusion prior to conducting an equitable and thorough investigation. R9-10-403 E 1.2 3 are new sections added that have not been a part of any discussions with providers: to report deaths within one day, report attempted suicides and self-injurious episodes within two days and to report a resident's accident or injury that is not an incident within three days. Why are providers reporting this separately from the required reporting process? R9-10-406 C requires "direct supervision" of BSW, MSW, etc. As the draft rule reads this does not take into consideration any BSW or MSW that holds a Medical Social Worker position. R9-10-409 has become extremely detailed and prescriptive in the role of "Transport; Transfer" and from the provider meeting I recollect the intent was to simplify systems. This is clearly an example of the opposite of simplicity - cumbersome. R9-10-414 continues to be by far the briefest rule (ten lines) considering the significant impact this makes in the "integrated rule", considering R9-10-409 is two pages. There continues to be no clear definition of "behavioral health" or "behavioral care." Has AHCCCS had the ability to voice any concerns related to reimbursement for behavioral health? R9-10-420 does not appear to be completely related to SNF's. R9-10-424 6 addresses the temperature requirements in a facility. Draft three reflects between 70°F - 85°F while Drafts One and Two reflect between 71°F - 84°F AND current rule is between 70°F and 85°F. Why a change from the established and why the change between drafts? Revisit the intent of the law to "reduce monetary or regulatory costs on persons or individuals and streamline the regulation process."

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

R9-10-401 DEFINITIONS were removed from Draft Three: Cognitive Status, Corporal Punishment, Discipline Emergency, Environmental Services, Hospital Services, Misappropriation of resident property, Reasonable Accommodation, Seclusion and Vital Signs. R9-10-424 does not reflect any rule for water temperatures.

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Respondent Type: Normal Response

Collector: Web Link (Web Link)

Custom Value: empty

IP Address: 206 82 203 100

Response Started: Wednesday, April 17, 2013 8:29:06 PM

Response Modified: Wednesday, April 17, 2013 8:31:07 PM

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

No Response

2. How can the draft rules be improved?

R9-10-403 Administration 1 CPR and first aid certification required for all personnel (why??) This was further referenced in R9-10-406 (E) (3)(g) that requires CPR documentation in every personnel's file (isn't this a waste of resources for those who don't need it i.e. maintenance staff, business office, etc?) 2 Under D.2 - the facility must report abuse, neglect or exploitation of resident immediately defined as "without delay" while Fed regs define it as "within 24 hrs " Submit written report within 48 hours. (why can't we just follow the Federal guidelines on the reporting requirement and timeframe??) 3. Under E 1 2 and 3 – the administrator must provide written notification within 1 working day after a resident's death within 2 working days of a resident's suicide attempt or infliction of self-injury requiring medical attention within 3 working days of a resident's accident, emergency or serious injury that results in the resident needing medical service (DHS discontinued this years ago as it was deemed unnecessary, why restart?) R9-10-404 Quality Management Talks about Quality Assurance activities but under 2. and 3 – it asks for a documented report to be submitted to the governing authority and maintaining the report for 12 months after the date the report is submitted. (QA is an internal privelege)

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

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2. How can the draft rules be improved?

can we follow the Federal guidelines (timeframes) for reporting incidents/ abuse allegations? simplify the rules to make it easy for the NCI to comply? why do we have to report deaths? and incidents requiring medical interventions? Az DHS stopped requiring this for a few years now, why go back to it now? Can we not make it a requirement for all personnel to get CPR and first aid? It is a waste of resources and time for those who don't need it i.e. maintenance staff, business office, etc?

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

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Respondent Type: Normal Response

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Custom Value: *empty*

IP Address: 24 249 169 3

Response Started: Tuesday, April 16, 2013 12:36:21 PM

Response Modified: Tuesday, April 16, 2013 12:59:27 PM

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

No Response

2. How can the draft rules be improved?

The time frames for reporting and completing full investigations places the facility in a situation of easily being out of compliance and/or shaving corners to complete reports rather than insuring a complete investigation is carried out. If you have a resident who has a change in condition and you send them out 911 if they die in the hospital ER are you responsible to notify the State of that person's death? If you have someone on Hospice and that person expires, is there an expectation a written report should be submitted? Again, expecting to have a thorough abuse investigation completed in 48 hours will increase the likelihood significantly of a glossed over review limited by time and ability to contact and bring in staff to interview. Administrator Immanuel Campus of Care

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

No Response

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Respondent Type: Normal Response

Collector: Web Link (Web Link)

Custom Value: *empty*

IP Address: 24 249 169 3

Response Started: Tuesday, April 16, 2013 12:36:21 PM

Response Modified: Tuesday, April 16 2013 12:58:59 PM

1 What parts of the draft rules do you believe are effective?No Response

2. How can the draft rules be improved?

The time frames for reporting and completing full investigations places the facility in a situation of easily being out of compliance and/or shaving corners to complete reports rather than insuring a complete investigation is carried out. If you have a resident who has a change in condition and you send them out 911 if they die in the hospital ER are you responsible to notify the State of that person's death? If you have someone on Hospice and that person expires, is there an expectation a written report should be submitted? Again, expecting to have a through abuse investigation completed in 48 hours will increase the likelihood significantly of a glossed over review limited by time and ability to contact and bring in staff to interview

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

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Respondent Type: Normal Response

Collector: Web Link (Web Link)

Custom Value: *empty*

IP Address: 24 249 169 3

Response Started: Tuesday, April 16, 2013 12:26:34 PM

Response Modified: Tuesday, April 16 2013 12:36:14 PM

1. What parts of the draft rules do you believe are effective?No Response

2. How can the draft rules be improved?

Expecting every volunteer, employee and student to have a current CPR card will reduce the likelihood attracting volunteer; the difficulty being many of our volunteers are elderly and may not be physically able to perform CPR. It is also challenging to expect every employee even the personnel who have limited contact with the residents to have CPR training, such as the business office, kitchen staff HR personnel, marketing There is also the nightmare of insuring everyone maintains the CPR card active Administrator Immanuel Campus of Care

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

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Respondent Type: Normal Response

Collector: Web Link (Web Link)

Custom Value: *empty*

IP Address: 68 14 252 70

Response Started: Tuesday, April 16, 2013 11:15:08 AM

Response Modified: Tuesday, April 16 2013 11:15:19 AM

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

No Response

2. How can the draft rules be improved?

Here are Sun Valley Lodge s comments regarding this latest Draft 1 Pg 4 R9-10-403 Administration A 4 We are not for profit Not for profits are governed by a voluntary Board of Directors. It is not practical for a voluntary Board of Directors to approve Policies and Procedures which they may have little understanding of. The wording in the current rule is acceptable as written which says the Governing Authority approves or designates an individual to approve 2 Pg 5 R9-10-403 Administration C 1 a We are opposed to requiring job descriptions for volunteers. The current rules do not require this. This would cost us lots of labor to produce many job descriptions for calling bingo and the like. This goes against the Legislature's Directive for HB 2634. 3. Pg 7 R9-10-403 D 7 In January, at the NCI stakeholders meeting, the Department promised to clean up and clarify what "incident" means in this situation. As written it's unclear and most impractical 4 Pg 8 R9-10-403 E.1 2 3 All are not currently required by rule. We are opposed to #1. We can live with #2. Regarding #3 requiring notification to the Department for an emergency that is unrelated to an accident or serious injury does not make any sense. Also, #3 is already required on Pg 7 R9-10-403 D 7. This is duplication of rules 5 Pg. 8 & 9 R9-10-404 Quality Management 1 e and 2 and 3 This requirement is not practical in not for profit organizations to report to the Governing Authority. Please consider using additional wording "or designated individual or administrator" 6 Pg 15 R9-10-409 Transport, Transfer B 1 b d and the entire R9-10-409 Requiring a medical practitioner or RN evaluation to transfer is costly to facility and to patient. All of these rules are very burdensome and costly to the facility and the patient. This goes against the Legislature's intent for HB 2634 7 Pg 28 R9-10-420 Medication Services A.1 a. This requirement is labor intensive and costly. This goes against the Legislature's Directive for HB 2634 8 Pg 10 R9-10-406 C We do not understand anything about this. 9 Pg 21 R9-10-412 B 1 This requirement is labor intensive and costly and duplicatory. See #2 This would go against the Legislature's intent for HB 2634 10 R9-10-423 A 4 5 & 6 We are opposed to this. The current rules call for fire drills and disaster drills which are acceptable. Respectfully submitted Sun Valley Lodge 4/16/13

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

No Response

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Respondent Type: Normal Response

Collector: Web Link (Web Link)

Custom Value: *empty*

IP Address: 63 151 254 142

Response Started: Monday, April 15, 2013 2:26:00 PM

Response Modified: Monday, April 15 2013 2:28:29 PM

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

DRAFT Rules (4/4/2013) Chapter 10 Department of Health Services- Health Care Institution Licensing Article 4 Nursing Care Institutions/ SNF AHCA Comments: Rp-10-401. Definitions• The definition of "resident" means a patient receiving nursing care institution services Under the assisted living rules (R9-10-801) definitions – the definition of "resident" means a patient accepted by the assisted living facility Can the definition of "resident" be different in different rule sets? R9-10-402. Application Requirements• In every meeting and discussion group seeking comment on these draft rules, it was repeatedly asked by multiple providers and interested associations including AHCA, if the integrated model was voluntary. I.e. if a nursing care institution provided services to behavioral residents, could they continue as they currently are, or must they adopt the integrated model? The answer was consistently made that choosing an integrated license was voluntary. These requirements were listed under a supplemental license application and now have been included to the regular license application. The language in this section includes the words "shall include:" and requires the facility to list all the services provided including behavioral health services. If the term "is requesting authorization to provide" is trying to state that these are optional services. it is unclear (Does this mean authorization from DHS or the appropriate state agency? "Authorization" is a term most commonly used with AHCCCS services)• Under 1 a ii – This section states that the facility must identify whether they have "an area for residents on ventilators." Under b. ventilator services are not listed. How do facilities identify their ventilator services if they do not have "an area" but just provide these services on a regular skilled unit or units? How does this address a facility that provides ventilator services just not in a designated area? R9-10-403. Administration• Under C 1 d – states that policies and procedures are established, documented, and implemented that cover CPR training. This requirement is new and was not included in the earlier drafts reviewed in the provider meetings. This requirement has never been mandatory in NCI rules. Reference is made to R9-10-406(E) (3) (g) that requires documentation in the personnel files of this CPR training and also references first aid training. Neither of these requirements has been discussed with the provider community. Further under the documentation requirement, there is reference made to this being included in every employee's personnel record. Are we to assume that every employee in an NCI is to have first aid and CPR training? (Maintenance, housekeeping, dietary, business office, etc.) It also refers to volunteers and students. Who is intended to have CPR and first aid and why is it included now when these rules are supposed to simplify?• Under D 2 - 4. The requirement now reads that the facility must report abuse, neglect, or exploitation of a resident immediately (that is defined as "without delay" – leaving room for interpretation) and must investigate and send a written report within 48 hours. "Immediately" is defined in federal regulation as 24 hours. It would be most helpful to have the same requirement to avoid confusion. Current rules require immediate reporting but written reports must be submitted within 5 days (mirroring the federal requirement and avoiding confusion between state and federal requirements). Submitting a report within 48 hours would be onerous for facilities and most likely would require additional resources for the SA to process. There is simply no staff presently to process, investigate and enforce what currently exists. Why would the department create additional, more stringent rules? Forty eight hours does not allow the facility to conduct a thorough investigation, leaving the potential for a rush to judgment. • Under E 1 2 and 3. – The DRAFT rules now require that under E 1 that an administrator must provide written notification within 1 working day after a resident's death. Again, new information, not discussed in any previous rules working meetings. AND entirely outside the philosophy of palliative care, avoiding unnecessary re-hospitalizations, providing comfort care and hospice services to provide dignified deaths to millions of our elders. Much less, the burden on both providers and the department to process this information. Why would the department require such an unnecessary and random piece of information?• Under E 2. a requirement to notify the department within 2 working days of a resident's attempted suicide or infliction of self-injury that results in the resident needing medical services. There is already a requirement to report "incidents" – why would this (again random) bit of information be needed. Requires increased burden on both sides. Never discussed in any previous rules meetings. • Under E 3. now required to report in 3 working days a resident's accident, emergency, or serious injury that results in needing medical services. Again, not discussed previously, new information and this goes back to an archaic practice of reporting all falls with injuries – the department discontinued this many years ago after identifying that it was an exercise in futility and in a specific study, found that none of these reports required further intervention by the department so the department specifically discontinued having facilities report this information. The department cannot keep up with the current workload – why would they inflict these random, burdensome unnecessary rules on themselves for oversight and on providers? This goes entirely against the statute to simplify these rules. It is hard to believe that anyone from LTC licensing was consulted in creating these requirements. R9-10-404. Quality Management• Under 2. And 3 – the DRAFT rules require a documented report regarding quality assurance activities that identifies each concern and

actions taken by the facility to correct the concern. The reports are to be submitted to the governing authority and kept along with supporting documentation for 12 months. AHCA has no quarrel with this requirement except that we would require a disclaimer that the reports constitute an internal privilege and would not be required to be submitted to the survey agency. This is the requirement federally and it would negate this process if the state agency had access to this information under state rule R9-10-406 Personnel and Staffing. Under A, the draft rules identify that behavioral health technicians and behavioral health paraprofessionals must be at least 21 years old. We are questioning consistency again---why this is listed in NCI/SNF rules and not in AL rules? • C This refers to BSWs and MSWs among others having to be under "direct supervision" as defined by the Board of Behavioral Health Examiners. This would be impractical and unnecessary in a skilled nursing facility. The requirements and definitions of social work requiring a BSW have been removed. New definitions for social worker and social work services have been inserted in the definitions both in Article 4 for SNFs but also in Article 1. It is confusing as to what preparation is required for the practice of social work in a SNF. In Article 1 – the reference is to A R S 32-3251 which identifies BSWs, MSWs, and CSWs. We feel strongly that SNFs must at least maintain a BSW level of preparation to coordinate the complex medically-related social services required with the acuity and complexity of our residents. • Under D the requirement for providing proof of freedom from infectious tuberculosis has been changed from volunteers to those who have direct interaction with a resident. The sentence should be clarified or rewritten to make it clear that this requirement applies ONLY to volunteers and not to a personnel member or an employee. The current sentence leaves room for an interpretation that only staff or employees that have direct resident contact would need proof of freedom from TB. • Under E.3 g – the DRAFT rules now require that individuals have documentation of CPR and first aid training. The applicable individuals are "each employee, volunteer, and student." As mentioned above, this has never been required in NCI/SNF rules. This was not discussed in any previous meetings or input sessions. This was not in previous DRAFT versions. This would pose a financial burden on facilities. Why would the department now require maintenance personnel, housekeepers, dietary personnel, etc to have CPR and first aid training? This is one of many examples where an arbitrary requirement has been ADDED to the current rules without merit or discussion. • Under G 4 – the DRAFT rules require the director of nursing to develop, document and implement. This should read the "director of nursing or designee" since many facilities have staff development coordinators or assistant directors of nursing who fulfill this requirement. R9-10-407 Admission. Under 3. The sentence should read: "A resident's needs do not exceed the medical services, nursing services or behavioral services available." Behavioral services are omitted under the DRAFT. R9-10-409 Transport; Transfer. Under A and B. These sections refer to the "transport" of a resident to another health care institution as an outpatient, with the intent of receiving the patient back at the sending institution; and to the "transfer" of a resident to another institution as an inpatient without the intent of returning to the sending institution. There is no guidance for discharging home. The description of the policies and procedures is excessively prescriptive and does not begin to compare with other policy and procedure requirements in these rules. For instance, there are one line requirements that describe almost all policies and procedures under R9-10-403 Administration. These rules go into excessive and prescriptive detail regarding residents who are transported and transferred. The rules do not specify if such things as consents are required (2 a) every time a resident goes to say a dialysis appointment. Not well thought out. Just someone's idea of a concern that needed to require a rule. Under A.e – is a good example of how prescriptive these rules are. This section says that the policy must "Specify how medical record information for the resident that is not provided at the time of transport but is requested by the receiving health care institution is communicated to the receiving health care institution." One would assume that the sending institution would call it over, send it by fax, email it, etc. Why would we be assuming in the first place that the medical information is not provided? A simple rule that requires all necessary information to assure a safe and appropriate transfer is sent with the resident would suffice. R9-10-414 Behavioral Health Services. This section refers back to the issue of choice. If the department is NOW saying that there is no choice in integrating these requirements for behavioral health services – then there needs to be significant dialogue with AHCCCS plans to assure that the nursing care institutions will be compensated appropriately for providing these services. The requirements here are understated at best. Nine short lines. Compared to 2 ½ pages on transferring and transporting a resident. R9-10-420. Medication Services. Under A 1 c – States that a pharmacist reviews a resident's medications every three months. This is outdated and should be at least monthly, especially with the multiple changes, the increased acuity, etc. • Under C 5 – 7. These sections refer to training for personnel members other than medical practitioners or a registered nurse for self administration of medications. First of all, LPNs can also administer meds in a NCI. And other personnel cannot. The only other persons who can administer meds or assist with medication administration in this setting are certified medication assistants – and they must be registered and trained according to the requirements from the State Board of Nursing. It appears that several of the changes in these rules that apply to skilled nursing facilities were made by people who are not familiar with this setting. R9-10-422. Food Services. Under B.10. This requirement reads that water is available and accessible to residents at all times. There is no clarification as to what accessible means. R9-10-423. Emergency and Safety Standards. Under B. Reads that an administrator shall ensure that if applicable, a sign is placed at the entrance to a room or area indicating that oxygen is in use. This should be clarified that this signage is only required when smoking is allowed in a building (LSC 18.7.4 and 19.7.4). R9-10-424. Environmental Standards. • Under A 6. This rule states that heating and cooling systems maintain the nursing care institution at a temperature between 70 degrees F and 85 degrees F at all times. These temperatures currently read 71 degrees to 84 degrees. The new assisted living rules state 70 – 84 degrees. Which temperatures are facilities supposed to adhere to and we were assured that these would all be consistent and uniform to all provider types and be placed in Article 1. • There are no rules for water temperatures in these NCI rules – yet the assisted living rules use 95 degrees to 120 degrees. Again, there is inconsistency.

DRAFT Rules (4/4/2013) Chapter 10 Department of Health Services- Health Care Institution Licensing Article 8 Assisted Living Facilities AHCA Comments: A general comment – this DRAFT includes requirements for both “Managers” and “Administrators” Only “Managers” apply to assisted living R9-10-802 1 b • The 10% ownership fingerprinting requirement for a corporation headquartered out of state seems excessive and burdensome, and difficult to accurately assess and document This number seems too low and unreasonable given the fact that there are many companies with multiple owners nationally R9-10—803 • Abuse Reporting: requirement for immediate reporting- WE AGREE but the 48 hours to create a written report is unrealistic Since the report has to be submitted in 5 days why does this requirement even exist? We want thorough investigations not a rush to judgment • C.1 d i and ii This is a new requirement adds a burden and increased regulation and cost to assisted living facilities This requirement regarding the method and content of CPR training will limit where facilities can receive training Once again, this is far more prescriptive than the current rules • G #2 Please note the incorrect alphabetical order of items G, H, G• G#2 Death reporting: where did this originate and why? Again, new information not discussed in any previous rules working meetings, AND entirely outside the philosophy of palliative care avoiding unnecessary re-hospitalizations providing comfort care and hospice services to provide dignified deaths to millions of our elders Much less, the burden on both providers and the department to process this information • Reporting timelines are all different, one two and three days- this can't possibly be streamlining and how will it be tracked? None of this has been discussed with stakeholders in public meetings. R9-10-805 • This entire section appears to have been taken from the skilled nursing rules It refers to an administrator ensuring contracted services according to the requirements in this article. This is new to assisted living It is confusing R9-10-806 Personnel• Same concern as noted in DNC/SNF rules: the requirement for providing proof of freedom from infectious tuberculosis has been changed from volunteers to those who have direct interaction with a resident The sentence should be clarified or rewritten to make it clear that this requirement applies ONLY to volunteers and not to a personnel member or an employee The current sentence leaves room for an interpretation that only staff or employees that have direct resident contact would need proof of freedom from TB • B 1 This is confusing. if you comply with Section (A) (1) aren't you a caregiver? R9-10-807 Residency and Residency Agreements• B 2.d States that the facility must submit documentation when the resident is admitted that includes whether the individual requires “restraints” Restraints are prohibited in assisted living (refer to C 6 of this same section where the manager shall NOT accept or retain an individual if: the individual requires restraints, including the use of bedrails. • C 2 states that a manager shall not accept or retain an individual if the individual requires “nursing services”. The definition of nursing services has been omitted from both this article and article one – making it difficult to identify what these services include • C 3 This section is seems unclear and if behavioral health is considered primary- why wouldn't this be true in skilled nursing care or other settings? This is not the case in the regulatory scheme as we know it, and we are uncertain as to the implications of this primary vs “secondary” language But it sounds important R9-10-808 Transport• Same as comments re: NCI/SNF- These sections refer to the “transport” of a resident to another health care institution as an outpatient, with the intent of receiving the patient back at the sending institution; and to the “transfer” of a resident to another institution as an inpatient without the intent of returning to the sending institution There is no guidance for discharging home The description of the policies and procedures is excessively prescriptive and does not begin to compare with other policy and procedure requirements in these rules For instance there are one line requirements that describe almost all policies and procedures under R9-10-403 Administration. These rules go into excessive and prescriptive detail regarding residents who are transported and transferred. The rules do not specify if such things as consents are required (2 a) every time a resident goes to say a dialysis appointment Not well thought out Just someone's idea of a concern that needed to require a rule. Under A e. – is a good example of how prescriptive these rules are This section says that the policy must “Specify how medical record information for the resident that is not provided at the time of transport but is requested by the receiving health care institution is communicated to the receiving health care institution” One would assume that the sending institution would call it over, send it by fax, email it, etc Why would we be assuming in the first place that the medical information is not provided? A simple rule that requires all necessary information to assure a safe and appropriate transfer is sent with the resident would suffice R9-10-810 Service Plans • A 3 a We do not know what an emotional condition is and cannot find a definition anywhere for it • C1 f This requirement for a caregiver to : “interact with a resident to detect deficits in a residents cognitive awareness -and reinforce remaining cognitive awareness” This may be a best practice but should not be a rule. How is this defined and measured? These are not even terms used in dementia care- i e cognitive awareness? R9-10-814• A.1 c has been revised and is now more confusing Current rule reads – A manager shall ensure that a nurse, pharmacist, or the resident's primary care provider reviews the medication and medication record of each resident receiving medication administration services each time the resident's service plan is reviewed and updated The new DRAFT rule reads that a manager shall ensure that a P&P include procedures to ensure that a resident's medication regimen is reviewed by a medical practitioner and meets the resident's needs. • C 4 This entire section EXCLUDES LPNs The LPN is the nurse in almost every assisted living facility in Arizona The training is currently completed by LPNs in most facilities. It would be prohibitive to require that physicians or registered nurses even initially train LPNs, (which is what the DRAFT states) who then could train the caregivers. This is new information, not reviewed with providers R9-10-815• C.19 c and d This states that an “assessment” of the resident's pain is made prior to administering pain medications or the resident's behavior prior to administering psychotropic medications There are two concerns with this requirement First, caregivers cannot “assess” and it would be more appropriate that the wording “observe and document” be used to reflect the abilities this level of staff have But most importantly and second: there is no qualifying language that these are “PRN” medications or given “as needed” Many of these

medications are given on a routine basis and it would be inappropriate and against the orders given by the physician to assess the resident's pain or behavior each time the medication is given. This is very prescriptive and burdensome. R-10-818 Environmental - Same as NCI/SNF - This rule currently states that heating and cooling systems should maintain an AL environment at a temperature between 68 degrees F and 85 degrees F at all times. The new assisted living rules state 70 - 84 degrees. The SNF rules are different yet and including the old and the new rules there are four different sets of temperatures. What is the import of this? We were assured in the meetings that these would all be consistent and uniform to all provider types and be placed in Article 1.

2. How can the draft rules be improved?

Thank you for taking AHCA's comments into consideration.

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

All comments are noted above. Thank You, Kathleen Collins Pagels, AHCA Executive Director
