Title 64 Series 13
Department of Health and Human Resources
Office of Inspector General
Office of Health Facility Licensure and Certification
NURSING HOME LICENSURE

Summary of Public Comments

Comment
We propose adding the following definition to limit repetition in 10.6.1, 10.6.2, and 10.6.3.:
2.15. Direct Access Personnel. Shall have the same meaning and definition as it is defined in West Virginia Code §16-49-1.
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue and, therefore, no changes were made.

Comment
Wording in the define of "Involuntary Seclusion" may need revised to capture intent. Broad wording may lead to an unintended interpretation. Proposed language:
2.27. Involuntary Seclusion. The separation of a resident, against his or her will or the will of the resident's representative, from other residents, from his or her room, or confinement to his or her room (with or without roommates).
Response
The Department has reviewed this comment and no changes were made in response. The rule provision is consistent with the requirements of the federal regulations.

Comment
Wording in the definition of "Mental Abuse" may need revised to clarify those situations where a resident does not want to voluntarily participate in an activity. Broad wording may lead to an unintended interpretation. Proposed language:
2.34.5. Isolating a resident from social interaction or activities against his or her will.
Response
The Department has reviewed this comment and no changes were made in response. The rule provision is consistent with the requirements of the federal regulations.

Comment
Wording in the definition of "Neglect" may need revised to capture intent. Broad wording may lead to an unintended interpretation and may be misconstrued to require extraneous goods and services. Proposed language:
2.37. Neglect. The failure of the facility, its employees, or service providers to provide goods and services required to be provided by law to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.
Response
The Department has reviewed this comment and no changes were made in response. The rule provision is consistent with the requirements of the federal regulations.

Comment
Wording in the definition of "Verbal Abuse" needs revised to remove contradictory wording from the definition. Proposed correction:

2.64. Verbal Abuse. A form of abuse, including, but not limited to, the use of oral, ~~written~~, or gestured communication or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability. Verbal abuse may be considered a form of mental abuse.

Response

The Department has reviewed this comment and no changes were made in response. The rule provision is consistent with the requirements of the federal regulations.

Comment

Addition to 64CSR13: 4.5.4.b.:

For informed consent related to the prescribing and administering of antipsychotic medications, refer to 64CSR13: 8.13.2 (b).

Response

The Department has reviewed this comment and finds clarification is needed; therefore, some changes were made.

Comment

Proposed Rule 4.10.4.c. The LTCOP recommends changing the word "available" to "*provided*". This change clarifies that the nursing home is expected to routinely provide the resident/representative with quarterly financial statements as opposed to the current language which suggests that the nursing home need not provide a statement unless one is requested. In addition to being the linchpin for the resident's right for information, access to regular, current financial information is essential to prevent and respond to financial exploitation.

Response

The Department has reviewed this comment and finds clarification is needed; therefore, some changes were made.

Comment

Proposed Rule 4.10.7.1. the LTCOP suggests moving this section to Proposed Rule 4.3 "Legal Representatives". Proposed Rule 4.10.7.1. delineates when staff are prohibited from serving as a resident representative. This is more appropriate to include in the legal representative section rather than the current placement under "Assurance of Financial Security".

Response

The Department has reviewed this comment and finds clarification is needed; therefore, some changes were made.

Comment

Proposed Rule 4.12.2.b. The LTCOP recommends replacing the section sentence of Proposed Rule 4.12.2.b. with "*If the nursing home determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of Proposed Rule 4.13.*" We believe the suggested language is clearer than the current language.

Response

The Department has reviewed this comment. Existing provisions in the rule address this issue and, therefore, no changes were made.

Comment

Proposed Rule 4.14.3.a. & b. The LTCOP recommends adding "*sexual orientation*" to the list of groups specifically protected from discrimination. LGBT seniors experience widespread discrimination in healthcare and the addition of this language would help assure that they have equal access to nursing home services.

Response

The Department has reviewed this comment and finds clarification is needed; therefore, some changes were made.

Comment
Addition to 64CSR13: 4.16.2.
For restraints involving the use of antipsychotic medications, refer to 64CSR13: 8.13.2.
Response
The Department has reviewed this comment and finds clarification is needed; therefore, some changes were made.

Comment
Proposed Rule 5.3. The LTCOP recommends adding a new section 5.3.7. "*The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research, provided that access is available to the nursing home. Access to electronic communications shall be at the resident's expense, if any additional expense is incurred by the nursing home to provide such access to the resident and such use must comply with State and Federal law.*" The addition of this language modernizes the rule to encompass the use of technology and recognizes the right of residents to privately access a computer or other electronic device and clarifies that the resident is responsible for any extra costs related to access.
Response
The Department has reviewed this comment and finds clarification is needed; therefore, some changes were made.

Comment
Proposed Rule 5.5.4.b. The LTCOP suggests replacing the proposed rule with "*A resident has the right to have family and friends meet in the nursing home with families of other residents.*" This reflects the fact that this right rests with the resident. Families and friends do not have the right to participate should the resident object.
Response
The Department has reviewed this comment and finds clarification is needed; therefore, some changes were made.

Comment
Proposed Rule 8.13. The LTCOP recommends expanding and strengthening the section on the inappropriate use of anti-psychotic medications to include all psychotropic medications. The inappropriate use of psychotropic medication has been recognized as a nationwide problem and impacts residents with dementia disproportionately. Although West Virginia's nursing home have made progress in reducing their use, West Virginia can and should do better in assuring that psychotropic medications are only used when clearly needed for established medical conditions and only after residents, or their appropriate legal representatives, provide informed consent. To accomplish this, we suggest including a definition for psychotropic medications. "*Psychotropic drug. A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: anti-psychotic; anti-depressant; anti-anxiety; and hypnotic.*" Additionally, we suggest replacing Proposed Rule 8.13.a. and 8.13.b. with
8.13.2.a. Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; 8.13.2.b. Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; 8.13.2.c. Residents do not receive psychotropic drugs pursuant to PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; 8.13.2.d. Residents, and the resident's legal representative in the case of incapacity to make health care decisions, receive a full explanation of the

reasons for using the psychotropic drug, including the benefits and risks of the psychotropic drug; and 8.13.2.e. Residents, and the resident's legal representative in the case of incapacity to male health care decisions, provide written consent to the use of the psychotropic drug. The nursing home shall maintain documentation of the information provided and consent received in the resident's medical record.

Response

The Department has reviewed this comment and finds clarification is needed; therefore, some changes were made.

Comment

To address the existing rule's lack of details to ensure the proper use and institution of patient protections surrounding the use of antipsychotic medications, and to increase the right of nursing home residents to receive proper care, AARP respectfully requests the addition of the following language [to 64CSR13: 8.13.2]:

(a) Except in case of emergency, no care facility resident shall be prescribed or administered an antipsychotic drug that was not already prescribed to the resident prior to admission to the facility unless each of the following conditions has been satisfied:

1) The resident has been examined by the prescribing clinician and diagnosed with a behavioral health condition and the prescribed drug is approved for that condition.

2) The prescribing clinician, or a previous prescribing clinician, has unsuccessfully attempted to accomplish the drug's intended effect using approved non-pharmacological care options, and has documented those attempts and their results in the resident's medical record.

3) The facility has provided to the resident or resident's legal representative a written explanation of applicable informed consent laws. The explanation must be written in language that resident or resident's legal representative can be reasonably expected to understand.

4) The prescribing clinician has obtained written, informed consent from the resident or resident's legal representative that meets the requirements of [section (b)].

(b) The prescribing clinician must obtain written, voluntary informed consent to authorize the administration of an antipsychotic drug to a facility resident from the resident or the resident's legal representative prior to the administration of the antipsychotic drug. Voluntary informed consent shall, at minimum, consist of the following:

1) The prescribing clinician has obtained signed, written affirmation from the resident or the resident's legal representative that s/he has been informed of all pertinent information concerning the administration of an antipsychotic drug in language that the signer can reasonably be expected to understand. Pertinent information must include, but is not limited to:

A) The reason for the drug's prescription and the intended effect of the drug on the resident's condition;

B) The nature of the drug and the procedure for its administration, including dosage, administration schedule, method of delivery, and expected duration for the drug to be administered;

C) The probable degree of improvement expected from the recommended administration of the drug;

D) Risks and likely side effects associated with administration of the drug;

E) The resident's or resident's legal representative's right to refuse the administration of the antipsychotic drug and the medical/clinical consequences of such refusal; and

F) An explanation of care alternatives to the administration of antipsychotic drugs and the resident's right to choose such alternatives.

2) The prescribing clinician shall inform the resident or the resident's legal representative of the existence of the care facility's policies and procedures for compliance with informed consent requirements and shall make these available to the resident or resident's legal representative prior to administering any antipsychotic drug upon request.

(c) Antipsychotic drug prescriptions and administration must be consistent with standards for dosage, duration, and frequency of administration that are approved for the resident's condition.
(d) Throughout the duration of the administration of an antipsychotic drug and at intervals approved for the resident's condition, the prescribing clinician or his/her delegate must monitor the resident's condition and evaluate drug performance with respect to the condition for which the drug was prescribed. The prescribing clinician must provide documentation of the status of the resident's condition to the resident or the resident's legal representative upon request and without unreasonable delay.
(e) Any change in dosage or duration of the administration of an antipsychotic drug must be justified by the prescribing clinician with documentation on the resident's record of the clinical observations that warranted the change.
(f) No care facility shall deny admission on continued residency to a person on the basis of the person/resident's or their legal representative's refusal to the administration of antipsychotic drugs, unless the prescribing clinician or care facility can demonstrate that the resident's refusal would place the health and safety of the resident, the facility staff, other residents, or visitors at risk.
(g) Any care facility that alleges that the resident's refusal to consent to the administration of antipsychotic drugs will place the health and safety of the resident, the facility staff, other residents, or visitors at risk as the basis for a facility-initiated discharge must document the alleged risk in detail, and shall present this documentation to the resident or the resident's legal representative, to the Office of Health Facility Licensure & Certification (OHFLAC), and to the Long Term Care Ombudsman; and must inform the resident or their legal representative of his/her right to appeal the proposed discharge and must otherwise comply with 64CSR13: 4.13 of this rule. The documentation of the alleged risk shall include a description of all non-pharmacological or alternative care options attempted and why they were unsuccessful.
(h) Within 60 days of the effective date of this rule, all care facilities must submit to the Office of Health Facility Licensure & Certification (OHFLAC), written policies and procedures for compliance with the provisions of 64CSR13: 8.13.2. The Office of Health Facility Licensure & Certification (OHFLAC) shall review these written policies and procedures and either:

1) give written notice to the facility that the policies procedures are sufficient to demonstrate the facility's intent to comply with sections (a) through (i); or
2) give written notice to the facility that the proposed policies and procedures are deficient, identify the areas that are deficient, and provide [30 days] for the facility to submit amended policies and procedures that demonstrate its intent to comply with 64CSR13: 8.13.2.

(i) A care facility's failure to submit the documentation sufficient to demonstrate its intent to comply with 64CSR13: 8.13.2 shall be grounds for review under the state's care facility licensure and survey process and/or the imposition of sanctions by the state.
(j) All care facilities must provide the state-approved written policies for compliance with 64CSR13: 8.13.2 to all personnel involved in providing care to residents and train and educate such personnel on the methods and procedures to effectively implement said policies. Training and education pursuant to this section must be documented on each personnel file.
(k) Violations of 64CSR13: 8.13.2 shall be subject to civil money penalties as contemplated under 64CSR13: 15.7, 15.8, 15.9, and 15.16.

Response

The Department has reviewed this comment and finds clarification is needed; therefore, some changes were made.

Comment

Proposed Rule 8.14.1. and 8.14.2.b. The LTCOP supports the retention of the current language "A nursing home shall have sufficient nursing personnel to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care," but recommends that the minimum nurse staffing ratio be increased from "2.25" to "*3.25*". The 2.25 ratio has been in place for many years. During that time, the complexion of care of nursing home residents has changed. Residents are much sicker and require more

hands-on care than they did when the 2.25 ratio was first established. Today's nursing home residents have higher care needs. There have been several evidence-based national studies that focus on appropriate staffing ratios. One of the most widely known studies supports a minimum staffing ratio of "4.10". Although that ratio may be the ideal, we recognize that suddenly increasing the requirement from 2.25 to 4.10 would cause a hardship on the industry and the Medicaid program that would not be in the best interests of the residents. Consequently, we propose a modest increase to 3.25. In reaching this figure, we have relied on the 2018 4th quarter Payroll Based Journal (PBJ) data submitted to the Center for Medicare and Medicaid Services (CMS). The PBJ data reflects the actual staffing hours that nursing homes paid for. 3.25 hours is slightly less than the average staffing maintained by free-standing, *i.e.*, not hospital based, nursing homes in West Virginia. Most are already staffing at, or above, the 3.25 hours. Raising the minimum staffing ratio would help assure that every nursing home provides enough staff to meet the needs to the residents who are actually in their buildings now as opposed to the historical residents who lived there when the 2.25 ratio established.

Response

The Department has reviewed this comment and finds clarification is needed; therefore, some changes were made.

Comment

The WVHCA supports the continued express exception of the nursing staffing provisions (8.14.1 and 8.15) from the federal exemption language contained in proposed section 3.2.3. We additionally support the continued average of 2.25 hours, as it represents an appropriate balance between existing workforce numbers and maintaining a high quality of care for residents.

Like other businesses and industries in our state, our members struggle with workforce availability and retention issues on a regional and statewide basis. The current staffing ratio is designed to account for these regional and statewide basis. The current staffing ratio is designed to account for these regional disparities, while maintaining an appropriate and safe minimum standard. Any increase in the current rate will disrupt the current balance, and likely lead to fewer available beds for seniors in need of care. We therefore would oppose any amendment to or alteration of section 8.14.1 or Table 64-13.A of the rule.

Response

The Department has reviewed this comment and finds clarification is needed; therefore, some changes were made.

Comment

According to 64CSR13: 8.14.1, the minimum amount of nursing personnel hours required for West Virginia nursing facilities is 2.25 hours per resident, per day (prpd). Per 8.14.2.b, a nursing home may combine licensed nurse time AND nursing assistant time to meet the 2.25 hours minimum requirement.

While a minimum staffing requirement of 2.25 prpd reflects the staffing threshold below which facilities may not fall, the 2.25 hours per resident, per day requirement is below the minimum staffing thresholds identified by The Centers for Medicare & Medicaid Services (CMS) as the absolute minimum necessary to prevent placing residents at risk and below which quality of care would be compromised. The CMS study highlighted the importance of having nursing home staffing of a minimum of 4.1 hours per resident, per day with the following breakdowns:

- 2.8 hours for nurse aides per resident per day;
- 1.3 hours of registered nurses (RNs) and licensed practical nurses, combined, per resident per day; and
- 0.75 hours for RNs per resident per day for a total of 4.1 hours per resident per day.

While AARP feels that West Virginia should strive to accomplish staffing at the CMS identified threshold of 4.1 hours, AARP acknowledges that reaching 4.1 hours in a short period of time may not be practicable. It is for that reason AARP asks that the rule be changed to require staffing at a minimum of 3.25 hours per resident, per day, which is slightly below the average staffing levels of West Virginia nursing homes in 4th

quarter 2018. Note that the change to 3.25 prpd raises the *minimum* staffing hours established by rule, these levels should and must be adjusted upwards as needed to meet the specific needs of residents.

Response

The Department has reviewed this comment and finds clarification is needed; therefore, some changes were made.

Comment

Proposed 8.21. The LTCOP supports the inclusion of the requirement that all nursing homes, not just those that participate in the Medicare/Medicaid program, provide culturally competent, trauma-informed, person-centered care to each resident. We suggest that OHFLAC consider developing additional guidance to help nursing homes accomplish this.

Response

The Department has reviewed this comment. This comment is general in nature and offers no specific areas for amendment.

Comment

Proposed Rule 10.10. The LTCOP suggests adding a new section, 10.10.6. "*providing or arranging for medical coverage of residents whose attending physician is unavailable.*" This new language would clarify that the medical director is responsible for providing or arranging for another provider to provide, medical services to residents when their attending physician is unavailable. There have been several situations over the past few years where the attending physician resigned from the resident's care and the medical director refused to provide coverage. This creates a dilemma for both the resident and the nursing home. Suggested section 10.10.6. would clarify that the medical director is the default medical provider.

Response

The Department has reviewed this comment and finds clarification is needed; therefore, some changes were made.

Comment

Proposed Rule 14.2.7. contains a typographical error. the rule should read "Before any complaint is disclosed to the nursing home or the public pursuant to the provisions of this rule, the *DIRECTOR* shall redact any information in the complaint that could reasonably identify the complainant or resident."

Response

The Department has reviewed this comment and finds clarification is needed; therefore, some changes were made.

Comment

Proposed Rule 14.2.12. The LTCOP suggests reorganizing this section for clarity. We recommend "*The director shall provide the State long-term care obmudsman with the date and time of any inspection and shall provide the following within 90 days:*

14.2.12.a. A statement of deficiencies reflecting nursing home noncompliance; and

14.2.12.b. Reports of adverse actions imposed on a nursing home." As currently written the director is required to provide the STLCO with the dates of inspections within 90 days. The information would be moot by that time.

Response

The Department has reviewed this comment and finds clarification is needed; therefore, some changes were made.

Comment

Proposed Rule 15.3.5. contains a typographical error, "nota void" should be "*not avoid*".

Response

The Department has reviewed this comment and finds clarification is needed; therefore, some changes were made.

Comment

Throughout the United States, as many as one in six nursing home residents are given antipsychotic drugs that are dangerous for older adults. In West Virginia, 16.1% of nursing home residents were found to have been taking an antipsychotic medication for a condition not appropriate for their use.

Unfortunately, existing West Virginia rules related to the use of antipsychotics fall short on safeguards to ensure that residents of long term care facilities and their legal representatives have the right to make informed decisions about care options with respect to the administration of these drugs.

For example, the existing rule lacks substantial details and requirements on important patient protections such as steps that must be taken if a resident is to be prescribed an antipsychotic drug that was not already prescribed prior to nursing facility admission; a requirement that alternatives to antipsychotic drugs be attempted and documented prior to administering of an antipsychotic medication; that consent to receive an antipsychotic medication be obtained from the resident or the resident's representative only after detailed treatment information is provided; that resident treatment by antipsychotic medications be regularly monitored, evaluated, and adjusted; and that staff training on antipsychotics be conducted, documented, and monitored.

Response

The Department has reviewed this comment. This comment is general in nature and offers no specific areas for amendment.

Comment

The West Virginia Long-term Care Ombudsman Program appreciates the opportunity to provide comments on the proposed rule and appreciates your consideration of these comments. In addition to its statutory purpose, the rule provides West Virginia specific protections to all nursing home residents, not just those who lived in Medicare/Medicaid certified homes. Even where those certified homes are exempted from compliance with the licensure rule, it assures that residents who live in noncertified homes are entitled to the same level of quality care. Currently, the only nursing home that is not certified is the Veteran's Nursing Home. The federal regulation governing veteran's nursing home care, 38 CFR 51, was not revised when the federal Medicare/Medicaid conditions of participation were updated in 2016. Consequently, it is essential that our state rule provide these veterans with the same protections as those enjoyed by residents living in certified facilities. The LTCOP's suggestions were made with goal of empowering and protecting all of West Virginia's nursing home residents and creating a culture of care that allows for maximum accommodation of each individual resident's needs and preferences and facilities the creation of a homelike environment.

Response

The Department has reviewed this comment. This comment is general in nature and offers no specific areas for amendment.

AARP Real Possibilities in
West Virginia

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July 12, 2019

Ms. April L. Robertson
One Davis Square
Suite 100, East
Charleston, WV 25301

Dear Ms. Robertson,

On behalf of AARP West Virginia and our nearly 300,000 members, we appreciate the opportunity to provide comments on the West Virginia Nursing Home Licensure Rule. AARP respectfully submits the following comments related to nursing home staffing and the inappropriate use of antipsychotic medications by West Virginia's nursing home residents.

Nursing Home Staffing

According to 64CSR13: 8.14.1, the minimum amount of nursing personnel hours required for West Virginia nursing facilities is 2.25 hours per resident, per day (prpd). Per 8.14.2.b, a nursing home may combine licensed nurse time AND nursing assistant time to meet the 2.25 hour minimum requirement.

While a minimum staffing requirement of 2.25 prpd reflects the staffing threshold below which facilities may not fall, the 2.25 hours per resident, per day requirement is significantly below the minimum staffing thresholds identified by The Centers for Medicare & Medicaid Services (CMS) as the absolute minimum necessary to prevent placing residents at risk and below which quality of care would be compromised.[i] The CMS study highlighted the importance of having nursing home staffing of a minimum of 4.1 hours per resident, per day with the following breakdowns:

- 2.8 hours for nurse aides per resident per day;
- 1.3 hours for registered nurses (RNs) and licensed practical nurses, combined, per resident per day; and
- .75 hours for RNs per resident per day for a total of 4.1 hours per resident per day.

While AARP feels that West Virginia should strive to accomplish staffing at the CMS identified threshold of 4.1 hours, AARP acknowledges that reaching 4.1 hours in a short period of time may not be practicable. It is for that reason AARP asks that the rule be changed to require staffing at a minimum of **3.25 hours per resident, per day**, which is slightly below the average staffing levels of West Virginia nursing homes in 4th quarter 2018. Note that the change to 3.25 prpd raises the *minimum* staffing hours established by rule, these levels should and must be adjusted upwards as needed to meet the specific needs of residents.

Antipsychotic Prescription Drugs

Throughout the United States, as many as one in six nursing home residents are given antipsychotic drugs that are dangerous for older adults.[ii] In West Virginia, 16.1% of nursing home residents were found to have been taking an antipsychotic medication for a condition not appropriate for their use.[iii]

Unfortunately, existing West Virginia rules related to the use of antipsychotics fall short on safeguards to ensure that residents of long term care facilities and their legal representatives have the right to make informed decisions about care options with respect to the administration of these drugs.

For example, the existing rule lacks substantial details and requirements on important patient protections such as steps that must be taken if a resident is to be prescribed an antipsychotic drug that was not already prescribed prior to nursing facility admission; a requirement that alternatives to antipsychotic drugs be attempted and documented prior to administering of an antipsychotic medication; that consent to receive an antipsychotic mediation be obtained from the resident or the resident's representative only after detailed treatment information is provided; that resident treatment by antipsychotic medications be regularly monitored, evaluated, and adjusted; and that staff training on antipsychotics be conducted, documented, and monitored.

To address existing rule's lack of details to ensure the proper use and institution of patient protections surrounding the use of antipsychotic medications, and to increase the right of nursing home residents to receive proper care, AARP respectfully requests the addition of the following language.

Addition to 64CSR13: 8.13.2

(a) Except in case of emergency, no care facility resident shall be prescribed or administered an antipsychotic drug that was not already prescribed to the resident prior to admission to the facility unless each of the following conditions has been satisfied:
    1) The resident has been examined by the prescribing clinician and diagnosed with a behavioral health condition and the prescribed drug is approved for that condition.
    2) The prescribing clinician, or a previous prescribing clinician, has unsuccessfully attempted to accomplish the drug's intended effect using approved non-pharmacological care options, and has documented those attempts and their results in the resident's medical record.
    3) The facility has provided to the resident or resident's legal representative a written explanation of applicable informed consent laws. The explanation must be written in language that resident or resident's legal representative can be reasonably expected to understand.
    4) The prescribing clinician has obtained written, informed consent from the resident or resident's legal representative that meets the requirements of [section (b)].

(b) The prescribing clinician must obtain written, voluntary informed consent to authorize the administration of an antipsychotic drug to a facility resident from the resident or the resident's legal representative prior to the administration of the antipsychotic drug. Voluntary informed consent shall, at minimum, consist of the following:
    1) The prescribing clinician has obtained signed, written affirmation from the resident or the resident's legal representative that s/he has been informed of all pertinent information concerning the administration of an antipsychotic drug in language that the signer can reasonably be expected to understand. Pertinent information must include, but is not limited to:
        A) The reason for the drug's prescription and the intended effect of the drug on the resident's condition;
        B) The nature of the drug and the procedure for its administration, including dosage, administration schedule, method of delivery, and expected duration for the drug to be administered;
        C) The probable degree of improvement expected from the recommended administration of the drug;
        D) Risks and likely side effects associated with administration of the drug;
        E) The resident's or resident's legal representative's right to refuse the administration of the antipsychotic drug and the medical/clinical consequences of such refusal; and
        F) An explanation of care alternatives to the administration of antipsychotic drugs and the resident's right to choose such alternatives.
    2) The prescribing clinician shall inform the resident or the resident's legal representative of the existence of the care facility's policies and procedures for compliance with informed consent requirements and shall make these available to the resident or resident's legal representative prior to administering any antipsychotic drug upon request.

(c) Antipsychotic drug prescriptions and administration must be consistent with standards for dosage, duration, and frequency of administration that are approved for the resident's condition.

(d) Throughout the duration of the administration of an antipsychotic drug and at intervals approved for the resident's condition, the prescribing clinician or his/her delegate must monitor the resident's condition and evaluate drug performance with respect to the condition for which the drug was prescribed. The prescribing clinician must provide documentation of the status of the resident's condition to the resident or the resident's legal representative upon request and without unreasonable delay.

(e) Any change in dosage or duration of the administration of an antipsychotic drug must be justified by the prescribing clinician with documentation on the resident's record of the clinical observations that warranted the change.

(f) No care facility shall deny admission or continued residency to a person on the basis of the person/resident's or their legal representative's refusal to the administration of antipsychotic drugs, unless the prescribing clinician or care facility can demonstrate that the resident's refusal would place the health and safety of the resident, the facility staff, other residents, or visitors at risk.

(g) Any care facility that alleges that the resident's refusal to consent to the administration of antipsychotic drugs will place the health and safety of the resident, the facility staff, other residents, or visitors at risk as the basis for a facility-initiated discharge must document the alleged risk in detail, and shall present this documentation to the resident or the resident's legal representative, to the Office of Health Facility Licensure & Certification (OHFLAC), and to the Long Term Care Ombudsman; and must inform the resident or their legal representative of his/her right to appeal the proposed discharge and must otherwise comply with 64CSR13: 4.13 of this rule. The documentation of the alleged risk shall include a description of all non-pharmacological or alternative care options attempted and why they were unsuccessful.

(h) Within 60 days of the effective date of this rule, all care facilities must submit to the Office of Health Facility Licensure & Certification (OHFLAC), written policies and procedures for compliance with the provisions of **64CSR13: 8.13.2**. The Office of Health Facility Licensure & Certification (OHFLAC) shall review these written policies and procedures and either:
    1) give written notice to the facility that the policies procedures are sufficient to demonstrate the facility's intent to comply with sections (a) through (i); or
    2) give written notice to the facility that the proposed policies and procedures are deficient, identify the areas that are deficient, and provide [30 days] for the facility to submit amended policies and procedures that demonstrate its intent to comply with **64CSR13: 8.13.2.**

(i) A care facility's failure to submit the documentation sufficient to demonstrate its intent to comply with **64CSR13: 8.13.2** shall be grounds for review under the state's care facility licensure and survey process and/or the imposition of sanctions by the state.

(j) All care facilities must provide the state-approved written policies for compliance with **64CSR13: 8.13.2** to all personnel involved in providing care to residents and train and educate such personnel on the methods and procedures to effectively implement said policies. Training and education pursuant to this section must be documented in each personnel file.

(k) Violations of **64CSR13: 8.13.2** shall be subject to civil money penalties as contemplated under 64CSR13: 15.7, 15.8, 15.9, and 15.16.

Addition to 64CSR13: 4.5.4.b

For informed consent related to the prescribing and administration of antipsychotic medications, refer to 64CSR13: 8.13.2 (b)

Addition to 64CSR13: 4.16.2 – Restraints

For restraints involving the use of antipsychotic medications, refer to 64CSR13: 8.13.2

AARP appreciates the opportunity to submit these comments and respectfully asks the Office of Health Facility Licensure & Certification (OHFLAC) to carefully consider implementing AARP West Virginia's recommendations in the final rule. If you have any questions, please contact Angela Vance, Associate State Director-Advocacy, at avance@aarp.org or 304.340.4603.

Sincerely,

Gaylene Miller
AARP West Virginia State Director

Rich Stonestreet
AARP West Virginia State President

[4] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4833431/

[5] http://www.longtermscorecard.org/~/media/Microsite/Files/2017/Web%20Version%20LongTerm%20Services%20and%20Supports%20State%20Scorecard%202017.pdf

[6] http://www.longtermscorecard.org/databystate/state?state=WV

Ms. April Robinson, General Counsel
WV DHHR
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July 15, 2019

RE: LTCOP Comments to the Proposed Nursing Home Licensure Rule (64 CSR 13)

Dear Ms. Robinson

Please consider these comments to the Proposed West Virginia Nursing Home Licensure Rule (64 CSR 13) on behalf of the West Virginia Long-term Care Ombudsman Program (LTCOP).

Resident Rights

Proposed Rule 4.10.4.c. The LTCOP recommends changing the word "available" to "*provided*". This change clarifies that the nursing home is expected to routinely provide the resident/representative with quarterly financial statements as opposed to the current language which suggests that the nursing home need not provide a statement unless one is requested. In addition to being the linchpin for the resident's right for information, access to regular, current financial information is essential to prevent and respond to financial exploitation.

Proposed Rule 4.10.7.1. The LTCOP suggests moving this section to Proposed Rule 4.3 "Legal Representatives". Proposed Rule 4.10.7.1. delineates when staff are prohibited from serving as a resident representative. This is more appropriate to include in the legal representative section rather than the current placement under "Assurance of Financial Security".

Proposed Rule 4.12.2.b. The LTCOP recommends replacing the second sentence of Proposed Rule 4.12.2.b. with "*If the nursing home determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of Proposed Rule 4.13.*" We believe the suggested language is clearer than the current language.

Proposed Rule 4.14.3.a. & b. The LTCOP recommends adding "*sexual orientation*" to the list of groups specifically protected from discrimination. LGBT seniors experience widespread discrimination in healthcare and the addition of this language would help assure that they have equal access to nursing home services.

Quality of Life

Proposed Rule 5.3. The LTCOP recommends adding a new section 5.3.7. "*The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research, provided that access is available to the nursing home. Access to electronic communications shall be at the resident's expense, if any additional expense is incurred by the nursing home to provide such access to the resident and*

such use must comply with State and Federal law." The addition of this language modernizes the rule to encompass the use of technology and recognizes the right of residents to privately access a computer or other electronic device and clarifies that the resident is responsible for any extra costs related to access.

Proposed Rule 5.5.4.b. The LTCOP suggests replacing the proposed rule with "*A resident has the right to have family and friends meet in the nursing home with families of other residents.*" This reflects the fact that this right rests with the resident. Families and friends do not have the right to participate should the resident object.

Quality of Care

Proposed Rule 8.13. The LTCOP recommends expanding and strengthening the section on the inappropriate use of anti-psychotic medications to include all psychotropic medications. The inappropriate use of psychotropic medication has been recognized as a nationwide problem and impacts residents with dementia disproportionately. Although West Virginia's nursing home have made progress in reducing their use, West Virginia can and should do better in assuring that psychotropic medications are only used when clearly needed for established medical conditions and only after residents, or their appropriate legal representatives, provide informed consent. To accomplish this, we suggest including a definition for psychotropic medications. "*Psychotropic drug. A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: anti-psychotic; anti-depressant; anti-anxiety; and hypnotic.*" Additionally, we suggest replacing Proposed Rule 8.13.a. and 8.13.b. with
8.13.2.a. Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; 8.13.2.b. Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; 8.13.2.c. Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; 8.13.2.d. Residents, and the resident's legal representative in the case of incapacity to make health care decisions, receive a full explanation of the reasons for using the psychotropic drug, including the benefits and risks of the psychotropic drug; and 8.13.2.e. Residents, and the resident's legal representative in the case of incapacity to make health care decisions, provide written consent to the use of the psychotropic drug. The nursing home shall maintain documentation of the information provided and consent received in the resident's medical record.

Proposed Rule 8.14.1. and 8.14.2.b. The LTCOP supports the retention of the current language "A nursing home shall have sufficient nursing personnel to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care," but recommends that the minimum nurse staffing ratio be increased from "2.25" to "*3.25*". The 2.25 ratio has been in place for many years. During that time, the complexion of care of nursing home residents has changed. Residents are much sicker and require more hands-on care than

they did when the 2.25 ratio was first established. Today's nursing home residents have higher care needs. There have been several evidence-based national studies that focus on appropriate staffing ratios. One of the most widely known studies supports a minimum staffing ratio of "4.10". Although that ratio may be the ideal, we recognize that suddenly increasing the requirement from 2.25 to 4.10 would cause a hardship on the industry and the Medicaid program that would not be in the best interests of the residents. Consequently, we propose a modest increase to 3.25. In reaching this figure, we have relied on the 2018 4th quarter Payroll Based Journal (PBJ) data submitted to the Center for Medicare and Medicaid Services (CMS). The PBJ data reflects the actual staffing hours that nursing homes paid for. 3.25 hours is slightly less than the average staffing maintained by the free-standing, *i.e.*, not hospital based, nursing homes in West Virginia. Most are already staffing at, or above, the 3.25 hours. Raising the minimum staffing ratio would help assure that every nursing home provides enough staff to meet the needs to the residents who are actually in their buildings now as opposed to the historical residents who lived there when the 2.25 ratio was established.

Proposed 8.21. The LTCOP supports the inclusion of the requirement that all nursing homes, not just those that participate in the Medicare/Medicaid program, provide culturally competent, trauma-informed, person-centered care to each resident. We suggest that OHFLAC consider developing additional guidance to help nursing homes accomplish this.

Administration & Human Resources

Proposed Rule 10.10. The LTCOP suggests adding a new section, 10.10.6. "*providing or arranging for medical coverage of residents whose attending physician is unavailable.*" This new language would clarify that the medical director is responsible for providing or arranging for another provider to provide, medical services to residents when their attending physician is unavailable. There have been several situations over the past few years where the attending physician resigned from the resident's care and the medical director refused to provide coverage. This creates a dilemma for both the resident and the nursing home. Suggested section 10.10.6. would clarify that the medical director is the default medical provider.

Inspections, Investigations, Enforcement and Due Process

Proposed Rule 14.2.7. contains a typographical error. The rule should read "Before any complaint is disclosed to the nursing home or the public pursuant to the provisions of this rule, the *DIRECTOR* shall redact any information in the complaint that could reasonably identify the complainant or resident."

Proposed Rule 14.2.12. The LTCOP suggests reorganizing this section for clarity. We recommend "*The director shall provide the State long-term care ombudsman with the date and time of any inspection and shall provide the following within 90 days:*
14.2.12.a. A statement of deficiencies reflecting nursing home noncompliance; and
14.2.12.b. Reports of adverse actions imposed on a nursing home." As currently written the director is required to provide the STLCO with the dates of inspections within 90 days. The information would be moot by that time.

Enforcement & Due Process

Proposed Rule 15.3.5. contains a typographical error, "nota void" should be "*not avoid*".

Conclusion

The West Virginia Long-term Care Ombudsman Program appreciates the opportunity to provide comments on the proposed rule and appreciates your consideration of these comments. In addition to its statutory purpose, the rule provides West Virginia specific protections to all nursing home residents, not just those who lived in Medicare/Medicaid certified homes. Even where those certified homes are exempted from compliance with the licensure rule, it assures that residents who live in noncertified homes are entitled to the same level of quality care. Currently, the only nursing home that is not certified is the Veteran's Nursing Home. The federal regulation governing veteran's nursing home care, 38 CFR 51, was not revised when the federal Medicare/Medicaid conditions of participation were updated in 2016. Consequently, it is essential that our state rule provide these veterans with the same protections as those enjoyed by residents living in certified facilities. The LTCOP's suggestions were made with goal of empowering and protecting all of West Virginia's nursing home residents and creating a culture of care that allows for maximum accommodation of each individual resident's needs and preferences and facilitates the creation of a homelike environment.

Please feel free to contact me directly if you require any clarification or additional information.

Respectfully submitted,

Suzanne E. Messenger

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State Long-term Care Ombudsman

WEST VIRGINIA
Health Care
ASSOCIATION

July 15, 2019

Ms. April Robertson
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RE: WVHCA Comments to Proposed Changes to 64CSR13 (Nursing Home Licensure Rule)

Dear Ms. Robertson:

On behalf of the West Virginia Health Care Association (WVHCA), which represents nearly all nursing homes in our state, I am writing to offer comments to the proposed revisions to the Nursing Home Licensure Rule (64CSR13) that have been published for public comment.

Overall, the members of the WVHCA are in general agreement with the proposed rule changes and believe it comports with the changes contained in HB 2607 that passed during the 2019 Regular Session of the Legislature. We do have suggested changes to add clarity and avoid unintended consequences.

For ease of reference and explanation, I categorized the comments by general topic and included specific reference to the relevant section citation.

I. Staffing Ratio

The WVHCA supports the continued express exception of the nursing staffing provisions (8.14.1 and 8.15) from the federal exemption language contained in proposed section 3.2.3. We additionally support the continued average of 2.25

hours, as it represents an appropriate balance between existing workforce numbers and maintaining a high quality of care for residents.

Like other businesses and industries in our state, our members struggle with workforce availability and retention issues on a regional and statewide basis. The current staffing ratio is designed to account for these regional disparities, while maintaining an appropriate and safe minimum standard. Any increase in the current rate will disrupt the current balance, and likely lead to fewer available beds for seniors in need of care. We therefore would oppose any amendment to or alteration of section 8.14.1 or Table 64-13.A of the rule.

II. Recommended changes to definitions section to avoid vagueness or unintended consequences:

A. Background Checks

We propose adding the following definition to limit repetition in 10.6.1, 10.6.2, and 10.6.3.:

2.15. Direct Access Personnel. Shall have the same meaning and definition as it is defined in West Virginia Code §16-49-1.

B. Involuntary Seclusion

Wording in the definition of "Involuntary Seclusion" may need revised to capture intent. Broad wording may lead to an unintended interpretation. Proposed language:

2.27. Involuntary Seclusion. The separation of a resident, against his or her will or the will of the resident's representative, from other residents, from his or her room, or confinement to his or her room (with or without roommates).

C. Mental Abuse

Wording in the definition of "Mental Abuse" may need revised to clarify those situations where a resident does not want to voluntarily participate in an activity. Broad wording may lead to an unintended interpretation. Proposed language:

2.34.5. Isolating a resident from social interaction or activities against his or her will.

D. Neglect

Wording in the definition of "Neglect" may need revised to capture intent. Broad wording may lead to an unintended interpretation and may be misconstrued to require extraneous goods and services. Proposed language:

2.37. Neglect. The failure of the facility, its employees, or service providers to provide goods and services required to be provided by law to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.

E. Verbal Abuse

Wording in the definition of "Verbal Abuse" needs revised to remove contradictory wording from the definition. Proposed correction:

2.64. Verbal Abuse. A form of abuse, including, but not limited to, the use of oral, ~~written,~~ or gestured communication or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability. Verbal abuse may be considered a form of mental abuse.

We appreciate your consideration of our suggested changes to the proposed amendments to the Nursing Home Licensure Rule (64CSR13). Should there be additional amendments adopted from outside sources, we request notification and an opportunity to address any further changes.

Please feel free to contact me with any questions or to seek further clarification as to these comments.

Sincerely,

Megan Roskovensky

Megan Roskovensky
Director of Government Relations