General Assembly **Amendment**

February Session, 2008 LCO No. **6460**

HB0586406460HD0

Offered by:

REP. AMANN, 118th Dist.
REP. DONOVAN, 84th Dist.
REP. SAYERS, 60th Dist.
REP. VILLANO, 91st Dist.
REP. RITTER, 38th Dist.
REP. ABERCROMBIE, 83rd Dist.
REP. TERCYAK, 26th Dist.

To: Subst. House Bill No. **5864** File No. 681 Cal. No. 407

"AN ACT CONCERNING A NURSING HOME IMPROVEMENT PLAN."

Strike everything after the enacting clause and substitute the following in lieu thereof:

"Section 1. (NEW) (*Effective July 1, 2009*) (a) As used in this section, (1) "direct care" means hands-on care provided to residents of chronic and convalescent nursing homes, including, but not limited to, feeding, bathing, toileting, dressing, lifting and moving such residents, but does not include (A) food preparation, housekeeping or laundry services, except when such services are required to meet the needs of any such resident on an individual situational basis, and (B) care provided by paid feeding assistants, as defined in 42 CFR 488.301; (2) "licensed nurse" means a person licensed under chapter 378 of the general statutes, as a registered nurse or a licensed practical nurse; and (3) "nurse's aide" means an individual providing nursing or nursing-related services to residents in a chronic and convalescent nursing

home, but does not include an individual who is a health professional otherwise licensed or certified by the Department of Public Health, or who volunteers to provide such services without monetary compensation.

(b) Each chronic and convalescent nursing home shall employ sufficient nurses and nurse's aides to provide appropriate direct care to residents of such nursing home, twenty-four hours per day, seven days per week. On and after October 1, 2009, over a twenty-four-hour period, each chronic and convalescent nursing home shall provide not less than 3.6 hours of direct care and services per resident provided in the aggregate by licensed nurses and nurse's aides.

(c) As part of the required 3.6 total number of hours of direct care provided, on and after October 1, 2009, there shall be a minimum staffing ratio of:

(1) For the day shift, one full-time nurse's aide for each five residents;

(2) For the evening shift, one full-time nurse's aide for each ten residents; and

(3) For the night shift, one full-time nurse's aide for each fifteen residents.

(d) A licensed practical nurse may substitute for a nurse's aide for the purposes of subsection (c) of this section.

Sec. 2. (NEW) (*Effective July 1, 2009*) (a) (1) In order to determine whether chronic and convalescent nursing homes are in compliance with the minimum direct care staffing hours specified in subsection (b) of section 1 of this act, and the minimum staffing ratios specified in subsection (c) of section 1 of this act, on and after October 1, 2009, during any annual inspection or follow-up inspection, the Department of Public Health shall request copies of each inspected facility's census records, schedules and payroll records for the month immediately

preceding the inspection. The Department of Public Health shall compare schedules and payroll records to determine whether or not the facility is in compliance with the minimum direct care staffing standards pursuant to subsections (b) and (c) of section 1 of this act. In making such determination, the Department of Public Health shall exclude from its calculation any hours paid but not worked, such as vacation time, sick time, personal time or other form of paid time off, but shall include any hours worked by temporary or agency staff.

(2) For the cost report year beginning October 1, 2010, and annually thereafter, the Department of Social Services shall calculate the average hours of direct care per resident per day at each facility by using the statistics reported on the Medicaid cost reports submitted annually to the department pursuant to section 17b-340 of the 2008 supplement to the general statutes and dividing the total number of resident days reported by the total number of licensed and unlicensed direct care hours reported, exclusive of any hours reported as administrative for licensed and unlicensed staff, the result of which calculation shall be the average number of hours of direct care per resident per day on average over the cost year. The department shall provide such calculations to the Department of Public Health to assist the Department of Public Health in determining compliance with the minimum direct care staffing hours required in subsection (b) of section 1 of this act.

(b) If the Department of Public Health determines that a facility is not in compliance with the minimum direct care staffing hours specified in subsection (b) of section 1 of this act or the minimum direct care staffing ratios specified in subsection (c) of section 1 of this act, the department shall notify such facility of such finding and require such facility to file a report with the department not later than fourteen days after the date of such notice explaining (1) why the facility was not in compliance at the time of determination, and (2) the facility's plan of correction. If subsequent inspections or information reveal that the facility has not implemented the plan of correction to meet the minimum direct care staffing hours or minimum direct care staffing

ratios, the facility shall be required to file monthly staffing reports with the department for a period of not less than one year after such finding of noncompliance, or until three months after such facility is found in compliance, whichever is longer.

(c) Upon receipt of any complaint against a facility by any person alleging inadequate staff to meet the minimum direct care staffing hours or minimum direct care staffing ratios, the Department of Public Health shall inspect the records of such facility for the specific day, days or period cited in such complaint.

Sec. 3. (NEW) (*Effective July 1, 2009*) On and after January 1, 2010, and annually thereafter, the Department of Public Health shall issue a report to the joint standing committees of the General Assembly having cognizance of matters relating to human services and public health on the average direct care staffing hours per resident per day and minimum direct care staffing ratios for each chronic and convalescent nursing home in the state, highlighting any that did not meet the standards required pursuant to section 1 of this act.

Sec. 4. (NEW) (*Effective July 1, 2009*) If a chronic or convalescent nursing home fails to comply with the minimum direct care staffing standards established pursuant to section 1 of this act, the Commissioner of Social Services may recover all or any part of the Medicaid funding allocated to such facility for the specific and targeted purpose of increasing direct care staffing at such facility. Such facility shall be allowed to retain a portion of the funds allocated to improve its staffing ratio during the relevant time period as determined by the commissioner.

Sec. 5. (NEW) (*Effective July 1, 2009*) In addition to any other disclosures required under any provision of the general statutes, on and after October 1, 2009, each chronic and convalescent nursing home shall maintain and make publicly available information about staffing schedules and ratios as follows:

(1) Each chronic and convalescent nursing home shall post for each

unit of the facility and for each shift the current number of licensed and unlicensed nursing staff directly responsible for resident care and the current ratios of residents to staff, which show separately the number of residents to licensed nursing staff and the number of residents to certified nurse's aides. This information shall be displayed on a uniform form supplied by the Department of Public Health.

(2) Such information shall be posted for the most recently concluded cost reporting period in the form of average daily staffing ratios for that period.

(3) Such information shall be posted in a manner that is visible and accessible to all residents, their families, caregivers and potential consumers in each facility.

(4) A poster provided by the Department of Public Health that describes the minimum staffing standards and ratios required pursuant to section 1 of this act shall be posted in the same vicinity.

(5) A list, in at least 48-point type, showing the first and last names of nursing staff on duty shall be posted at the beginning of each shift prominently on each unit.

Sec. 6. (NEW) (*Effective July 1, 2009*) The Department of Public Health shall adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, to implement the provisions of sections 1, 2 and 5 of this act.

Sec. 7. (NEW) (*Effective October 1, 2008*) (a) For purposes of this section:

(1) "Department" means the Department of Public Health; and

(2) "Direct care" means hands-on-care provided to residents of nursing homes, including, but not limited to, feeding, bathing, toileting, dressing, lifting and moving such residents, but does not include food preparation, housekeeping or laundry services, except when such services are required to meet the needs of any such resident

on an individual situational basis. Direct care does not include care provided by paid feeding assistants, as defined in 42 CFR 488.301.

(b) On and after July 1, 2009, each chronic and convalescent nursing home or rest home with nursing supervision licensed by the department pursuant to chapter 368v of the general statutes shall, as a condition of continued licensure, develop, and upon request of the department, make available for inspection a nurse staffing plan that is sufficient to provide adequate and appropriate delivery of health care services to patients in the ensuing period of licensure. The nurse staffing plan shall promote a collaborative practice in such facility that enhances patient care and the level of services provided by nurses and other members of the nursing home's patient care team.

(c) Each chronic and convalescent nursing home or rest home with nursing supervision shall establish a staffing committee to assist in the preparation of the nurse staffing plan required pursuant to subsection (b) of this section. The staffing committee shall include registered nurses who provide direct patient care, licensed practical nurses and certified nursing assistants. Each chronic and convalescent nursing home or rest home with nursing supervision, in collaboration with its staffing committee, shall develop and implement the nurse staffing plan. Such plan shall: (1) Include the minimum professional skill mix for each patient care unit in such facility, including any special care units; (2) identify such facility's employment practices concerning the use of licensed temporary and traveling nurses; (3) set forth the level of administrative staffing in each patient care unit of such facility that ensures direct care staff are not utilized for administrative functions; (4) set forth such facility's process for internal review of the nurse staffing plan; (5) identify collective bargaining agreements that such facility is a party to and certify such facility's compliance with such agreements; (6) include such facility's mechanism of obtaining input from direct care staff, including licensed nurses and other members of the nursing home's patient care team, in the development of a nurse staffing plan; and (7) for a chronic and convalescent nursing home, set forth the steps necessary for the chronic and convalescent nursing

home to provide a minimum of 4.13 hours of direct care per resident by October 1, 2011.

Sec. 8. Section 19a-550 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2008*):

(a) (1) As used in this section, (A) "nursing home facility" shall have the same meaning as provided in section 19a-521, and (B) "chronic disease hospital" means a long-term hospital having facilities, medical staff and all necessary personnel for the diagnosis, care and treatment of chronic diseases; and (2) for the purposes of subsections (c) and (d) of this section, and subsection (b) of section 19a-537, "medically contraindicated" means a comprehensive evaluation of the impact of a potential room transfer on the patient's physical, mental and psychosocial well-being, which determines that the transfer would cause new symptoms or exacerbate present symptoms beyond a reasonable adjustment period resulting in a prolonged or significant negative outcome that could not be ameliorated through care plan intervention, as documented by a physician in a patient's medical record.

(b) There is established a patients' bill of rights for any person admitted as a patient to any nursing home facility or chronic disease hospital. The patients' bill of rights shall be implemented in accordance with the provisions of Sections 1919(b), 1919(c), 1919(c)(2), 1919(c)(2)(D) and 1919(c)(2)(E) of the Social Security Act. The patients' bill of rights shall provide that each such patient: (1) Is fully informed, as evidenced by the patient's written acknowledgment, prior to or at the time of admission and during the patient's stay, of the rights set forth in this section and of all rules and regulations governing patient conduct and responsibilities; (2) is fully informed, prior to or at the time of admission and during the patient's stay, of services available in the facility, and of related charges including any charges for services not covered under Titles XVIII or XIX of the Social Security Act, or not covered by basic per diem rate; (3) is entitled to choose the patient's own physician and is fully informed, by a physician, of the patient's

medical condition unless medically contraindicated, as documented by the physician in the patient's medical record, and is afforded the opportunity to participate in the planning of the patient's medical treatment and to refuse to participate in experimental research; (4) in a residential care home or a chronic disease hospital is transferred from one room to another within the facility only for medical reasons, or for the patient's welfare or that of other patients, as documented in the patient's medical record and such record shall include documentation of action taken to minimize any disruptive effects of such transfer, except a patient who is a Medicaid recipient may be transferred from a private room to a nonprivate room, provided no patient may be involuntarily transferred from one room to another within the facility if (A) it is medically established that the move will subject the patient to a reasonable likelihood of serious physical injury or harm, or (B) the patient has a prior established medical history of psychiatric problems and there is psychiatric testimony that as a consequence of the proposed move there will be exacerbation of the psychiatric problem which would last over a significant period of time and require psychiatric intervention; and in the case of an involuntary transfer from one room to another within the facility, the patient and, if known, the patient's legally liable relative, guardian or conservator or a person designated by the patient in accordance with section 1-56r, is given at least thirty days' and no more than sixty days' written notice to ensure orderly transfer from one room to another within the facility, except where the health, safety or welfare of other patients is endangered or where immediate transfer from one room to another within the facility is necessitated by urgent medical need of the patient or where a patient has resided in the facility for less than thirty days, in which case notice shall be given as many days before the transfer as practicable; (5) is encouraged and assisted, throughout the patient's period of stay, to exercise the patient's rights as a patient and as a citizen, and to this end, has the right to be fully informed about patients' rights by state or federally funded patient advocacy programs, and may voice grievances and recommend changes in policies and services to facility staff or to outside representatives of the patient's choice, free from

restraint, interference, coercion, discrimination or reprisal; (6) shall have prompt efforts made by the facility to resolve grievances the patient may have, including those with respect to the behavior of other patients; (7) may manage the patient's personal financial affairs, and is given a quarterly accounting of financial transactions made on the patient's behalf; (8) is free from mental and physical abuse, corporal punishment, involuntary seclusion and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the patient's medical symptoms. Physical or chemical restraints may be imposed only to ensure the physical safety of the patient or other patients and only upon the written order of a physician that specifies the type of restraint and the duration and circumstances under which the restraints are to be used, except in emergencies until a specific order can be obtained; (9) is assured confidential treatment of the patient's personal and medical records, and may approve or refuse their release to any individual outside the facility, except in case of the patient's transfer to another health care institution or as required by law or third-party payment contract; (10) receives quality care and services with reasonable accommodation of individual needs and preferences, except where the health or safety of the individual would be endangered, and is treated with consideration, respect, and full recognition of the patient's dignity and individuality, including privacy in treatment and in care for the patient's personal needs; (11) is not required to perform services for the facility that are not included for therapeutic purposes in the patient's plan of care; (12) may associate and communicate privately with persons of the patient's choice, including other patients, send and receive the patient's personal mail unopened and make and receive telephone calls privately, unless medically contraindicated, as documented by the patient's physician in the patient's medical record, and receives adequate notice before the patient's room or roommate in the facility is changed; (13) is entitled to organize and participate in patient groups in the facility and to participate in social, religious and community activities that do not interfere with the rights of other patients, unless medically contraindicated, as documented by the

patient's physician in the patient's medical records; (14) may retain and use the patient's personal clothing and possessions unless to do so would infringe upon rights of other patients or unless medically contraindicated, as documented by the patient's physician in the patient's medical record; (15) is assured privacy for visits by the patient's spouse or a person designated by the patient in accordance with section 1-56r and, if the patient is married and both the patient and the patient's spouse are inpatients in the facility, they are permitted to share a room, unless medically contraindicated, as documented by the attending physician in the medical record; (16) is fully informed of the availability of and may examine all current state, local and federal inspection reports and plans of correction; (17) may organize, maintain and participate in a patient-run resident council, as a means of fostering communication among residents and between residents and staff, encouraging resident independence and addressing the basic rights of nursing home and chronic disease hospital patients and residents, free from administrative interference or reprisal; (18) is entitled to the opinion of two physicians concerning the need for surgery, except in an emergency situation, prior to such surgery being performed; (19) is entitled to have the patient's family or a person designated by the patient in accordance with section 1-56r meet in the facility with the families of other patients in the facility to the extent the facility has existing meeting space available which meets applicable building and fire codes; (20) is entitled to file a complaint with the Department of Social Services and the Department of Public Health regarding patient abuse, neglect or misappropriation of patient property; (21) is entitled to have psychopharmacologic drugs administered only on orders of a physician and only as part of a written plan of care developed in accordance with Section 1919(b)(2) of the Social Security Act and designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually, an independent external consultant reviews the appropriateness of the drug plan; (22) is entitled to be transferred or discharged from the facility only pursuant to section 19a-535 or section 19a-535b <u>of the 2008 supplement to the general statutes</u>, as applicable;

(23) is entitled to be treated equally with other patients with regard to transfer, discharge and the provision of all services regardless of the source of payment; (24) shall not be required to waive any rights to benefits under Medicare or Medicaid or to give oral or written assurance that the patient is not eligible for, or will not apply for benefits under Medicare or Medicaid; (25) is entitled to be provided information by the facility as to how to apply for Medicare or Medicaid benefits and how to receive refunds for previous payments covered by such benefits; (26) on or after October 1, **[**1990**]** 2008, shall not be required to **[**give a third party guarantee of**]** bind or obligate a third party for payment to the facility **[**as a condition of**]** in connection with the admission to, or continued stay in, the facility; (27) in the case of an individual who is entitled to medical assistance, is entitled to have the facility not charge, solicit, accept or receive, in addition to any amount otherwise required to be paid under Medicaid, any gift, money, donation or other consideration as a precondition of admission or expediting the admission of the individual to the facility or as a requirement for the individual's continued stay in the facility; and (28) shall not be required to deposit the patient's personal funds in the facility.

(c) The patients' bill of rights shall provide that a patient in a rest home with nursing supervision or a chronic and convalescent nursing home may be transferred from one room to another within a facility only for the purpose of promoting the patient's well-being, except as provided pursuant to subparagraph (C) or (D) of this subsection or subsection (d) of this section. Whenever a patient is to be transferred, the facility shall effect the transfer with the least disruption to the patient and shall assess, monitor and adjust care as needed subsequent to the transfer in accordance with subdivision (10) of subsection (b) of this section. When a transfer is initiated by the facility and the patient does not consent to the transfer, the facility shall establish a consultative process that includes the participation of the attending physician, a registered nurse with responsibility for the patient and other appropriate staff in disciplines as determined by the patient's

needs, and the participation of the patient, the patient's family, a person designated by the patient in accordance with section 1-56r or other representative. The consultative process shall determine: (1) What caused consideration of the transfer; (2) whether the cause can be removed; and (3) if not, whether the facility has attempted alternatives to transfer. The patient shall be informed of the risks and benefits of the transfer and of any alternatives. If subsequent to the completion of the consultative process a patient still does not wish to be transferred, the patient may be transferred without the patient's consent, unless medically contraindicated, only (A) if necessary to accomplish physical plant repairs or renovations that otherwise could not be accomplished; provided, if practicable, the patient, if the patient wishes, shall be returned to the patient's room when the repairs or renovations are completed; (B) due to irreconcilable incompatibility between or among roommates, which is actually or potentially harmful to the well-being of a patient; (C) if the facility has two vacancies available for patients of the same sex in different rooms, there is no applicant of that sex pending admission in accordance with the requirements of section 19a-533 and grouping of patients by the same sex in the same room would allow admission of patients of the opposite sex, which otherwise would not be possible; (D) if necessary to allow access to specialized medical equipment no longer needed by the patient and needed by another patient; or (E) if the patient no longer needs the specialized services or programming that is the focus of the area of the facility in which the patient is located. In the case of an involuntary transfer, the facility shall, subsequent to completion of the consultative process, provide the patient and the patient's legally liable relative, guardian or conservator if any or other responsible party if known, with at least fifteen days' written notice of the transfer, which shall include the reason for the transfer, the location to which the patient is being transferred, and the name, address and telephone number of the regional long-term care ombudsman, except that in the case of a transfer pursuant to subparagraph (A) of this subsection at least thirty days' notice shall be provided. Notwithstanding the provisions of this subsection, a patient may be involuntarily transferred immediately

from one room to another within a facility to protect the patient or others from physical harm, to control the spread of an infectious disease, to respond to a physical plant or environmental emergency that threatens the patient's health or safety or to respond to a situation that presents a patient with an immediate danger of death or serious physical harm. In such a case, disruption of patients shall be minimized; the required notice shall be provided within twenty-four hours after the transfer; if practicable, the patient, if the patient wishes, shall be returned to the patient's room when the threat to health or safety which prompted the transfer has been eliminated; and, in the case of a transfer effected to protect a patient or others from physical harm, the consultative process shall be established on the next business day.

(d) Notwithstanding the provisions of subsection (c) of this section, unless medically contraindicated, a patient who is a Medicaid recipient may be transferred from a private to a nonprivate room. In the case of such a transfer, the facility shall (1) give at least thirty days' written notice to the patient and the patient's legally liable relative, guardian or conservator, if any, a person designated by the patient in accordance with section 1-56r or other responsible party, if known, which notice shall include the reason for the transfer, the location to which the patient is being transferred and the name, address and telephone number of the regional long-term care ombudsman; and (2) establish a consultative process to effect the transfer with the least disruption to the patient and assess, monitor and adjust care as needed subsequent to the transfer in accordance with subdivision (10) of subsection (b) of this section. The consultative process shall include the participation of the attending physician, a registered nurse with responsibility for the patient and other appropriate staff in disciplines as determined by the patient's needs, and the participation of the patient, the patient's family, a person designated by the patient in accordance with section 1-56r or other representative.

(e) **[**Any facility that negligently deprives a patient of any right or benefit created or established for the well-being of the patient by the

provisions of this section shall be liable to such patient in a private cause of action for injuries suffered as a result of such deprivation. Upon a finding that a patient has been deprived of such a right or benefit, and that the patient has been injured as a result of such deprivation, damages shall be assessed in the amount sufficient to compensate such patient for such injury.**]** The rights or benefits specified in subsections (b), (c) and (d) of this section may not be reduced, rescinded or abrogated by contract. Any facility that fails to comply with any provision of this section with respect to any patient shall be liable to such patient in a private cause of action for damages. In addition, where the **[**deprivation of any such right or benefit**]** failure is found to have been wilful or in reckless disregard of the rights of the patient, punitive damages may be assessed. A patient may also maintain an action pursuant to this section for any other type of relief, including injunctive and declaratory relief, permitted by law. Exhaustion of any available administrative remedies shall not be required prior to commencement of suit under this section.

(f) In addition to the rights specified in subsections (b), (c) and (d) of this section, a patient in a nursing home facility is entitled to have the facility manage the patient's funds as provided in section 19a-551."

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2009*	New section
Sec. 2	*July 1, 2009*	New section
Sec. 3	*July 1, 2009*	New section
Sec. 4	*July 1, 2009*	New section
Sec. 5	*July 1, 2009*	New section
Sec. 6	*July 1, 2009*	New section
Sec. 7	*October 1, 2008*	New section
Sec. 8	*October 1, 2008*	19a-550