CONSUMER ATTORNEYS OF CALIFORNIA
Seeking Justice for All

October 2, 2017

Scott Vivona, Assistant Deputy Director
Center for Health Care Quality
Chelsea Driscoll, Chief
Policy and Enforcement Branch
California Department of Public Health
MS 3203, P.O. Box 997377
Sacramento, CA 95899-7377

RE: Implementation of SB 97 amendments to minimum staffing requirements for SNFs

Dear Mr. Vivona and Ms. Driscoll:

Please accept these comments on behalf of the Consumer Attorneys of California and we look forward to participating in the Department's Stakeholder meetings related to Skilled Nursing Facility (SNF) Staffing Requirements. CAOC Member Michael Thamer, who drafted these comments, and I will be participating for CAOC.

The purpose of an increase in the minimum direct care nursing staffing requirement to 3.5 NHPPD is to increase the quality and safety of patient care. Every regulation contemplated by the Department to implement SB 97 should be calculated to achieve this goal.

Second, the stated purpose of specific direct care staff to resident ratio requirement is to allow residents, families of residents, facility employees, state inspectors and others to easily determine if a facility is complying with California's minimum staffing requirement. [AB 1075.] This allows stakeholders the opportunity to ensure compliance. Every regulation contemplated by the Department should likewise be calculated to achieve this goal.

Over the last 30 plus years the acuity level of California SNFs has increased. As a result, the direct care staffing needs of the resident population have correspondingly increased. Every contemplated regulation must reflect this reality. The regulations must *increase*, both qualitatively and quantitatively, the *delivery* and *quality* of direct care nursing staff. Inadequately staffed facilities place residents at an unreasonable risk of neglect, injury and harm. In 2001 a study for the Centers for Medicare and Medicaid Services (CMS) reported that 4.1 direct care hours per resident day, which included a minimum .75 RN HPPD ["hours per resident day"] and .55 LVN HPPD, were the minimum staffing levels associated with a lower probability of poor resident outcomes, such as pressure sores, urinary tract infections and weight loss. [Kramer and Fish, 2001.]

Having a minimum number of 2.4 CNA HPPD will not increase the quality or safety of the nursing care patients require. At best, it increases the probability that residents will receive some assistance with activities of daily living, such as dressing, transferring, eating, bathing and hygiene. To ensure that the assistance CNAs provide is adequate and safe, they must be closely supervised by licensed staff. This is especially true if facilities employ nursing assistants

who have not demonstrated competency and/or completed minimally required certified nursing assistant training. As a result, regulations to implement SB 97 must include minimum RN staffing HPPD requirement, as well as sufficient minimum licensed nursing staff HPPD, which can be made up of a combination of RN and LVN hours.

Day and evening shifts include significant tasks for CNAs to accomplish in critical time frames, especially before, during and after meals. During these shifts poor resident outcomes are likely if CNA to resident ratio exceeds 1 to 8. [See *Relationship of Nursing Home Staffing to Quality of Care*, 2004 Schnelle JF, Simmons SF, Harrington C.] For example, after lunch many residents require assistance with locomotion and transfer to and from bathroom facilities. It is not uncommon for residents to line hallways while waiting for assistance with toileting. If the needed assistance is not timely, residents often unnecessarily soil themselves. Because of the time associated with changing residents clothing and transferring them to wheelchairs and/or to activity locations, often residents' soiled clothing is stripped and they are left in bed for the remainder of the shift. This otherwise avoidable time in bed increases the likelihood of pressure sores and contractures. Any contemplated CNA to resident ratio should not exceed 1 to 8 on both day and evening shifts.

If a waiver of the 2.4 requirement is sought, it should be granted only if the minimum of 3.5 NHPPD is met. Facilities can accomplish this by increasing the staffing of LVN and RN staffing. As CAHF recently pointed out, "SNFs with greater numbers of licensed nurses (LVNs and/or RNs) are more likely to produce better outcomes." [CAHF letter of Sept. 1, 2017, re SB 97 Implementation.] If a SNF cannot meet the 3.5 requirement, and cannot meet the 2.4 CNA staffing component with licensed nurses, the SNF should be required to freeze admissions until staffing consistent with these minimum staffing requirements are met. Allowing a SNF to continue admissions in the face of these staffing deficits necessarily increases the risks of sub-standard care and unreasonably increases the likelihood of resident harm.

A recent Brius case in Northern California illustrates this point. There a resident was admitted to a SNF on November 17, 2015, for a contemplated short term rehabilitation from a heart valve replacement Surgery, with the plan of a discharge back to home. During his 22 day residency, which lasted until December 8, 2015, the resident never received a bath or shower, and failed to receive any assistance with ADLs (i.e. repositioning, bed mobility, locomotion, dressing, toileting, hygiene) on 19 different shifts. Not surprisingly, the resident developed a Stage IV pressure sore. On December 5, 2015, a CNA finally alerted a LVN of the existence of the resident's skin condition. On that same day, another LVN advised an evening shift licensed staff of the skin condition. No actions were taking by licensed staff to notify the treating physician or the residents family, or treat the condition, until late in the afternoon on December 7th, notwithstanding the fact that the resident developed a fever during the same time-period. The resident was discharged to the emergency room the following day, December 8th, and died a couple weeks later from sepsis. The facility reports that it met California's minimum of 3.2 NHPPD every day during the residency. This case alone illustrates the need for a facility to have both minimally adequate CNA *and* licensed nursing staffing, and that failing to have both unreasonably increases the risk of harm to residents

Staff not engaged in providing direct patient care should not be counted towards either the 2.4 or 3.5 direct nursing care staffing requirements. This includes time spent during orientation, meals, and 15-minute rest breaks. Stated another way, how can time spent by staff outside the facility smoking cigarettes or talking on their cell phones to family and friends be counted as time spent providing direct nursing care?

Understaffed facilities often misrepresent their direct care nursing staffing by misrepresenting the true assignments of staff. For example, CNAs often work in non-nursing assignments, such as Central Supply, Activity Assistants, Dietary Aides, and Therapy Aides. Notwithstanding these assignments, these CNAs' names are placed on Assignment Sheets as Direct Care staff and the facilities wrongly count these staff in their daily posted staffing numbers. By changing the definition of direct caregiver to include nursing assistants not yet certified if they are participating in an approved training program will increase the difficulty of residents, families and state inspectors to determine if minimum staffing requirements are being met by the facility. To reduce this difficulty, the daily required documentation of hours should include a clear description of the specific tasks assigned to the direct care staff, including the room and bed number of residents the nursing assistants are responsible for. Since it is virtually impossible for a CNA to accurately chart the assistance with activities of daily living [ADLs] they did not personally provide to a resident, the regulations should require that all charting of ADL activities should be completed by the nursing assistant who provided the care. This will both increase the accuracy of ADL charting and make it much more difficult for facilities to misrepresent the true assignments of staff.

The health and safety of nursing home residents should drive any regulation developed to implement SB 97. Thank you for considering these comments.

Sincerely,

Nancy Peverini
CAOC Legislative Director