

## **Office of Health Care Quality Regulation Review Public Comments: COMAR 10.07.02 (Sections .01 - .12)**

The Office of Health Care Quality (OHCQ) within the Maryland Department of Health and Mental Hygiene (DHMH) extends its gratitude for all of the comments, suggestions, and recommendations suggested by our valued stakeholders. Due to your efforts we have been able to revise and update COMAR 10.07.02 Comprehensive Care Facilities and Extended Care Facilities. A public comment period was held September 26, 2014 through November 14, 2014 to collect input on the draft regulation. This document represents the public comments received as of December 31, 2014.

During the public comment period, the draft regulation was posted on the Office of Health Care Quality's website and distributed to the public through emails and stakeholder meetings. Individuals and groups had the opportunity to submit comments through an electronic public comment form, email, or in person. Three public stakeholder meetings were held on site at the OHCQ. The meetings were advertised on the OHCQ website, through the email distribution list, and word of mouth.

Comments and Responses – This document contains responses to all substantive comments received on the Draft COMAR 10.07.02, organized by regulation in the order of regulations presented in the Draft COMAR 10.07.02 (i.e., beginning with .01. Definitions). Similar comments were combined and are addressed below.

Each comment has been coded by the letter C for comment, regulation number and comment's sequential order. For example, the first comment for .01 Definitions would be denoted as "C.01-1". The second comment is "C.01-2".

If you have any questions please contact Amanda Thomas at [Amanda.thomas@maryland.gov](mailto:Amanda.thomas@maryland.gov). Thank you once again for your continued participation and partnership.

The table provides an overview of all responses as provided through the online comment platform. The staff of OHCQ did not make any changes or corrections of grammar in the comments.

**Office of Health Care Quality Regulation Review Public Comments:  
COMAR 10.07.02 (Sections .01 - .12)**

**Regulation .01 Definitions**

	<b>Comments</b>	<b>Responses</b>
C.01 - 1	Re: Definition [(28)] (53) – “other qualified person” (page 7 of proposed regulations) I strongly urge a change in definition for - [(28)] (53). “Other qualified person”. This definition should be changed to “means a person who is eligible for registration under the requirements of the Academy of Nutrition and Dietetics, and who has successfully passed the national Dietetic Technician, Registered Examination” establishing proficiency in non-medical nutrition therapy practice.” An individual who has a baccalaureate degree with major studies in food and nutrition, dietetics or food service management, has 1 year supervisory experience in the dietetic service of a health care institution and participates annually in continuing dietetic education HAS NOT established by examination (or other measurable outcome) proficiency in non-medical nutrition therapy practice.	The term “other qualified person” was removed from the regulation.
C.01 - 2	We would like to acknowledge and thank OHCQ for amending the definitions of chemical and physical restraints that were originally proposed, and for adding the requirement of physician involvement in the use of protective devices	OHCQ appreciates your comment.

The table provides an overview of all responses as provided through the online comment platform. The staff of OHCQ did not make any changes or corrections of grammar in the comments.

**Office of Health Care Quality Regulation Review Public Comments:  
COMAR 10.07.02 (Sections .01 - .12)**

	<b>Comments</b>	<b>Responses</b>
C.01 - 3	We are encouraged by the addition of the definitions for “chemical restraints” and “physical restraints,” although we are not sure why they are defined twice: first as standalone terms in proposed .01B(11) and .01B(58) and then again a second time within .01B(81), the definition of “Restraint.”	OHCQ agrees with these concerns and has made appropriate modifications in the final regulation. The terms, “chemical restraint” and “physical restraint” are now solely listed under the term “restraints”.
C.01 - 4	[(52)] (89) "Supportive personnel" means an aide, assigned to a particular service such as nursing, dietary, physical therapy, or occupational therapy, who has been approved by the chief of the services as having sufficient training and experience to perform [his] the assigned duties. This is a problem when it is used in the context of nursing home staffing as in 10.07.02.12 (J). For nursing home minimum staffing levels, the count must include only nurses and certified geriatric nursing aides. As written in these nursing home regulation, this is far too ambiguous.	The term “supportive personnel” was used in an effort to include the staffing of various long-term care facility sizes and dynamics. All staff are required to meet the standards and requirements of their position and are still subject to designated supervision.
C.01-5	Please provide definitions that everyone can understand and that do not simply refer the term back to a "clinician" for interpretation for the following terms that are used in multiple proposed and current regulations. 1. Bedside Care 2. Emergency Dental Care 3. Routine Dental Care 4. Ombudsman --State or Local Long-Term Care Ombudsman 5. Also, "acceptable force" if it is still used in any regulations.	The Centers for Medicare and Medicaid provides guidance and definitions for “emergency dental care”, “routine dental care”, and “ombudsman”. OHCQ deems the CMS definitions for the aforementioned terms sufficient. The term Bedside Care was not defined as OHCQ believes the term is sufficient as written. The term “acceptable force” was not used in COMAR 10.07.02.
C.01 - 6	.01B(8) "Certified Dietary Manager" (page 1 of 77): It is often difficult for facilities to find CDMs, particularly in rural regions, so they will hire someone with a strong food service background	OHCQ fully supports the hiring of qualified and trained staff. The CDM license ensures that the certified dietary manager is able to provide quality nutritional care for residents. The

The table provides an overview of all responses as provided through the online comment platform. The staff of OHCQ did not make any changes or corrections of grammar in the comments.

**Office of Health Care Quality Regulation Review Public Comments:  
COMAR 10.07.02 (Sections .01 - .12)**

	Comments	Responses
	and assist in that individual obtaining certification after hire. However, some facilities have had issues during surveys where their dietetic supervisor was not given enough time to complete the training and certification process. There needs to be an allowance for the time it takes to train and assist a individual to become licensed as a CDM because it is not unusual that there is a no licensed CDM available to hire when the position needs to be filled.	Association of Nutrition and Foodservice Professionals describes four pathways to obtaining the CDM license.
C.01 - 7	.01B(15)(a) (page 2 of 77): What would be considered a "change in behavioral status" during the concurrent review that would trigger a more comprehensive evaluation of a resident's medications, labs, clinical data, etc.? How does this differ from "mental status"?	OHCQ convened a stakeholder work group to review and make recommendations for the regulation.
C.01 - 8	.01B(32)(a) (page 5 of 77): The approved training required to complete the 15 contact hours to become an infection preventionist are not offered frequently enough. Facilities have faced delays filling a vacancy until the next training is available to certify a healthcare worker as the infection preventionist. We ask that the trainings be offered more frequently and/or approve organizations outside of the Department to host these trainings.	Staff has the flexibility to utilize any training approved by the Department. The training provider has the latitude and flexibility to offer training as frequently as necessary. Additional information pertaining to training can be found on the Department's website.
C.01 - 9	.01B(5) "Certified Social Worker" (page 2 of 77): In response to a comment made at the regulatory review session, HFAM does not support expanding the definition to specify that the certified social worker be a clinical social worker	OHCQ appreciates your comment. OHCQ agrees with these concerns and has made appropriate modifications in the final regulation. OHCQ has clarified the requirements of a "licensed social worker" to function as a social worker in

The table provides an overview of all responses as provided through the online comment platform. The staff of OHCQ did not make any changes or corrections of grammar in the comments.

**Office of Health Care Quality Regulation Review Public Comments:  
COMAR 10.07.02 (Sections .01 - .12)**

	<b>Comments</b>	<b>Responses</b>
	(LCSW-C) defined under COMAR 10.42.01.05D. Under the current regulations, a certified social worker must already be licensed, have a master’s level education, pass an examination with the Maryland Board of Social Worker Examiners and have significant experiential background under .01B(44)(b). This is sufficient to provide the social work consulting services in the facility and do not require the credentials of a clinical social worker.	the long-term care facility.
C.01 - 10	.01B(73) "Qualified social work consultant" (page 10 of 77): In response to a comment made at the regulatory review session, the term "qualified" does not need to be replaced with "licensed." The definition already means a person who is a certified social worker, which as defined under .01B(9) "Certified social worker" means any person who is licensed to practice as a certified social worker in the State.	The term "qualified social work consultant" will not be changed, however the term "certified social worker" will be changed to "licensed social worker".
C.01 - 11	0.1 Definitions: B. (10) "Charge Nurse, a registered or licensed practical nurse who is responsible for day-to-day operations of a unit..." Comment: The above definition suggests 24 hour responsibility for all nursing services and operations of a unit. This would wrongly require a licensed practical nurse (LPN) to perform functions beyond LPN level of training and licensed practice. See Concurrent review.	OHCQ has not made this suggested change, as OHCQ believes the regulation is sufficient as written.
C.01 - 12	B. (15) "Concurrent review" means daily rounds by a licensed nurse..." Comment: The list of duties includes	OHCQ has not made this suggested change, as OHCQ believes the regulation is sufficient as written.

The table provides an overview of all responses as provided through the online comment platform. The staff of OHCQ did not make any changes or corrections of grammar in the comments.

**Office of Health Care Quality Regulation Review Public Comments:  
COMAR 10.07.02 (Sections .01 - .12)**

	<b>Comments</b>	<b>Responses</b>
	nursing assessment of residents' status, which is a responsibility for a Registered Nurse (RN). Recommendations: Change: "Charge Nurse" definition to say: "a licensed nurse, responsible for resident care on a unit during a single shift or tour of duty, working with oversight and advice of a supervisory RN."	
C.01 - 13	Add an Additional Nursing Position :(15-1) "Unit Nurse Manager" or "Unit Head Nurse" – an RN who is responsible for day-to-day nursing services on a resident care unit."	OHCQ has not made this suggested change, as OHCQ believes the regulation is sufficient as written.
C.01 - 14	B. (38) "Medicine aide..." Recommendation: Add: "The medicine aide reports to and works under supervision of an RN."	OHCQ has not made this suggested change, as OHCQ believes the regulation is sufficient as written.
C.01 - 15	B. (45) "Nurse"....Recommendation: define Registered Nurse (RN) and Licensed Practical Nurse (LPN), separately – each, in terms of their education and licensed scope of practice.	OHCQ has not made this suggested change, as OHCQ believes the regulation is sufficient as written.
C.01 - 16	B. (48) "Nursing Facility...." This is described as a facility offering nonacute inpatient care to residents who have a disease or disability requiring maximal nursing care... who require medical services and nursing services rendered by or under the supervision of a licensed nurse..." Comment:"Maximal nursing	OHCQ has not made this suggested change, as OHCQ believes the regulation is sufficient as written.

The table provides an overview of all responses as provided through the online comment platform. The staff of OHCQ did not make any changes or corrections of grammar in the comments.

**Office of Health Care Quality Regulation Review Public Comments:  
COMAR 10.07.02 (Sections .01 - .12)**

	Comments	Responses
	<p>care for nursing services is care rendered by or under the supervision of an RN. A nonacute resident population is subject to serious injury and change in health status that must be assessed by a professional RN who decides appropriate action. Recommendation: Change "...rendered by or under the supervision of a licensed nurse...": to say "nursing services rendered by or under the supervision of an RN."</p>	

The table provides an overview of all responses as provided through the online comment platform. The staff of OHCQ did not make any changes or corrections of grammar in the comments.

**Office of Health Care Quality Regulation Review Public Comments:  
COMAR 10.07.02 (Sections .01 - .12)**

**Regulation .06 New Construction, Conversion, Alteration, or Addition.**

	Comments	Responses
C.06 - 1	Any regulations in this category need to incorporate all Culture Change features and principles as a part of the regulations and not require "waivers" for these critical improvements in care and quality of life.	OHCQ appreciates your comment.
C.06 - 2	Please clarify the timing of Section C(1). The language states that an existing facility that wishes to convert, alter, modify or add to an existing infrastructure must notify OHCQ in writing that local and State governments have "issued all required permits." Typically facilities are issued permits immediately prior to starting construction and those permits have specific construction timeframes. Given Section E., which requires documentation that verifies the work was approved by local and State government, it does not seem that C(1) is necessary. As an alternative, the requirement for C(1) could be a description of the proposed project and how all residents, staff and the general public will be kept safe during the duration of the project.	In order to eliminate any confusion, OHCQ has clarified the requirements of this provision in the final regulation.  E. The facility shall provide the Office of Health Care Quality with documentation that verifies that all applicable local and State governmental authorities have approved of work that was conducted. This documentation may include, but is not limited to building permits.
C.06 - 3	.06B (page 14 of 77): What qualifies as a conversion, alteration, modification or addition to an existing infrastructure that would require OHCQ to be notified in writing? This seems overly broad. For example, if a facility converted an office space to a conference room, would this require notification? Or if a resident room was converted to a recreation room? Or if the bathroom was modernized? None of these examples	In order to eliminate any confusion, OHCQ has clarified the requirements of this provision in the final regulation.

The table provides an overview of all responses as provided through the online comment platform. The staff of OHCQ did not make any changes or corrections of grammar in the comments.

**Office of Health Care Quality Regulation Review Public Comments:  
COMAR 10.07.02 (Sections .01 - .12)**

	Comments	Responses
	<p>would require a permit or approval, but would they meet the standard that would trigger required notification to OHCQ in writing? We would suggest that if it's significant enough to require a permit to make the change to the infrastructure, notification should be required, but if no such prior approval is needed, there isn't a need to notify OHCQ of relatively insignificant building modifications.</p>	
C.06 - 4	<p>.06E (page 14 of 77): In the proposed regulation, the facility shall provide the Office of Health Care Quality with documentation that verifies that all applicable local and State governmental authorities have approved of work that was conducted. This documentation may include, but is not limited to, permits, Use and Occupancy permits, and reports from testing of building systems. We have previously commented that this is unrealistic because not all permits will, nor can they, be obtained before documentation is submitted to OHCQ for proposed facility changes. In conversations, OHCQ has indicated that it would not expect permits to be provided that are not yet available, but that needs to be reflected in writing through these regulations to avoid uncertainty on the part of the facility.</p>	<p>In order to eliminate any confusion, OHCQ has clarified the requirements of this provision in the final regulation.</p>

The table provides an overview of all responses as provided through the online comment platform. The staff of OHCQ did not make any changes or corrections of grammar in the comments.

**Office of Health Care Quality Regulation Review Public Comments:  
COMAR 10.07.02 (Sections .01 - .12)  
Regulation .07 Administration and Resident Care**

	<b>Comments</b>	<b>Responses</b>
C.07 - 1	.07-1 Dementia training - is severely lacking - especially how to respond to a resident with BPSD - training and oversight that is in real-time hands-on - and on-going - during real-life situations/care. GNA's lack information to help them provide care - how to care for and how to respond to each resident - care plans are written and out of sight - only for the regulators to review - NOT reviewed by GNA's - even for the tasks that they are responsible for.	OHCQ convened a stakeholder work group to review and make recommendations for the regulation.
C.07 - 2	Multiple comments were received for this regulation 10.07.02.07 Administration and Resident Care, section M. Some commenter's offered support for OHCQ's revised proposed regulation, which included a mandate for specified font and size. While other commenter's opposed the revised proposed regulation.	OHCQ highly encourages the visibility of identification tags. However, the Department lacks the regulatory authority to prescribe the size, font, construction and or use of hardware to secure the tags.
C.07 - 3	10.07.02.07-1 A,B,C I have worked at nursing homes as a Dance Therapist for many years. The staff training needs to be much more comprehensive and detailed with on-floor demonstrations and interventions. It is the communication between staff and resident that needs to be vastly improved. I have many ideas along these lines.	OHCQ appreciates your comment.
C.07 - 4	.07-1 page 17, Employee Training on Cognitive Impairment and Mental Illness This area was not addressed in the MHAMD original submission of recommendations however several stakeholders of the Maryland Coalition	OHCQ convened a stakeholder work group to review and make recommendations for the regulation.

The table provides an overview of all responses as provided through the online comment platform. The staff of OHCQ did not make any changes or corrections of grammar in the comments.

**Office of Health Care Quality Regulation Review Public Comments:  
COMAR 10.07.02 (Sections .01 - .12)**

	<b>Comments</b>	<b>Responses</b>
	<p>on Mental Health and Aging agree that this area should be revisited to better reflect the growing "behavioral" health challenges in nursing homes. In lieu of offering specific language, we recommend discussion at the stakeholder meeting or, better, a small workgroup of individuals with experience and expertise in this area to decide an appropriate hour assignment of education for particular segments of the workforce and topics that more broadly encompass the current causes and nature of behavioral health disorders in nursing facilities.</p>	
C.07 - 5	<p>F. Staffing. (1) "The Administrator shall employ....." Recommendation: Delete: ".sufficient and satisfactory personnel" and Substitute: "appropriate numbers of personnel qualified by training, experience and licensed or certified scope of practice. "</p> <p>Delete: "to give adequate resident care" and Substitute: "to provide care meeting highest medical and nursing standards."</p>	<p>OHCQ has not made this suggested change, as OHCQ believes the regulation is sufficient as written.</p>
C.07 - 6	<p>J. New Supportive Personnel Comment: "Supportive Personnel" is a vague term. Recommendation:. Please specify that supportive personnel are not counted as nursing services personnel unless they are qualified as nursing personnel by training and licensing and scope of practice criteria.</p>	<p>OHCQ has not made this suggested change, as OHCQ believes the regulation is sufficient as written.</p>

The table provides an overview of all responses as provided through the online comment platform. The staff of OHCQ did not make any changes or corrections of grammar in the comments.

**Office of Health Care Quality Regulation Review Public Comments:  
COMAR 10.07.02 (Sections .01 - .12)  
Regulation .08 Admission and Discharge**

	<b>Comments</b>	<b>Responses</b>
C.08 - 1	Room move notification - there needs to be a plan in place to move a resident - not just "notice". Frequently residents are given notice and then just moved without an actual plan that involves all of the necessary staff (i.e. nursing, housekeeping, maintenance, social work...basically the TEAM should oversee and plan for any move - it can be very traumatic for residents).	In addition to notification given in .08 admission and discharge, the following regulations require the development of a plan when a resident is moved: regulations .24 Emergency and disaster plan regulation,.26 Nursing care unit, and .42 Relocation of residents.
C.08 - 2	We need more specific and robust regulations around mental illness and patients with dementia. There should be legal ramifications in place if a nursing facility is trying to dump these patients in the hospital.	OHCQ convened a stakeholder work group to review and make recommendations for the regulation.
C.08 - 3	We commend OHCQ for prohibiting discrimination on the basis of sexual orientation or gender identity under 10.07.02.08A.	OHCQ appreciates your comment.
C.08 - 4	The proposal does not include current Regulation .08-1. We urge that it be maintained in its current form.	Regulation .08 – 1 will be included in the final version of the regulations. It wasn't included in the proposed regulation due to their being no proposed changes.
C.08 - 5	Page 17, 08 Admission and Discharge.A. Discrimination Prohibited reads... "A facility licensed under these regulations may not discriminate in admitting or providing care to an individual because of the race, color, national origin, sexual orientation, gender identity, or physical or mental handicap of the individual." We would like the last part of this to instead read "physical or brain based disability of the individual."	OHCQ agrees with these concerns and has made appropriate modifications in the final regulation.
C.08 - 6	On page 17 of 77, there is a new requirement that the nursing facility	OHCQ has not made this suggested change as the notification of a resident

The table provides an overview of all responses as provided through the online comment platform. The staff of OHCQ did not make any changes or corrections of grammar in the comments.

**Office of Health Care Quality Regulation Review Public Comments:  
COMAR 10.07.02 (Sections .01 - .12)**

	Comments	Responses
	<p>must notify the private or public agency or resident or responsible party and persons designated by the resident when the resident is transferred from the facility for any reason or at time of death. The requirement to notify any persons designated by the resident is a new requirement. While this seems benign on its face, it could represent an administrative burden for the nursing facility. First, this requirement is shifting the responsibility to notify from the responsible party to the nursing facility. Second, there are no "reasonable" parameters on the number of individuals that can be listed or the relationship for the individuals listed. In reality, the resident could designate multiple persons with no limit. What is the responsibility of the nursing facility? Is it through a written notice, phone call, etc.? How much effort does the nursing facility have to undertake if an individual is on the list but the nursing facility can no longer find the person. Again, this should be the responsible of the "responsible party" and not of the nursing facility. In 2012, SB27 was introduced and then subsequently withdrawn on this very same issue because of concerns raised regarding the scope.</p>	<p>moving may be critical to the health and wellness of the resident. However, the facility has the ability to determine the number and method of notification.</p>

The table provides an overview of all responses as provided through the online comment platform. The staff of OHCQ did not make any changes or corrections of grammar in the comments.

**Office of Health Care Quality Regulation Review Public Comments:  
COMAR 10.07.02 (Sections .01 - .12)  
Regulation .09 Resident Care Policies**

	<b>Comments</b>	<b>Responses</b>
C.09 - 1	10.07.02.09 A (11) There needs to be more individual activities plans with greater recognition of each resident's interests, abilities and need for purpose and meaning in their life. I have many ideas along these lines.	OHCQ appreciates your comment.
C.09 - 2	(text unchanged) Written Policies. Comprehensive care facilities and extended care facilities shall develop written policies, consistent with these regulations, to govern the nursing care and related medical or other services they provide covering the following: Suggest adding a requirement here than any proposed policy changes or new proposed policies be submitted to any existing Family Council to comply with the federal regulations for Family Councils. It is not possible for a Family Council to comment, suggest, or grieve policies they are unaware of. Actually, this courtesy should be extended to all people living in the facility and their representatives. -- Reference QAPI	The provision of the nursing facilities policies and procedure are addressed in COMAR 10.07.09 Residents' Bill of Rights: Comprehensive Care Facilities and Extended Care Facilities. The regulations don't limit residents, interested family members, or representative's option to request further information from facilities.
C.09 - 3	(17) Disaster plan. ADD: "which shall be shared intact with the local fire department and the local emergency management agency."	The provision and requirements of a disaster plan is addressed in regulation 10.07.02.24.
C.09 - 4	C. (text unchanged) (1) Upon the request of the Secretary or the Secretary's designee, the facility's policies and procedures shall be made available to the Secretary for onsite review. ADD (2) and renumber: "Upon the request of the State Long-Term Care Ombudsman the facility's policies and procedures shall be made available to the State and Local	The policies and procedures of the Ombudsman program are addressed in COMAR 10.07.09.

The table provides an overview of all responses as provided through the online comment platform. The staff of OHCQ did not make any changes or corrections of grammar in the comments.

**Office of Health Care Quality Regulation Review Public Comments:  
COMAR 10.07.02 (Sections .01 - .12)**

	<b>Comments</b>	<b>Responses</b>
	Ombudsman for onsite review.” (2) The licensee shall submit to the Department and the State and Local Long-Term Care Ombudsman any significant substantive changes to the policies and procedures which have occurred since review of the policies and procedures and any comments, objections, or recommendations submitted by the Family Council where one exists within 2 weeks of implementation of the change-- it is necessary to begin working with the Ombudsman Program.	
C.09 - 5	(4) A patient in a protective device or devices shall be observed periodically by personnel, to insure that the patient's health needs are met -- A person or a person's representative has the right to refuse protective devices (4) A [patient] resident in a protective device or devices shall be observed periodically ADD: “at least every 15 minutes” by personnel, to insure that the [patient’s] resident’s health needs are met.--This cannot be left to a subjective decision. A definite time frame must be included and charted. (5) A [patient] resident who is in a protective device or devices may not be left in the same postural position for more than 2 consecutive hours.--Suggest adding, “or 15 minutes if the person is in a wheelchair or other seating device.” This provides consistence with the repositioning required in other regulations for people in wheelchairs.	The definition for protective device is clarified in .01 Definitions. The regulation stipulates that a protective device must be prescribed by a physician.
C.09 - 6	Page 18 .09 A. (20) Behavioral Health Services YEAHHHHHHH! .09 B. (5) Because it can be excruciating for people to immobilized in a painful position, likely	OHCQ has not made this suggested change, as there are existing requirements related to pain management in Title 42 CFR 483.25 -

The table provides an overview of all responses as provided through the online comment platform. The staff of OHCQ did not make any changes or corrections of grammar in the comments.

**Office of Health Care Quality Regulation Review Public Comments:  
COMAR 10.07.02 (Sections .01 - .12)**

	<b>Comments</b>	<b>Responses</b>
	exacerbating the problematic situation, we feel there should be language added the if the resident requests re-positioning due to pain, the staff need to reposition the resident.	Quality of Care. OHCQ deems the federal regulation as sufficient.
C.09 - 7	.09A(20) (page 18 of 77): What are Behavioral Health Services? To ensure that facilities are developing written policies to provide behavioral health services in line with OHCQ's expectations, clarification is needed.	OHCQ convened a stakeholder work group to review and make recommendations for the regulation.

**Regulation .10 Physician Services**

	<b>Comments</b>	<b>Responses</b>
C.10 - 1	Assess a new admission in a timely manner Change to “within 48 hours”, based on a facility-developed protocol, depending on:	OHCQ has not made this suggested change, as there are federal requirements that require that there be physician’s orders in place to meet immediate needs of residents, Title 42 CFR 483.20 Resident Assessment.
C.10 - 2	Change “a new admission” to “a newly admitted person”. Let’s acknowledge that we are dealing with people not refrigerators here, please. (4) Provide for the authorization of admission orders in a timely manner, based on a facility-developed protocol, to enable the nursing facility to provide safe, appropriate, and timely care; and Change “in a timely manner” to “within 12 hours”	OHCQ agrees with this concern and has changed “ a new admission” to “ a newly admitted resident” OHCQ has not made this suggested change, due to the necessity of facilities to individually assess residents based on their specific health issues.
C.10 - 3	(3)(c) Manage and document ethics issues consistent with relevant laws and regulations and with residents' wishes, including advising residents and families	The management and documentation of ethics issues is addressed in 10.01.21 Medical Orders for Life-Sustaining Treatment (MOLST) Form – Procedures

The table provides an overview of all responses as provided through the online comment platform. The staff of OHCQ did not make any changes or corrections of grammar in the comments.

**Office of Health Care Quality Regulation Review Public Comments:  
COMAR 10.07.02 (Sections .01 - .12)**

	<b>Comments</b>	<b>Responses</b>
	about formulating advance directives or other care instructions and helping identify individuals for whom aggressive medical interventions may not be indicated; Suggest a rewrite: Manage and document ethics issues consistent with the wishes of the people living in the facility and with relevant laws and regulations, including advising people living in the facility and their families about formulating advance directives, counseling the people and their families about the MOLST form and the options that are available on that form, or other care instructions and helping identify individuals for whom aggressive medical interventions may not be indicated and ensure that copies of MOLST form are given to the people living in the facility and their representatives within 48 hours of completion.	and Requirements.
C.10 - 4	(l)(2) Complete death certificates in a timely fashion, after the death of the individual, including all information required of a physician.	Policies and procedures regarding the completion of death certificates are found in COMAR 10.29 Board of Morticians and Funeral Directors. As well as the following regulations: 10.03.01.02 and 10.35.01.05.
C.10 - 5	Page 18 .10 (9) Just want to thank you for specifying that physicians need to refer out when resident needs exceed the scope of physician practice and expertise. This will hopefully facilitate more appropriate behavioral health referrals to behavioral health professionals.	OHCQ appreciates your comment.
C.10 - 6	.10G(9) (page 18 of 77): How is "properly" being defined? What will the standard be for deciding whether an attending physician's decision to refer or not refer a resident for specialty services	OHCQ convened a stakeholder work group to review and make recommendations for the regulation.

The table provides an overview of all responses as provided through the online comment platform. The staff of OHCQ did not make any changes or corrections of grammar in the comments.

**Office of Health Care Quality Regulation Review Public Comments:  
COMAR 10.07.02 (Sections .01 - .12)**

	<b>Comments</b>	<b>Responses</b>
	<p>was appropriate? General Comment: There are a number of references to “physician” orders and actions in the provisions of COMAR 10.07.02.10 and elsewhere in regulations. We reiterate our previous comments that recommend a reference to nurse practitioners and physician assistants because they do write orders. Even if OHCQ believes an “attending physician” should be identified for each resident, a reference to the role of NPs and PAs is warranted. We propose a change in language along the lines that “a nurse practitioner or physician assistant practicing in compliance with that practitioner’s scope of practice under the applicable licensing law may provide attending physician services except for such services that must be personally performed by a physician.”</p>	

**Regulation .11 Medical Director Qualifications**

	<b>Comments</b>	<b>Responses</b>
C.11- 1	<p>11.1 B(2) Ensure that there is a procedure for the review of the practitioners' credentials and the granting of privileges for licensed or certified professional health care practitioners who treat residents of the nursing facility; and -- Add "nothing in this section shall be construed to permit the abrogation of a resident's right to have a physician of his or her choice.</p>	<p>The patients right to a physician of his or her choice is addressed in COMAR 10.07.09 Resident’s Rights .</p>

The table provides an overview of all responses as provided through the online comment platform. The staff of OHCQ did not make any changes or corrections of grammar in the comments.

**Office of Health Care Quality Regulation Review Public Comments:  
COMAR 10.07.02 (Sections .01 - .12)  
Regulation .12 Nursing Services**

	<b>Comments</b>	<b>Responses</b>
C.12 - 1	I commend OHCQ for the increase from 2.0 to 3.0 hours. However, it is essential for good care that staffing be at a minimum of 4.1. Additionally, staffing must take into consideration the acuity level of the residents. Both the acuity related to their overall health status related to diagnoses and to their overall status related to any behavioral issues. It was noted by someone at the meeting on 10/09/14 that facilities are already staffing at over 3.0, so it only makes sense that if the facilities realize it can't be done at a low level of 3.0, that the regulation reflects what the industry is already aware of and doing.	The health and well-being of residents is a central tenet of OHCQ's mission. Due to this, OHCQ has recommended an increase in the staffing ratio and a decrease in the nursing service personnel ratio. The staffing ratio was increased from 2 to 3 hours of bedside care per licensed bed per day. The nursing service personnel on duty ratio decreased from 1 to 25 to 1 to 15.
C.12 - 2	.12J (page 21 of 77): Why is the ward clerk's time being taken out of the calculation of total bedside hours? While overtime some ward clerks' duties have become more clerical and administrative in nature, many still provide hands on care. In facilities such as these, will ward clerks' time be counted, at least if the hours spent on bedside care is documented?	OHCQ has not made this suggested change, as OHCQ believes the regulation is sufficient as written.
C.12 - 3	.12L (page 21 of 77): Why is this regulation, which has only applied to Extended Care Facilities, now being applied to Comprehensive Care Facilities? The table in Regulation .12I(1) already establishes the number of full-time RN staff by number of beds. By changing the wording, all nursing	OHCQ has not made this suggested change, as OHCQ believes the regulation is sufficient as written.

The table provides an overview of all responses as provided through the online comment platform. The staff of OHCQ did not make any changes or corrections of grammar in the comments.

**Office of Health Care Quality Regulation Review Public Comments:  
COMAR 10.07.02 (Sections .01 - .12)**

	Comments	Responses
	<p>facilities would have to have an RN in the facility at all times. Facilities staff according to resident needs and not all facilities need RN coverage at all times. This would be a substantial change from the current requirement, requiring not only round the clock RN coverage but back up coverage when an RN is unexpectedly absent. For that shift, the facility would be out of compliance, even though the facility is already equipped with sufficient licensed nursing service personnel on duty 24 hours a day, as is required under .12O. We oppose this change as it is both unnecessary, from the perspective of ensuring quality resident care, as well as being impractical and cost prohibitive.</p>	
C.12 - 4	<p>.12O(7) (page 22 of 77): How would a "prompt and appropriate response" be defined? Considering that call bells are mostly outdated, it would make more sense to say "Respond to requests for assistance."</p>	<p>OHCQ has not made this suggested change, as OHCQ believes the regulation is sufficient as written.</p>
C.12 - 5	<p>.12O(8) (page 22 of 77): This seems redundant to (4) "is kept comfortable, clean, and well-groomed". Isn't good dental hygiene part of being well-groomed? More importantly, why should Nursing Personnel assist the resident in carrying out routine dental hygiene when this could just as easily and safely be done by supportive</p>	<p>OHCQ has not made this suggested change, as OHCQ believes the regulation is sufficient as written.</p>

The table provides an overview of all responses as provided through the online comment platform. The staff of OHCQ did not make any changes or corrections of grammar in the comments.

**Office of Health Care Quality Regulation Review Public Comments:  
COMAR 10.07.02 (Sections .01 - .12)**

	Comments	Responses
	personnel?	
C.12 - 6	B. Director of Nursing. Recommendation: Director of Nursing shall be a full time RN in both Comprehensive Care facilities and Extended Care facilities.	OHCQ has not made this suggested change, as OHCQ believes the regulation is sufficient as written.
C.12 - 7	G. Responsibilities of the Director of Nursing. Recommendation: Delete: "recommending the assignment of ... for each tour of duty." Substitute: "... assigning a sufficient number of qualified licensed, and certified nursing personnel to meet total nursing needs for each tour of duty; and assigning approved supportive personnel for non-nursing functions.	OHCQ has not made this suggested change, as OHCQ believes the regulation is sufficient as written.
C.12 - 8	I. Supervisory Personnel - Comprehensive Care Facilities. Recommendation: Add to title: "and Extended Care Facilities." A supervisory RN must be present at each facility on each tour of duty, 7 days per week. If 40 hours per week counts as full-time, then three full-time supervisory RNs are required for each 24- hour period. In large facilities additional supervisory nurses shall be assigned by the Director of Nursing in number necessary for support and oversight of all nursing units.	OHCQ has not made this suggested change, as OHCQ believes the regulation is sufficient as written.

The table provides an overview of all responses as provided through the online comment platform. The staff of OHCQ did not make any changes or corrections of grammar in the comments.

**Office of Health Care Quality Regulation Review Public Comments:  
COMAR 10.07.02 (Sections .01 - .12)**

	Comments	Responses
C.12 - 9	<p>J. Hours of Bedside Care – Comprehensive Care Facilities Recommendations: Add to title: “and Extended Care Facilities.” Substitute (for proposed text), the following text: “On each nursing care unit bedside nursing care shall be provided by qualified RNs, LPNs, certified nursing assistants (CNAs), Geriatric Nursing Assistants, Medication aides, and other licensed or certified nursing personnel. Approved supportive personnel may be assigned to the unit only for non-nursing functions.” Specify exclusions: “Time worked by supportive personnel who are not licensed or certified as nursing personnel may not be counted in nursing care hours per resident day. A ward clerk who is not licensed or certified as nursing personnel may not be counted in nursing hours per resident day. Hours on duty of the Director of Nursing, the nursing supervisor and the director of in-service education may not be counted in nursing care hours per resident day.”</p>	<p>OHCQ has not made this suggested change, as OHCQ believes the regulation is sufficient as written.</p>

The table provides an overview of all responses as provided through the online comment platform. The staff of OHCQ did not make any changes or corrections of grammar in the comments.