

Testimony submitted to the Massachusetts Department of Public Health

Regarding **Proposed Amendments** to

**105 CMR 150.000 *Standards for Long Term Care Facilities***

March 1, 2021

With the purposes to improve the quality of care, dignity, and life of Massachusetts nursing home residents, Dignity Alliance Massachusetts <https://dignityalliancema.org/> is providing this testimony regarding the second public hearing and comment period on proposed amendments to 105 CMR 150.000 *Standards for Long Term Care Facilities.* Dignity Alliance Massachusetts is dedicated to transformative change to ensure the dignity of older adults, people with disabilities, and caregivers. We are committed to advancing new ways of providing long-term services, support, living options, and care while respecting choice and self-determination.  Dignity Alliance works through education, legislation, regulatory reform, and legal strategies to realize this vision throughout the Commonwealth*.*

**105 CMR** **150.001** **Definitions** - new definition for “Hours of care per resident per day (HPRD)”.

The new definition allows long term care facilities to count “nurse aides in training”. Remarkably, there appears to be no definition for a “nurse aide in training” in section 150.001. What amount and quality of training would such “aides in training” need to be qualified to perform direct patient care? If there is no clear definition of what constitutes a “qualified” person to be included in calculating direct care HPRD, the proposed amendment could shockingly lower quality care, making a year of tragic consequences from the COVID-19 Pandemic even more tragic.

**105** **CMR 150.007** - 3.58 HPRD minimum, inclusive of .5 RN HPRD, in Massachusetts long-term care facilities.

This is another important concern regarding quality of care. A CMS study in 2001 established the importance of having a minimum of 0.75 RN HPRD, 0.55 licensed nurse (LVN/LPN) HPRD, and 2.8 CNA HPRD, for a total of 4.1 HPRD to prevent harm or jeopardy to residents[[1]](#endnote-1). However, it also should be noted that these statistics do not consider the higher acuity level of the resident population that exists 20 years after publication of the 2001 report. And 4.1 HPRD does not consider quality of life and dignity issues which are important components of the nursing home requirements and rightful expectations for residents and their families. 4.1 HPRD represents a clinical standard. This standard would undoubtedly be much higher if higher acuity levels were considered[[2]](#endnote-2) and all services truly required were provided --- all services including resident dignity, person-centered care, etc. Some experts have recommended even higher staffing standards (a total of 4.55 HPRD[[3]](#endnote-3)) to improve the quality of nursing home care, with higher adjustments for higher resident acuity.

Most recently, New Jersey implemented staffing standards equivalent to 4.1 HPRD[[4]](#endnote-4) and Washington, DC[[5]](#endnote-5) implemented the 4.1 HPRD more than a decade ago. Several organizations have also endorsed the minimum of 4.1 HPRD standard and have suggested that at least 30% of hours should be provided by RNs and LVNs/LPNs[[6]](#endnote-6), and facilities should have 24/7  RN[[7]](#endnote-7) care.

Higher RN staffing levels are associated with better resident care quality in terms of fewer pressure ulcers; lower restraint use; decreased infections; lower pain; improved activities of daily living (ADLs) independence; less weight loss, dehydration, and insufficient morning care; less improper and overuse of antipsychotics; and lower mortality rates. Misuse of antipsychotics is a special concern since Massachusetts reports much higher percentages of residents on antipsychotics than many other states. MA had the 8th highest antipsychotic usage rate in the country as of Q2, 2019 (updated 1/24/20), according to the last reported statistics by the CMS Partnership to Improve Dementia Care[[8]](#endnote-8).

There is also a strong relationship between higher nurse staffing levels in nursing homes and reduced emergency room use and rehospitalizations from nursing homes. The strongest relationships are found between higher nurse staffing levels and lower deficiencies (violations of federal regulations) for poor quality issued by state surveyors.

The proposed amendments to the regulations provide for 3.58 HPRD. This is much too close to the danger level for quality and safety. Studies have found that nursing levels below 3.53 HPRD are dangerously low. Haven’t residents of nursing homes suffered enough from poor quality of care? Haven’t enough nursing home residents died in Massachusetts?

Last November, Dignity Alliance Massachusetts testified in favor of a 4.1 HPRD[[9]](#endnote-9) requirement in the regulations. We submit that given the track record of too many Massachusetts long-term care facilities, we strongly recommend that the standard be set at 4.55 HPRD, and certainly no less than 4.1 HPRD. If the Department adopts the proposed 3.80 HPRD standard, it would be a signal that the current Administration appears more concerned with the industry than with the lives and well-being of countless older adults and people with disabilities currently residing in long-term care facilities.

Additionally, we believe that the formula should be evidence-based, rather than one that simply divides the total number of hours worked by nurses, nurse aides, certified nurse assistants, and nurse aides in training. Furthermore,research literature suggests a calculation for determining whether a nursing home has sufficient and appropriate nurse staffing. It is proposed that facilities follow five basic steps to: (1) determine the collective resident acuity and care needs, (2) determine the actual nurse staffing levels, (3) identify appropriate nurse staffing levels to meet residents care needs, (4) examine evidence regarding the adequacy of staffing, and (5) identify gaps between the actual staffing and the appropriate nursing staffing levels based on resident acuity.[[10]](#endnote-10)

In addition, federal regulations demand a higher proficiency than “nurse aides in training”. According to federal law, “…sufficient nursing personnel with the appropriate competencies and skills sets to provide nursing and related services must be maintained to assure safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, based on acuity, resident assessments, care plans, census and other relevant factors in accordance with the facility assessment...”[[11]](#endnote-11)

**105 CMR** **150.017 -** proposed amendments to standards for Resident Bedrooms.

Instead of reducing the space and failing to provide residents with sufficient personal storage closets and dressers, the regulations need to provide greater privacy for residents. This could best be accomplished by requiring all rooms to be single occupancy, except for married couples or those agreeing to shared rooms (i.e., siblings, friends, etc.). Moving to no more than two residents per room should not be postponed and should be implemented immediately.

**150.017 (B)(3) Resident Bedrooms**

**We strongly support the limitation to “not more than two beds per room.** However, we believe the goal should be one bed per room with a private bathroom for each room. We would recommend adding at the end of this section: “provided, however, if two residents are assigned to a room, each resident must provide written agreement to share the room and, if one of the residents vacates the bed, both the remaining resident, and any new resident, must similarly provide written agreement to share the room.

------

**150.017 (B)(3)(a) 2.: This phrase should be kept in regulation: “shall not be increased to more than two beds per room”.**

We submit that deleting this phrase works against the intent of the new bed number requirements and therefore, should remain in the regulations.

------

**150.017 (B)(3)(a) 3.: No resident bedroom should contain more than four beds although exceptions will be allowed for existing facilities upon written approval of the Department.**

We submit that this language should be deleted, since it works against the new 2-bed bedroom capacity.

------

**150.017 (B)(3)(a) 4.: Each bed shall be placed at least three feet from any other bed. Facilities must maximize the distance between resident beds and ensure that bed placement is in accordance with Department guidelines, if any.** ~~and~~ **Each bed shall be** **at least three feet from any window or radiator. An unobstructed passageway of at least three feet shall be maintained at the foot of each bed.**

**150.017 (B)(3)(b) On and after April 30, 2022, in facilities that provide Level I, II or III care, resident bedrooms must adhere to the following occupancy and square footage requirements:**

**2.i.: …In double occupancy rooms, resident beds must be spaced at least 6 feet apart.**

We recommend that bed placement be “at least 12 feet from any other bed” rather than the current regulation of 3 feet or proposed 6 feet. This is in keeping with many studies on social distancing to provide adequate distance to minimize contagion in accordance with scientific guidelines. See study in footnote[[12]](#endnote-12) supporting at least 12 feet. Recent studies have shown that the virus spreads 10-12 feet.  A lot depends on the air flow or ventilation in the room, and nursing home ventilation systems are not particularly good.  There is also the issue of length of time in contact, and of course residents share a room 24/7.  So 6ft. is better than the 3 feet, but it is not going to be as effective as 12 feet which we strongly recommend.

------

**150.017 (B)(3)(a) 7.:   Adequate closet and drawer space shall be provided for each resident. In general, this shall mean closet space of not less than two feet by two feet by the height of the closet per resident for the storage of personal belongings, and either a built‑in or free-standing multiple drawer bureau not less than two‑feet, six inches wide with a minimum of one drawer per individual. When feasible, these should be located within the resident’s room.**

We recommend that closets are not less than thirty inches deep and five feet wide and that a dresser of at least three drawers be assigned to each resident. All dressers to be located in the resident’s room. *This section is needed to provide adequate storage space and privacy for residents.*

------

**150.017 (B)(3)(b) 1.:**  **On and after April 30, 2022, in facilities that provide Level I, II or III care, resident bedrooms must adhere to the following occupancy and square footage requirements: 1. No resident bedroom shall contain more than two beds;…”**

As stated in the introduction to this section, 105 CMR 150.017 and 150.320, we strongly support the limitation “not more than two beds per room. We believe the goal should be one bed per room with a private bathroom for each room. We also recommended adding: “provided, however, if two residents are assigned to a room, each resident must provide written agreement to share the room and, if one of the residents vacates the bed, both the remaining resident, and any new resident, must similarly provide written agreement to share the room.

**We recommend adding a new section to Resident Bedrooms: 150.017 (B)(3)(c)**

**Suggested new text:**

**“Prior to January 31, 2025, new construction and substantial renovation to existing** **resident bedrooms shall all be single occupancy except where a married couple or two residents with prior written request apply for two bed occupancy. All bedrooms shall have environmental controls for airborne infectious disease management.”**

We recommend single occupancy rooms be the goal for improved privacy and safety. While limits of two beds per room is a good first step, the goal should be for single-room occupancy, except in the case of a married couple or when two residents agree in writing to share a room for cost-savings or other reasons.

**105 CMR** **150.320 – Bedrooms – Nursing Care Units: proposed amendments.**

**150.320 (A)(1) & (2): Bedrooms Nursing Care Units Floor Area**

We recommend that the following phrase be added after **“multiple occupancy rooms”** in order to limit rooms to two beds: “provided, however, that no more than two beds shall be placed in such rooms.”

------

**150.320 (B): No resident bedroom shall contain more than four beds…”**

Strike “more than four beds” and replace with “more than two beds”.

------

**150.320 (C): “…Beds shall be spaced at least three feet from any other bed...”**

Strike “more than four beds” and replace with “more than two beds”.

Thank you for the opportunity to provide testimony regarding these proposed regulations.  We are concerned that any retreat from standards for long-term care will reduce safety and quality care, harm what little privacy resident may have, and seriously harm the dignity of residents and caregivers.

This testimony has been endorsed by twenty-eight participants of Dignity Alliance Massachusetts including the following:

Center for Public Representation

COP Amputee Association, Inc. – COPAA

Disability Resource Center, Inc.

Easterseals Massachusetts

Greater Boston Chapter of the United Spinal Association

Judi Fonsh, MSW

Lachlan Forrow, MD

Pamela Goodwin, Stop Bullying Association

Paul J. Lanzikos

James A. Lomastro, PhD

Mike Kennedy, Center for Independent Living

Richard T. Moore

Sandra Allyssa Novack, MBA, MSW

Paul Spooner, MetroWest Center for Independent Living

1. Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Report to Congress: Phase II Final Volume 1 Contract # 500-0062/TO#3, Prepared for Centers for Medicare and Medicaid Services, Prepared by Abt Associates Inc. Cambridge, MA, December 24, <https://theconsumervoice.org/uploads/files/issues/CMS-Staffing-Study-Phase-II.pdf> Overview of Phase II Report-Background: [https://theconsumervoice.org/uploads/files/issues/HHS\_Staffing\_Study\_-\_Background\_(1).pdf](https://theconsumervoice.org/uploads/files/issues/HHS_Staffing_Study_-_Background_%281%29.pdf), page 6: “..For each measure, there was a pattern of incremental benefits of increased staffing until a threshold was reached at which point there were no further significant benefits with respect to quality when additional staff were utilized. [↑](#endnote-ref-1)
2. Op.Cit., page 11: “…Although the Phase II analysis did not identify different staffing levels that maximized quality for different case mix groupings, it did find that adverse outcomes were significantly higher at the same staffing levels for facilities of higher case mix. The investigators concluded that higher staffing levels are warranted for facilities with residents of higher acuity and functional limitations…” [↑](#endnote-ref-2)
3. Libertas Academica, *The Need for Higher Minimum Staffing Standards in U.S. Nursing Homes***,**  Charlene Harrington, John F. Schnelle, Margaret McGregor5 and Sandra F. Simmons3, 4/12/16, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4833431/> [↑](#endnote-ref-3)
4. New Jersey staffing law, equivalent to 4.1 HPRD: [S2712](https://www.njleg.state.nj.us/2020/Bills/AL20/112_.PDF) - Mandatory Minimum Staffing Ratios for Direct Care Workers in Nursing homes [↑](#endnote-ref-4)
5. Washington, DC – see 3211.5 in the following link: <https://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/Nursing_Facility_Regulations_Health_Care_Facilities_Improvement_2012.pdf>. [↑](#endnote-ref-5)
6. ###  Op.Cit., Libertas Academica, *The Need for Higher Minimum Staffing Standards in U.S. Nursing Homes***: “**CMS and experts recommend higher minimum staffing levels”

 [↑](#endnote-ref-6)
7. Op.Cit., Libertas Academica, *The Need for Higher Minimum Staffing Standards in U.S. Nursing Homes* Page 15. [↑](#endnote-ref-7)
8. <https://www.cms.gov/files/document/antipsychotic-medication-use-data-report-updated-01242020.pdf> [↑](#endnote-ref-8)
9. Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Report to Congress: Phase II Final Volume 1 Contract # 500-0062/TO#3, Prepared for Centers for Medicare and Medicaid Services, Prepared by Abt Associates Inc. Cambridge, MA, December 24, <https://theconsumervoice.org/uploads/files/issues/CMS-Staffing-Study-Phase-II.pdf> Overview of Phase II Report-Background: [https://theconsumervoice.org/uploads/files/issues/HHS\_Staffing\_Study\_-\_Background\_(1).pdf](https://theconsumervoice.org/uploads/files/issues/HHS_Staffing_Study_-_Background_%281%29.pdf), page 6: “..For each measure, there was a pattern of incremental benefits of increased staffing until a threshold was reached at which point there were no further significant benefits with respect to quality when additional staff were utilized. These thresholds for NAs [nursing assistants] occurred at 2.4 hours per resident day for the short-stay quality measures and 2.8 hours per resident day for the long-stay quality measures, and for licensed staff [RNs+LPNs]at 1.15 hours per resident day for the hospital transfer short-stay measures and 1.3 hours per resident day for the long-stay quality measures. Within these totals, RN thresholds were at .55 for the short-stay quality measures and .75 hours per resident day for the long-stay quality measures…” [↑](#endnote-ref-9)
10. NCBI, [US National Library of Medicine](https://www.nlm.nih.gov/) [National Institutes of Health](https://www.nih.gov/), *Appropriate Nurse Staffing Levels for U.S. Nursing Homes*, Charlene Harrington,Mary Ellen Dellefield, Elizabeth Halifax, Mary Louise Fleming, Debra Bakeriian,, 6/29/20, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7328494/. [↑](#endnote-ref-10)
11. ##  Electronic Code of Federal Regulations, Title 42: Public Health, PART 483—REQUIREMENTS FOR STATES AND LONG TERM CARE FACILITIES, 2/11/21, <https://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&sid=e3979b25f8d8b29c78b1b3f6c66dbdaa&rgn=div5&view=text&node=42:5.0.1.1.2&idno=42#se42.5.483_135> §483.35  Nursing services.

The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).

(a) *Sufficient staff.* (1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

(i) Except when waived under paragraph (e) of this section, licensed nurses; and

(ii) Other nursing personnel, including but not limited to nurse aides.

(2) Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs...”. [↑](#endnote-ref-11)
12. Healthline, *Staying 6 Feet Apart Often Isn’t Enough During COVID-19 Pandemic*, 8/28/20, https://www.healthline.com/health-news/staying-6-feet-apart-often-isnt-enough-during-covid-19-pandemic. [↑](#endnote-ref-12)