To: Katherine Chickey, Minnesota Department of Health

From: Kari Thurlow, LeadingAge MN

Date: October 30, 2020

Re: Comments on MDH's 10/08/2020 Proposed Rules for Licensed Assisted Living

Thank you for the opportunity to review and respond to Proposed Assisted Living Licensure Rules dated October 8, 2020. LeadingAge MN staff have prepared these written comments in advance of the November 5th Assisted Living Rulemaking Advisory Committee so that you would have an opportunity to see some of our questions and concerns in advance of that discussion. Please note that our review is ongoing, and we may identify additional questions and concerns through our continued examination and discussions with our members. We do not wish to make these comments public at this time but did want to share these with MDH staff.

We fundamentally believe these proposed rules should be evaluated context of the shared values identified by stakeholders from the beginning of this work (*see, e.g.* MDH Summary Report, Elder and Vulnerable Adult Abuse Prevention Working Groups01/24/19). These values include:

- Improve quality of life for all;
- Respect the rights, dignity and choice of elders and vulnerable adults;
- Strive to balance personal rights, autonomy, choice and privacy with safety and health protection for vulnerable adults;
- Value person-centered solutions over those that are primarily institution-centered;
- Fill gaps in regulation to increase quality and safety, but don't drive more people into institutions;
- Care settings need to be and remain accessible to low income populations;
- Must allow sustained access to Home and Community Based Services Medicaid funding;
- Access should be improved for those on Elderly Waiver;
- Whatever we do as a state we need to be able to pay for.

Furthermore, an overarching concern is that these rules are implementable at the facility level, understandable for providers and consumers alike, and affordable. We also look forward to an evaluation of the cost of these regulations, keeping in mind that the bulk of these new costs will impact consumers.

Our hope that the feedback provided in this document will provide constructive feedback consistent with the shared values and that our suggestions will be incorporated into the proposed rules prior to the rules being published for public comments. Thank you for your consideration. We look forward to continued discussion.

Proposed Rule Topic or Reference Concern Rational Recommendation-

Section	Comments and Recommendations
4659.XXXX Definitions	"Elopement" Concerns that proposed definition is overly broad and does not reflect resident autonomy. Most AL residents do not require authorization to leave the premises. The impact of an overly broad definition here could trigger missing resident plans unnecessarily. "Prospective Resident" May need further clarification, given its use in the rule. "Resident" Definition incorporates definition under 144G.08, subd. 59, which covers all residents of a setting, and does not distinguish between those taking services and those who do not have services. This could create interpretive issues throughout. .
4659.XXXX Licensing in General	Subpart 1: This language is problematic. This means that any person or entity that manages an AL must hold a license. This is different language than what is in statute under 144G.10, subd. 1. Presumably, that is not actually the intent of this language. The law explicitly permits management contracts, and if the owner is the licensee and contracts with a management company, that management company will not be required to hold a license as well. That was not the intent. This should be clarified. Technically clause (2) of this subpart is overly broad because it could be interpreted to require SNFs or any other provider type to also hold an AL license if they too promote themselves as providing services to the dementia population. This should be clarified.

	LAMN opposes Subpart 4 and Subpart 5. We believe that there is no authority for this rule and do not think there is a strong public policy reason to support. Nothing in 144G supports this requirement and this greatly expands the disclosure requirements of 325F.72.
4659.XXXX ALL; Conversion of Existing AL Providers	This section only speaks to conversion of those currently operating under AL title protection, the new requirements will require some other (HWS with homecare but not currently assisted living) to convert, may need language added to broaden conversion process for those sites to facilitate smooth transition to licensure.
4659.0040 Variance	We would encourage discussion/specificity on timeframes for rulings and appeals to infuse clarity into the process.
4659.0060 Emergency-Disaster-And-Preparedness Plan	• As a matter of principle and overall approach to the work of regulating MN's assisted living facilities, we oppose wholesale incorporation of federal nursing home standards. CMS did not have AL settings in mind when they wrote the nursing facility rules, did not seek public comment on their applicability to AL settings, nor will they have AL settings in mind when they update the rules over time. • As a general approach, we also oppose blindly incorporating successor requirements or model code updates and the like. Even if we wanted to take federal regulation as a model to consider, good policymaking would be to review new or amended federal requirements when they come out and determine which of those to include in our regs, or to include with edits, or not to include. Locking in ahead of time to standards that are not developed for AL settings, and certainly not MN's variety of AL settings, is not good government. • It appears MDH is proposing to adopt both the CFR language and the interpretive guidance from CMS in "Appendix Z." Appendix Z is written for all Medicare provider and supplier types and not assisted living settings. It is the opposite of user friendly. • While there are general topics that the CMS regulations cover are reasonable, some of the specific details do not work for all assisted living settings, either in content or in language. Because all of 42CFR §483.73 is incorporated into these rules, we have provided comments to the federal references: o 42CFR §483.73 (b)(2) includes a requirement to track "sheltered residents in the LTC facility's care." This will feed interpretive issues about whether every tenant, whether taking services or not is "under the facility's care." o 42 CFR §483.73 (b)(5) appears to effectively require all licensed assisted living setting to have an electronic health record by requiring "A system of medical documentation that preserves resident information, protects confidentiality of resident information, and secures and maintains the availability of records." AL settings have typically not had the same level of funding and support for implementation of EHRs as hospitals and nursing homes.

	o 42 CFR §483.73 (c) is an example where Appendix Z provides significantly more detail to the regs, making it difficult for providers to ensure they are keeping up with regulations. Moreover (c)(1)(iii) is another example of where the federal language doesn't fit AL settings, as facilities may not have resident physician information. o 42 CFR §483.73 (d)(2) related to testing seems unnecessary and could create confusion. 144G.45 and the MN State Fire Code addresses fire-safety related training and drilling for AL facilities. Interpretive question: would those exercises suffice to meet this requirement, even partially? o 42 CFR §483.73 (d)(2)(i) requires settings to participate in an annual full-scale exercise that is community-based; or when a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. Nursing facilities typically meet this requirement by participating in an event put on by the regional healthcare coalition. But those events historically have not necessarily including assisted living, at least not consistently. The coalitions have worked with AL on PPE and staffing of late, but not clear if their broader emergency prep work would include AL, given their funding has been targeted to supporting compliance with federal requirements, not state. o 42 CFR §483.73 (e) incorporates CMS requirements for emergency and standby power systems. In essence this would incorporate Life Safety Code and related code requirements for ALs, which we strongly oppose. This will especially not scale well for small residential care homes. • We would recommend reverting back to working off of the draft rule dated 12/12/19 and shared with the ALL advisory committee. There was good work and discussion by the Advisory Committee and aligns well with the 144G without abdicating policymaking authority to CMS. • If the current approach is retained in the proposed rules, we would recommend a delayed effective date to implement. When CMS introduced these requirements for nursing homes, even in a pre-COVID time, they gave facilities a year to implement the standards.
4659.0065 Missing Resident Plan	The rule requires a search for a suspected missing resident, while maintaining care of other residents. This would create a minimum staffing ratio at all times. There may be alternative ways of searching for the missing resident besides using staff, and the rule should allow flexibility in the plan to determine how the area will be searched. Subp. 4 A quarterly review of the missing resident plan is overburdensome. Recommend a plan review on an annual basis.
4659.0070Procedures for Resident Termination and Discharge Planning	Subp. 1 . This entire subpart seems unnecessary and duplicative to what is already in statute. A required five-business day notice of the pre termination meeting is too long, especially if remote participation by telephone, video or other means is allowed. 144G.52 subd. 2(2)(b) already

	requires that the meeting must take place at least seven days before the notice of termination. This effectively adds nearly another week to the process. We also have concerns with Subp. 1B. This has potential for abuse by residents and/or their representatives. They have an incentive to make themselves unavailable for the meeting, thus prolonging the process. This is also contrary to the statute, which only requires that "The facility must make reasonable efforts to ensure that the resident, legal representative, and designated representative are able to attend this meeting." The rule appears to inflict a higher duty than the statute, and the statutory language was carefully crafted to avoid the concerns of abuse and unnecessary delay. Subp. 2B The requirement that the facility make reasonable efforts to ensure that anyone else a resident invites to the meeting is able to participate is unreasonable and exceeds the scope of the statute. The statute requires reasonable efforts to ensure the resident, legal representative, and designated representative are able to attend, but the rule would create an obligation to attempt to accommodate an unlimited number of people. While the resident has the right to invite others, this proposed requirement has potential for abuse. What happens if five of the six people the resident wants at the meeting can be there? Does the provider have to rescheduled because of the unavailability of one person? At what point does the situation of trying to schedule a pre-termination meeting become unreasonable? Subp. 4 While it is perhaps a good idea for providers to summarize meeting outcomes, the 24-hour requirement seems a bit aggressive. Also, it should be made clear that any agreements reached at the pre-termination meeting do not negate the provider's ability to issue a termination notice at least seven days following the meeting (unless the provider has affirmatively agreed to refrain from doing this, either entirely or for a specified period of time). Related to the pre-termination meeting, what happens if a certain course of action is identified at the meeting but is either not adhered to by the resident or does not resolve the issue that gave rise to the termination process? Will the provider have to go back to and start the termination process over again, or will the provider be allowed to proceed with a termination notice? Language should be included stating that a provider need not hold more than one pre-termination meeting in the course of a specific period of time (One year?). Subp. 5 A. There is no reason to require an affidavit of service. The statute simply requires written notice. This isn't reasonable and should be removed.

	C. We are interpreting this paragraph to require a separate notice to the Ombudsman. 144G.52, subd. 7 (a) simply requires a copy of the same notice of termination to be sent to the Ombudsman, so we believe this exceeds the scope of the statute. Why does the provider need to take yet another step in this process beyond forwarding a copy of the notice to the Ombudsman? Subp. 6 What is the required timing for this? Needs to be clarified. A. The requirement to prepare a relocation evaluation and a relocation plan should not apply if a resident elects to move out after the termination process is initiated. Such a situation should be treated as a voluntary discharge, even if the impetus for the move was triggered by the provider. Also, this language treats the pre-termination and termination processes as separate. That's not appropriate. The pre-termination meeting notice is the first step in the termination process. Pre-termination is a component of the greater whole, not a separate process. The requirement that the evaluation include a list of providers is appropriate. However, what does *reasonably close geographic proximity* mean? Can we not use the language in the current home care law requiring a list of a reasonable number of providers in the geographic area of the AL provider? Also, this should not place an obligation of the provider to identify who is able to accept new residents. Subp. 7: Same comment as provided for subp. 6 above. If a resident chooses to move, even if it is because a termination notice has been issued, the resident or the resident's representative should be able to request and receive assistance from a provider with respect to relocation. However, if the move is voluntary and a provider is not asked for help, there should be no obligation on the part of the provider to develop a relocation plan. By when must the planning conference occur? Depending on the timing of the planning meeting, several of the items listed here may not be known yet. Subpart 7 C requires several pieces of information that may not be known. With regard to item number 10, This is not reasonable information to require. If the resident is obligated to pay moving expenses, the provider will likely not have this information. Even if the resident shares it so that it may be included in the relocation plan, payment remains the resident's obligation, not the provider's. There can be no consequence to the provider if the resident fails to pay his or her moving expenses or elects to pay in a different way. Subp. 8

	HIPAA allows a health care provider to disclose an individual's protected health information for the purpose of treatment, which includes the transfer of care from one provider to another. While obtaining a resident's consent may be a good practice, it should not be a requirement. If it is, it could serve as a barrier to transferring a resident's care to another provider. Also, if this language remains, the resident could deliberately refuse to consent to the provider disclosing information to prospective providers in an effort to thwart the termination process. Subp. 8 C raises an important question, as it implies this process would apply even if the resident isn't using services. The statute uses language that in the case of terminated housing, coordinated moves are only required if it is "appropriate to the resident." Subp. 9 A. What is the scope of this information? What time period must be covered? Does it need to be current as of the date on which the resident is discharged or must it cover the entirety of the resident's stay? Is the expectation that a discharging provider summarize all labs, treatments, etc.? The expectations identified here should be clarified. B. C. What is intended by this provision? What is meant by post-discharge prescribed and over-the-counter medications? Providers will not have access to any information regarding the resident after the resident leaves. If the intent is to identify those meds the resident was on prior to discharge and reconcile them with the meds sent with the resident upon discharge, that should be more clearly stated here. If something else is intended, that too should be more clearly identified. D. Requiring the discharging provider to develop a care plan for the resident post-discharge doesn't make any sense. The resident will no longer be under the provider's care and the provider will have no responsibility for the resident. To the extent the intent of this language is to require the provider to identify services needed by the resident following discharge, that is a different document. It is not a care plan. MDH should clarify its intentions with respect to this requirement and amend the language accordingly. Subp. 10 Not all residents will have a case manager. As such the words *if any* should be added after case manager. Subp. 11

	A. Given all of the (very time-consuming) steps identified in this rule part, this language does not make any sense. If a situation meets the standard for an expedited termination, it goes without saying that the process itself should be expedited. Providers should not be held to the drawn-out process identified in Part 4659.0070 when dealing with an expedited termination situation. B. This language should only refer to an expedited termination; it should not refer to a "regular" termination. I recommend removing the words a termination or from this sentence (replace a with an).
4659.0075 Conditions for Planned Closures	• We assume facility closures will continue to be relatively rare and this rule will be invoking infrequently. At the same time, the key issue here is what level of scrutiny and oversight is appropriate for MDH to have during planned closures and how to ensure balance that oversight with the rights of the facility to cease operations when needed. To strike the proper balance we would like to hear more from MDH about its experience with closures and where there is significant need for oversight. • We would also urge the Department to review this language to ensure person-centered throughout. At times it appears to be devoid of resident choice (e.g. the State will "relocate" people). • Below are suggested changes: **Subp. 1** A 1) 2) In many sites there will only be one person with operational/management responsibility. We suggest deleting or changing to say "another individual, in addition to the facility director, who is knowledgeable about the facility's planned closure process". B. C. Is the intention for this to be the exclusive scenario when the rule would apply? If not, consider saying "Without limiting the application of this rule part, a facility's decision to not renew the assisted living contracts of all of its residents constitutes a planned closure".

	The term “Housing contract” is not used in 144G or elsewhere in the proposed rule. Should this be “assisted living contract”? Subp. 2 A. We are concerned that this gives MDH discretion to decide what’s a good reason or a bad reason to close and how soon to close. That is a business decision, and MDH’s only role should be oversight of residents’ rights and safety. We would recommend deleting this. B. C. Not clear if this means all residents, or a subset. If all, see the comment below. If a subset, needs better definition. D. (1) This level of detail appears to gives OOLTC/MDH a role in scrutinizing the needs of all residents, whether or not they are receiving services and whether or not they can make decisions for themselves. This merits a broader discussion on what the goal is of this disclosure and the need to better tailor this language to that goal. E. F. This is unnecessary and should be deleted. It is reasonable for MDH to have a contact that can address questions, and so on, but that is covered in (A)(2). G. We recommending striking this item (G). This rule part should focus on actions specifically relating to orderly relocation, not on-going operations pending closure. Items (1)-(4) are overbroad and presume the facility is in crisis. Items (5) – (7) are reasonable to address, but we recommend taking out of the relocation plan that we submit to MDH and simply state, in a separate sub-section, that facilities that close shall assist with item (5) and shall do items (6)-(7). Subp. 3 Based on the timeline for approval identified on pg. 23, this could be 60-120 days after MDH receives notice of the closure. Although this rule draft indicates resident relocations can occur once MDH approves the closure plan, 144G.55 requires a 60-day notice to residents, which can't be issued until MDH approves the closure. As a result, depending on the circumstances, it could be 120-180 days before a provider who is closing a building is able to move residents out. We would like some additional discussion here. The process should ensure that facilities get a reasonably quick response from MDH and that the process is transparent and consistent; i.e. reasonable assurance up-front of what the approval criteria are going to be. This is important, especially knowing that notification to families and residents can’t realistically occur until MDH approves. 1) This section is overly broad we would suggest that MDH can suggest but not require changes to the plan. We would additionally request language that makes clear that as

	long as the plan includes the elements identified in subpart 2 MDH must approve it. Finally, we would like to include language that states that if MDH does not approve the closure plan within 45 days that it will be deemed approved. 2) This needs clarification. Does the facility have an obligation to proactively send updates or information to MDH while the plan is under review? If so, state how often and what must be communicated. If not, strike all except "timely respond to the commissioner's inquiries".
4659.0100 Initial Assessment And Continuing Assessments	Subpart 2. Nursing Assessment 2(a) does this whole assessment need to be conducted on a prospective resident? What if there is something about the resident – ex) requires 2-person transfer and the community does not provide 2 person transfers as a service – that would allow the community to say "no" to a potential admission without the entire assessment? Seems silly to go through an entire assessment where there are things that can be screened out. 2(b)(2) Would suggest adding language to add or by electronic / remote methods. This requires assessments to be conducted in person; however, during COVID or other similar circumstances and in-person assessment may not always be appropriate or available. They aren't requiring a uniform assessment tool – if we leave the language this way, if MDH comes up with a "suggested" or "example" tool, this language could eventually be interpreted as requiring that tool. 2(b)(3) Suggest changing to "uniform assessment" & not "uniform assessment tool". Subpart. 3 Individualized Review This seems redundant with Subpart 2 – Don't think they're both necessary. Would advocate for combining these – as they say the same thing. Subpart 4. We would advocate to allow LPNs to complete some of the assessments – after the initial admission assessment. The nurse practice act allows for LPN's to complete focused assessments. Subpart 7. We advocate to take this language out. It is not appropriate or practical to require AL's to staff licensed nurses on the weekends for admissions. AL's are not nursing homes and do not always have licensed staff in-house of the weekend. This should continue to be left to the discretion of

	the assisted living particularly as they may not have work required to have a nurse on-site 24/7 or on weekends at least. Subpart 7. This should be deleted. It is not appropriate or practical to require AL's to staff licensed nurses on the weekends for admissions. AL's are not nursing homes and do not always have licensed staff in-house of the weekend. This should continue to be left to the discretion of the assisted living particularly as they may not have work required to have a nurse on-site 24/7 or on weekends at least.
4659.0105 Uniform Assessment Tool	Subp. 2 Not all providers offer all services for all of the areas being assessed. Will providers be able to customize their assessment tools based on the services they offer? They should not have to assess for a resident's service needs beyond the scope of services they provide. Subpart 2(d)(1). Remove nursing diagnosis for pre-admission assessment. This is something we may not have available for review at that time. Subpart 2(d)(4) Add word(s) "as available" or "if available." This information may or may not be available during the pre-admission assessment; or to some extent; even during the assessment once admitted. Subpart 2(d)(4) Add word(s) "as available" or "if available" Subpart 2(d)(5) Add word(s) "as available" or "if available" Subpart 2(d)(7) Add word(s) "as available" or "if available" Subpart 2(e) Add word(s) "as available" or "if available." These documents are emotional and mental health documents and require a separate consent which families or residents may not consent to. Subpart 2(L) " including potential to receive nursing-delegated services" . . . We do not understand what this means. Not standard. We would remove. Subpart 2(M)(1) -(4) Add "current" to the front of the sentence As a new admission pre-admission screen the nurse may not necessarily know this or be able to discern this. Subpart 2(M)(3) Add . . . "if receiving medication services. This will depend upon whether or not someone will receive medication administration services.

	Subpart 2(M)(7) Add “current” or “as information is made available.” This information is not always shared with the provider. Subpart 2(M)(6). This should be removed. Nurses may not be able to evaluate unsuccessful prior placements as these records / information may not be available. Additionally, there is no time frame on prior placements – so is this forever and ever, within the last 12 months, within the last 36 months? Subpart 2 Recommend adding reference to MDH guidance or rules in here. It’s currently just left as per the CDC. As with emergency and disaster planning, this should not be left up to federal agencies exclusively. Also, recommend removing “comply with accepted health care, medical, and nursing standards for infection control.” These are subjective – and require substantive research and synthesis to determine an actual “standard of care” or “best practice”. It should be sufficient to address in terms of CDC an MDH infection prevention and control guidance.
4659.0130 RELINQUISHING AN ASSISTED LIVING FACILITY WITH DEMENTIA CARE LICENSE	Subp 6 Verifying resident relocation – resident should be allowed to decline to disclose and the provider then be absolved of further responsibility to verify
4659.XXXX Disease prevention and Control	No Comments at this time
4659.XXXX Staffing	Subp 2 Clinical Nurse Supervisor. Should address/clarify that a clinical nurse supervisor can serve more than one location. Subpart 3 We do not oppose the concept of creating and posting a daily work schedule, but several of the details required are overburdensome and create privacy issues for staff and residents. Add “or designee” Also, need to clarify that this is based on the residents that need and have contracted for services. Subpart 4(A) We recommend adding “or designee.” There is no reason the clinical nurse supervisor must prepare the schedule. Is direct care staff defined? Lines 31-32 Remove resident assignments – would just leave work location. Subpart4(b) Lines 34-35 Change language to say “work schedule in item A must be posted at least DAILY in a central location. 1 central location is sufficient – may buildings have more than 2-3 floors. The front entrance should be sufficient, and this reduces the possibility for errors should

	the schedule change/adjust over time. AL's with multiple floors would need to spend the time running from floor to floor to adjust all schedules. Subpart 6 Lines 7-9. We recommend deleting. Why is night-time singled out? 10 minutes appears to be arbitrary. If it remains, we recommend keeping the "as soon as possible" and delete "no later than 10 minutes".
4659.XXXX TRAINING REQUIREMENTS.	In general, the Rule should not be simply restating requirements that are already articulated in statute. Subp 3 (b) We have concerns about the approach taken in this subpart, as it gives no clarity regarding the competency testing. This is unreasonable, given that providers will be expected to meet some unknown threshold that may change arbitrarily outside the rules process.
4659.XXXX 1 4659.XXXX TERMINATION APPEALS; PROCEDURES AND TIMELINES FOR APPEALS	Still under review by LAMN and Legal Counsel