Senate

General Assembly

File No. 457

January Session, 2021

Substitute Senate Bill No. 1030

Senate, April 14, 2021

The Committee on Public Health reported through SEN. DAUGHERTY ABRAMS of the 13th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING LONG-TERM CARE FACILITIES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective October 1, 2021*) (a) As used in this section and sections 2 to 12, inclusive, of this act, "long-term care facility" means a nursing home, as defined in section 19a-521 of the general statutes, a residential care home, as defined in section 19a-521 of the general statutes, a home health agency, as defined in section 19a-490 of the general statutes, an assisted living services agency, as defined in section 19a-490 of the general statutes, an intermediate care facility for individuals with intellectual disability, as described in 42 USC 1396d(d), except any such facility operated by a Department of Developmental Services' program subject to background checks pursuant to section 17a-227a of the general statutes, a chronic disease hospital, as defined in section 19a-550 of the general statutes, or an agency providing hospice care which is licensed to provide such care by the Department of Public Health or certified to provide such care pursuant to 42 USC 1395x.

(b) Each long-term care facility shall employ a full-time infection prevention and control specialist who shall be responsible for the following:

(1) Ongoing training of all employees of the long-term care facility on infection prevention and control using multiple training methods, including, but not limited to, in-person training and the provision of written materials in English and Spanish;

(2) The inclusion of information regarding infection prevention and control in the documentation that the long-term care facility provides to residents regarding their rights while in the facility;

(3) Participation as a member of the long-term care facility's infection prevention and control committee; and

(4) The provision of training on infection prevention and control methods to supplemental or replacement staff of the long-term care facility in the event an infectious disease outbreak or other situation reduces the facility's staffing levels.

Sec. 2. (NEW) (*Effective October 1, 2021*) The administrative head of each long-term care facility shall participate in the development of the emergency plan of operations of the political subdivision of this state in which it is located which is required pursuant to the Intrastate Mutual Aid Compact made and entered into under section 28-22a of the general statutes.

Sec. 3. (NEW) (*Effective October 1, 2021*) (a) Not later than six months after the termination of a public health emergency declared by the Governor pursuant to section 19a-131a of the general statutes, (1) the Department of Public Health shall have and maintain at least a three-month stockpile of personal protective equipment, including, but not limited to, gowns, masks, full-face shields, goggles and disposable gloves as a barrier against infectious materials, for use by long-term care facilities, and (2) the administrative head of each long-term care facility shall ensure that the facility acquires from the department and maintains at least a three-month supply of personal protective equipment for its staff. The administrative head of each long-term care facility shall ensure that the personal protective equipment is of various sizes based on the needs of the facility's staff. The personal protective

equipment (A) shall not be shared amongst the facility's staff, and (B) may only be reused in accordance with the strategies to optimize personal protective equipment supplies in health care settings published by the National Centers for Disease Control and Prevention. The administrative head of each long-term care facility shall hold quarterly fittings of his or her staff for N95 masks or higher rated masks certified by the National Institute for Occupational Safety and Health.

(b) On or before January 1, 2022, the Department of Emergency Management and Homeland Security, in consultation with the Department of Public Health, shall establish a process to evaluate, provide feedback on, approve and distribute personal protective equipment for use by long-term care facilities in a public health emergency.

Sec. 4. (NEW) (*Effective October 1, 2021*) The administrative head of each long-term care facility shall ensure that there is at least one staff member during each shift who is licensed or certified to start an intravenous line.

Sec. 5. (NEW) (*Effective October 1, 2021*) Each long-term care facility's infection prevention and control committee shall meet (1) at least monthly, and (2) during an outbreak of an infectious disease, daily, provided daily meetings do not cause a disruption to the operations of the facility, in which case the committee shall meet at least weekly. The prevention and control committee shall be responsible for establishing infection prevention and control protocols for the long-term care facility. Not less than biannually and after every outbreak of an infectious disease in the facility, the prevention and control committee shall evaluate the implementation and analyze the outcome of such protocols.

Sec. 6. (NEW) (*Effective October 1, 2021*) On or before January 1, 2022, every administrator and supervisor of a long-term care facility shall complete the Nursing Home Infection Preventionist Training course produced by the National Centers for Disease Control and Prevention in collaboration with the Centers for Medicare and Medicaid Services.

Sec. 7. (NEW) (*Effective October 1, 2021*) Each long-term care facility shall, during an outbreak of an infectious disease, test staff and residents of the facility for the infectious disease at a frequency determined by the Department of Public Health as appropriate based on the circumstances surrounding the outbreak and the impact of testing on controlling the outbreak.

Sec. 8. (NEW) (*Effective October 1, 2021*) On or before January 1, 2022, the administrative head of each long-term care facility shall facilitate the establishment of a family council to encourage and support open communication between the facility and each resident's family members and friends. As used in this section, "family council" means an independent, self-determining group of the family members and friends of a long-term care facility's residents that is geared to meeting the needs and interests of the residents and their family members and friends.

Sec. 9. (NEW) (*Effective October 1, 2021*) (a) On or before January 1, 2022, the administrative head of each long-term care facility shall (1) ensure that each resident's care plan addresses (A) the resident's potential for isolation, ability to interact with family members and friends and risk for depression, (B) how the resident's social and emotional needs will be met, and (C) measures to ensure that the resident has regular opportunities for in-person and virtual visitation, (2) disclose the facility's visitation protocols, any changes to such protocols and any other information relevant to visitation in a form and manner that is easily accessible to residents and their family members and friends, (3) advise residents and their family members and friends of their right to seek redress with the Office of the Long-Term Care Ombudsman under section 17a-410 of the general statutes when the resident or a family member or friend of the resident believes the facility has not complied with its visitation protocols, and (4) establish a timeline by which the facility will ensure the safe and prompt reinstatement of visitation following the termination of the public health emergency declared by the Governor in response to the COVID-19 pandemic and a program to monitor compliance with such timeline. As used in this section "COVID-19" means the respiratory disease

designated by the World Health Organization on February 11, 2020, as coronavirus 2019, and any related mutation thereof recognized by the World Health Organization as a communicable respiratory disease.

(b) On or before January 1, 2022, the administrative head of each long-term care facility shall ensure that its staff is educated regarding (1) best practices for addressing the social, emotional and mental health needs of residents, and (2) all components of person-centered care.

Sec. 10. (NEW) (*Effective October 1, 2021*) On or before January 1, 2022, the Department of Public Health shall establish an essential caregiver program for implementation by each long-term care facility. The program shall (1) set forth visitation requirements for essential caregivers of long-term care facility residents, and (2) require the same infection prevention and control training and testing standards for an essential caregiver of a resident of the facility that are required for the facility's staff. As used in this section "essential caregiver" means a person deemed critical, as determined by a long-term care facility, to the daily care and emotional well-being of a resident of the facility.

Sec. 11. (*Effective from passage*) On or before October 1, 2021, the Public Health Preparedness Advisory Committee established pursuant to section 19a-131g of the general statutes shall amend the plan for emergency responses to a public health emergency prepared pursuant to said section to include a plan for emergency responses to a public health emergency in relation to long-term care facilities and providers of community-based services to residents of such facilities.

Sec. 12. (NEW) (*Effective from passage*) (a) On and after July 1, 2021, each long-term care facility shall permit a resident to use a communication device, including a cellular phone, tablet or computer, in his or her room, in accordance with the requirements established under subsection (b) of this section, to remain connected with their family members and friends and to facilitate the participation of a resident's family caregiver as a member of the resident's care team.

(b) On or before June 30, 2021, the Commissioner of Public Health

shall (1) establish requirements regarding the use of communication devices by long-term care facility residents under subsection (a) of this section to ensure the privacy of other long-term care facility residents, and (2) communicate such requirements to each long-term care facility.

Sec. 13. (NEW) (*Effective October 1, 2021*) (a) As used in this section, "nursing home" means (1) any chronic and convalescent nursing home or any rest home with nursing supervision that provides nursing supervision under a medical director twenty-four hours per day, or (2) any chronic and convalescent nursing home that provides skilled nursing care under medical supervision and direction to carry out nonsurgical treatment and dietary procedures for chronic diseases, convalescent stages, acute diseases or injuries.

(b) On or before January 1, 2022, the Department of Public Health shall (1) establish minimum staffing level requirements for nursing homes of at least four and one-tenth hours of direct care per resident per day, including three and three-quarter hours of care by a registered nurse, fifty-four hundredth hours of care by a licensed practical nurse and two and eighty-one hundredth hours of care by a certified nurse's assistant, (2) modify staffing level requirements for social work and recreational staff of nursing homes such that the requirements are lower than the current requirements, as deemed appropriate by the Commissioner of Public Health, and (3) eliminate the distinction between a chronic and convalescent nursing home and a rest home, as defined in section 19a-490 of the general statutes, as such distinction relates to nursing supervision, for purposes of establishing a single, minimum direct staffing level requirement for all nursing homes.

(c) On and after January 1, 2022, each nursing home shall offer its staff the option to work twelve-hour shifts.

(d) The commissioner shall adopt regulations in accordance with the provisions of chapter 54 of the general statutes that set forth nursing home staffing level requirements to implement the provisions of this section.

Sec. 14. (NEW) (*Effective October 1, 2021*) (a) For purposes of this section: (1) "Ombudsman" means the Office of the Long-Term Care Ombudsman established pursuant to section 17a-405 of the general statutes; (2) "electronic monitoring" means the placement and use of an electronic monitoring device by a nonverbal resident or his or her resident representative in the resident's room or private living unit in accordance with this section; (3) "electronic monitoring device" means a camera or other device that captures, records or broadcasts audio, video, or both, and may offer two-way communication over the Internet that is placed in a nonverbal resident's room or private living unit and is used to monitor the nonverbal resident or activities in the room or private living unit; (4) "nursing home facility" has the same meaning as provided in section 19a-490 of the general statutes; (5) "nonverbal resident" means a resident of a nursing home facility who is unable to verbally communicate due to physical or mental conditions, including, but not limited to, Alzheimer's disease and dementia; and (6) "resident representative" means (A) a court-appointed guardian, (B) a health care representative appointed pursuant to section 19a-575a of the general statutes, or (C) a person who is not an agent of the nursing home facility and who is designated in a written document signed by the nonverbal resident and included in the resident's records on file with the nursing home facility.

(b) A nonverbal resident or his or her resident representative may install an electronic monitoring device in the resident's room or private living unit provided: (1) The purchase, installation, maintenance, operation and removal of the device is at the expense of the resident, (2) the resident and any roommate of the resident, or the respective resident representatives, sign a written consent form pursuant to subsection (c) of this section, (3) the resident or his or her resident representative places a clear and conspicuous note on the door of the room or private living unit that the room or private living area is subject to electronic monitoring, and (4) the consent form is filed with the nursing home facility not less than seven days before installation of the electronic monitoring device except as provided in subsection (e) of this section.

(c) No electronic monitoring device shall be installed in a nonverbal resident's room or living unit unless the resident and any roommate of the resident, or a resident representative, has signed a consent form that includes, but is not limited to:

(1) (A) The signed consent of the nonverbal resident and any roommate of the resident; or (B) the signed consent of a resident representative of the nonverbal resident or roommate if the nonverbal resident or roommate lacks the physical or mental capacity to sign the form. If a resident representative signs the consent form, the form must document the following:

(i) The date the nonverbal resident or any roommate was asked if the resident or roommate wants electronic monitoring to be conducted;

(ii) Who was present when the nonverbal resident or roommate was asked if he or she consented to electronic monitoring;

(iii) An acknowledgment that the nonverbal resident or roommate did not affirmatively object to electronic monitoring; and

(iv) The source of the authority allowing the resident representative of the nonverbal resident or roommate to sign the consent form on behalf of the nonverbal roommate or resident.

(2) A waiver of liability for the nursing home facility for any breach of privacy involving the nonverbal resident's use of an electronic monitoring device, unless such breach of privacy occurred because of unauthorized use of the device or a recording made by the device by nursing home facility staff.

(3) The type of electronic monitoring device to be used.

(4) A list of conditions or restrictions that the nonverbal resident or any roommate of the resident may elect to place on the use of the electronic monitoring device, including, but not limited to: (A) Prohibiting audio recording, (B) prohibiting video recording, (C) prohibiting broadcasting of audio or video, (D) turning off the electronic

monitoring device or blocking the visual recording component of the electronic monitoring device for the duration of an exam or procedure by a health care professional, (E) turning off the electronic monitoring device or blocking the visual recording component of the electronic monitoring device while the nonverbal resident or any roommate of the resident is dressing or bathing, and (F) turning off the electronic monitoring device for the duration of a visit with a spiritual advisor, ombudsman, attorney, financial planner, intimate partner or other visitor to the nonverbal resident or roommate of the resident.

(5) An acknowledgment that the nonverbal resident, roommate or the respective resident representative shall be responsible for operating the electronic monitoring device in accordance with the conditions and restrictions listed in subdivision (4) of this subsection unless the resident, roommate or the respective resident representative have signed a written agreement with the nursing home facility under which nursing home facility staff operate the electronic monitoring device for this purpose. Such agreement may contain a waiver of liability for the nursing home facility related to the operation of the device by nursing home facility staff.

(6) A statement of the circumstances under which a recording may be disseminated.

(7) A signature box for documenting that the nonverbal resident or roommate of the resident, or the respective resident representative, has consented to electronic monitoring or withdrawn consent.

(d) The ombudsman, within available appropriations, shall make available on the ombudsman's Internet web site a downloadable copy of a standard form containing all of the provisions required under subsection (c) of this section. Nursing home facilities shall (1) make the consent form available to nonverbal residents and inform such residents and the respective resident representatives of their option to conduct electronic monitoring of their rooms or private living units, (2) maintain a copy of the consent form in the nonverbal resident's records, and (3) place a notice in a conspicuous place near the entry to the nursing home

facility stating that some rooms and living areas may be subject to electronic monitoring.

(e) Notwithstanding subdivision (4) of subsection (b) of this section, a nonverbal resident or his or her resident representative may install an electronic monitoring device without submitting the consent form to a nursing home facility if: (1) The nonverbal resident or the resident representative (A) reasonably fears retaliation against the nonverbal resident by the nursing home facility for recording or reporting alleged abuse or neglect of the resident by nursing home facility staff, (B) submits a completed consent form to the ombudsman, and (C) submits a report to the ombudsman, the Commissioner of Social Services, the Commissioner of Public Health or appropriate law enforcement agency, with evidence from an electronic monitoring device that suspected abuse or neglect of the nonverbal resident has occurred; (2) (A) the nursing home facility has failed to respond for more than two business days to a written communication from the nonverbal resident or his or her resident representative about a concern that prompted the resident's desire for installation of an electronic monitoring device, and (B) the nonverbal resident or his or her resident representative has submitted a consent form to the ombudsman; or (3) (A) the nonverbal resident or his or her resident representative has already submitted a report to the ombudsman, Commissioner of Social Services, Commissioner of Public Health or appropriate law enforcement agency regarding concerns about the nonverbal resident's safety or well-being that prompted the resident's desire for electronic monitoring, and (B) the nonverbal resident or his or her resident representative has submitted a consent form to the ombudsman.

(f) If a nonverbal resident is conducting electronic monitoring and a new roommate moves into the room or living unit, the nonverbal resident shall cease use of the electronic monitoring device unless and until the new roommate signs the consent form and the nonverbal resident or his or her resident representative files the completed form with the roommate's consent to electronic monitoring with the nursing home facility. If any roommate of a nonverbal resident wishing to use

electronic monitoring refuses to sign the consent form, the nursing home facility shall reasonably accommodate the nonverbal resident's request to move into a private room or a room with a roommate who has agreed to consent to such monitoring, if available, not later than thirty days after the request. The nonverbal resident requesting the accommodation shall pay any difference in price if the new room is more costly than the resident's previous room.

(g) Subject to applicable rules of evidence and procedure, any video or audio recording created through electronic monitoring under this section may be admitted into evidence in a civil, criminal or administrative proceeding.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2021*	New section
Sec. 2	*October 1, 2021*	New section
Sec. 3	*October 1, 2021*	New section
Sec. 4	*October 1, 2021*	New section
Sec. 5	*October 1, 2021*	New section
Sec. 6	*October 1, 2021*	New section
Sec. 7	*October 1, 2021*	New section
Sec. 8	*October 1, 2021*	New section
Sec. 9	*October 1, 2021*	New section
Sec. 10	*October 1, 2021*	New section
Sec. 11	*from passage*	New section
Sec. 12	*from passage*	New section
Sec. 13	*October 1, 2021*	New section
Sec. 14	*October 1, 2021*	New section

Statement of Legislative Commissioners:
In Section 14(e), two occurrences of "police" were changed to "appropriate law enforcement agency" for clarity.

PH *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 22 $	FY 23 $
Public Health, Dept.	GF - Cost	5.4 million	2.4 million
State Comptroller - Fringe Benefits[1]	GF - Cost	82,130	84,600
Social Services, Dept.	GF - Cost	See Below	See Below

Note: GF=General Fund

Municipal Impact: None

Explanation

The bill results in cost to the Department of Public Health (DPH) and the Department of Social Services (DSS) associated with requirements for long-term care facilities to build infection control capacity and new minimum staffing levels for nursing homes.

Section 1 results in a cost of approximately $96,340 in FY 22 and $96,170 to DPH (with associated fringe of $38,160 in FY 22 and $39,310 in FY 23) for infection control training. The Healthcare-Associated Infections & Antimicrobial Resistance (HAI-AR) Program provides technical assistance to healthcare facilities in infection control and prevention. HAI-AR will need an additional Nurse Consultant to support technical assistance with infection control to allow long-term care facilities to comply with the bill.

Section 3 results in a cost associated with requiring DPH to maintain

[1]The fringe benefit costs for most state employees are budgeted centrally in accounts administered by the Comptroller. The estimated active employee fringe benefit cost associated with most personnel changes is 41.3% of payroll in FY 22 and FY 23.

a 90-day stockpile of personal protective equipment (PPE) that will be used to supply long-term care facilities during a public health emergency. Funding of approximately $106,460 in FY 22 and $109,660 in FY 23 (with associated fringe of $43,970 in FY 22 and $45,290 in FY 23) will support two Material Storage staff to help manage PPE. DPH will also incur costs of approximately $3.2 million in FY 22 and $200,000 in FY 23 associated with PPE supplies, storage, and an inventory management system. In addition, the bill results in a cost of approximately $2 million in FY 22 and FY 23 to support a maintenance contract with a vendor to resupply the needed PPE prior to expiration.

Section 13 results in a cost to DSS associated with revising nursing home staffing levels and eliminating the distinction between a chronic and convalescent nursing home and a rest home with nursing supervision.

Staffing ratio requirements will result in a significant cost to DSS to the extent nursing home staffing costs are reflected in future Medicaid payments. The bill specifies that a total of 4.1 hours of direct care be provided per resident per day, including 3.75 hours by a registered nurse (RN), 0.54 hours by a licensed practical nurse (LPN), and 2.81 hours by a certified nurse's assistant (CAN).

Based on 2019 nursing home staffing data, none of the approximately 200 homes can meet the bill's requirements for RNs (with an average of 0.70 hours of direct care provided per resident per day). Approximately 10% of homes do not meet the LPN staffing requirements, while approximately 80% do not meet the requirements for CNAs. The cost for nursing homes to staff at the proposed levels will depend on the actual number and level of staff required and their associated wages but is anticipated to be at least $200 million.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

OLR Bill Analysis

sSB 1030

AN ACT CONCERNING LONG-TERM CARE FACILITIES.

TABLE OF CONTENTS:

Requires LTC facilities, by January 1, 2022, to take certain actions to ensure residents have regular opportunities for in-person and virtual visitation with family members and friends and that their social and emotional needs are met

SUMMARY

This bill makes various unrelated changes concerning long-term care (LTC) facilities and the delivery of long-term care services. Under the bill, a "long-term care facility" includes a nursing home, residential care home, assisted living facility, home health agency, chronic disease hospital, hospice agency, and intermediate care facility for individuals with intellectual disability, except those operated by a Department of Developmental Services program subject to comprehensive background checks under existing law.

EFFECTIVE DATE: October 1, 2021, except the provisions (1) allowing facility residents to use communication devices in their rooms and (2) requiring the Public Health Preparedness Advisory Committee to amend its public health emergency response plan, take effect upon passage.

§1 — INFECTION PREVENTIONISTS

Requires LTC facilities to employ a full-time infection and prevention control specialist

The bill requires each LTC facility to employ a full-time infection and prevention control specialist responsible for:

1. ongoing employee training on infection prevention and control using multiple training methods, including in-person training and providing written materials in English and Spanish;

2. including information on infection prevention and control in the documentation the facility provides to residents regarding their rights while in the facility;

3. participating as a member of the facility's infection prevention and control committee; and

4. providing training on infection prevention and control methods to the facility's supplemental or replacement staff in the event of an infectious disease outbreak or other situation reducing the facility's staffing levels.

§2 — LOCAL EMERGENCY OPERATIONS PLAN

Requires a LTC facility's administrative head to participate in developing the local emergency operations plan required under the Intrastate Mutual Aid Compact

The bill requires each LTC facility's administrative head to participate in developing the local emergency operations plan for the municipality in which the facility is located. The plan is required under the Intrastate Mutual Aid Compact, which by law, provides a legal framework for municipalities to request and provide mutual aid when any member municipality declares a local civil preparedness emergency.

§3 — PERSONAL PROTECTIVE EQUIPMENT

Requires, within six months after the governor terminates a declared public health emergency, (1) DPH to maintain at least a three-month supply of personal protective equipment for LTC facilities and (2) facilities' administrative heads to ensure they acquire the supply from DPH and maintain it for their staff

The bill requires, within six months after the governor terminates a

declared public health emergency:

1. the Department of Public Health (DPH) to have and maintain at least a three-month stockpile of personal protective equipment (PPE) for LTC facility use, including gowns, masks, full-face shields, goggles, and disposable gloves as a barrier against infectious materials, and

2. each LTC facility's administrative head to ensure that the facility acquires from DPH and maintains at least a three-month supply of PPE for its staff.

For the latter, the bill requires administrative heads to ensure that the PPE is of various sizes based on the facility staff's needs. PPE cannot be shared amongst facility staff and may only be used in accordance with the federal Centers for Disease Control and Prevention's (CDC) strategies to optimize PPE supplies in health care settings.

The bill also requires administrative heads to hold quarterly staff fittings for N95 masks or higher rated masks certified by the National Institute for Occupational Safety and Health.

The bill requires the Department of Emergency Management and Homeland Security, by January 1, 2022, to consult with DPH and establish a process to evaluate, provide feedback on, approve, and distribute PPE for use by LTC facilities in a public health emergency.

§4 — INTRAVENOUS LINES

Requires a LTC facility's administrative head to ensure there is at least one staff member during each shift who is licensed or certified to start an intravenous line

The bill requires the administrative head of each LTC facility to ensure that there is at least one staff member during each shift who is licensed or certified to start an intravenous line.

§5 — INFECTION PREVENTION AND CONTROL COMMITTEES

Generally, requires a LTC facility's infection prevention and control committee to meet at least monthly, and, during an infectious disease outbreak, daily

The bill requires a LTC facility's infection prevention and control

committee to meet at least monthly and, during an infectious disease outbreak, daily. But if daily meetings disrupt the facility's operations, the committee must instead meet at least weekly.

Under the bill, the committee is responsible for establishing infection prevention and control protocols for the LTC facility. It must also evaluate the implementation and outcome of these protocols at least biannually and after every infectious disease outbreak at the facility.

§6 — NURSING HOME INFECTION PREVENTIONIST TRAINING

Requires every LTC facility's administrator and supervisor, by January 1, 2022, to complete the Nursing Home Infection Preventionist Training Course produced by the CDC in collaboration with the Centers for Medicare and Medicaid Services

The bill requires every LTC facility administrator and supervisor, by January 1, 2022, to complete the Nursing Home Infection Preventionist Training Course produced by the CDC in collaboration with the Centers for Medicare and Medicaid Services.

§7 — INFECTIOUS DISEASE TESTING IN LTC FACILITIES

Requires LTC facilities to test staff and residents for an infectious disease during an outbreak at an appropriate frequency determined by DPH

The bill requires LTC facilities to test staff and residents for an infectious disease during an outbreak. They must do so at an appropriate frequency determined by DPH based on the circumstances surrounding the outbreak and the impact of testing on controlling it.

§8 — FAMILY COUNCILS

Requires a LTC facility's administrative head, by January 1, 2022, to facilitate the establishment of a family council to encourage and support open communication between the facility and residents' families and friends

The bill requires a LTC facility's administrative head, by January 1, 2022, to facilitate the establishment of a family council to encourage and support open communication between the facility and each resident's family members and friends. Under the bill, a "family council" is an independent, self-determining group of residents' family members and friends that is geared to meeting the needs and interests of residents and their families and friends

§9 — RESIDENT VISITATION AT LTC FACILITIES

Requires LTC facilities, by January 1, 2022, to take certain actions to ensure residents have regular opportunities for in-person and virtual visitation with family members and friends and that their social and emotional needs are met

The bill requires each LTC facility's administrative head, by January 1, 2022, to do the following:

1. ensure that each resident's care plan addresses (a) the resident's potential for isolation, ability to interact with family and friends, and risk for depression; (b) how the resident's social and emotional needs will be met; and (c) measures to ensure that the resident has regular opportunities for in-person and virtual visitation;

2. disclose the facility's visitation protocols, and changes to them, and any other information relevant to visitation in a form and manner that is easily accessible to residents and their family and friends;

3. advise residents and their family and friends on their right to seek redress with the Office of the State Long-Term Care Ombudsman when any of these individuals believe the facility has not complied with its visitation protocols;

4. establish a (a) timeline by which the facility will ensure the safe and prompt reinstatement of visitation after the governor terminates the declared public health emergency in response to the COVID-19 pandemic and (b) program to monitor compliance with the timeline; and

5. ensure that facility staff is educated on best practices for addressing residents' social, emotional, and mental health needs and all components of person-centered care.

§10 — ESSENTIAL CAREGIVER PROGRAM

Requires DPH, by January 1, 2022, to establish an essential caregiver program for LTC facilities to implement

The bill requires DPH, by January 1, 2022, to establish an essential

care program for LTC facilities to implement. The program must (1) set visitation requirements for essential caregivers of LTC facility residents and (2) require the same infection prevention and control training and testing standards for essential caregivers that are required for facility staff.

Under the bill, an "essential caregiver" is a person the LTC facility deems critical to a resident's daily care and emotional well-being.

§11 — PUBLIC HEALTH PREPAREDNESS ADVISORY COMMITTEE

Requires the Public Health Preparedness Advisory Committee, by October 1, 2021, to amend the plan for emergency responses to public health emergencies to include responses related to LTC facilities and providers of community-based services to facility residents

The bill requires the state's Public Health Preparedness Advisory Committee, by October 1, 2021, to amend the plan for emergency responses to public health emergencies to include a plan for emergency responses related to LTC facilities and providers of community-based services to facility residents.

By law, the advisory committee advises DPH on responses to public health emergencies. It consists of the DPH and emergency services and public protection commissioners; six top legislative leaders; the chairs and ranking members of the Public Health, Public Safety, and Judiciary Committees; representatives of municipal and district health directors appointed by the DPH commissioner; and any other organizations or individuals the DPH commissioner deems relevant to the effort.

§12 — RESIDENT COMMUNICATION DEVICES

Starting July 1, 2021, requires LTC facilities to allow residents to use communication devices (e.g., phones and tablets) in their rooms to remain connected with family and friends and facilitate the participation of family caregivers in their care team

Starting July 1, 2021, the bill requires LTC facilities to allow a resident to use communication devices (e.g., cell phone, tablet, or computer) in his or her room to (1) remain connected with family members and friends and (2) facilitate the participation of a family caregiver as a member of the resident's care team.

Residents must use the communication devices in accordance with

DPH requirements, which the bill requires the commissioner to establish by June 30, 2021. She must communicate the requirements to LTC facilities and ensure that the requirements safeguard the privacy of other LTC facility residents.

§13 — NURSING HOME MINIMUM STAFFING LEVELS

Requires DPH, by January 1, 2022, to modify minimum nursing home daily staffing levels to require at least 4.10 hours of direct care per resident; requires nursing homes to offer staff the option to work 12-hour shifts

The bill requires DPH, by January 1, 2022, to modify minimum staffing levels in nursing homes as follows:

1. establish at least 4.10 hours of direct care per resident per day, including 3.75 hours of care by a registered nurse, 0.54 hours of care by a licensed practical nurse, and 2.81 hours of care by a certified nurse's assistant;

2. modify staffing level requirements for social worker and recreational staff so that they are lower than current requirements, as deemed appropriate by the DPH commissioner;

3. eliminate the nursing supervision-related distinction between a chronic and convalescent nursing home and a rest home with nursing supervision in order to establish a single, minimum direct staffing level requirement for all nursing homes; and

4. adopt regulations to implement the above requirements.

The bill also requires nursing homes to offer staff the option to work 12-hour shifts starting January 1, 2022.

Current law requires nursing homes to maintain aggregate licensed nurse and nurse's aide staffing levels of at least 1.9 hours of direct care per resident per day (see BACKGROUND).

§14 — ELECTRONIC MONITORING DEVICES IN NURSING HOMES

Allows a non-verbal nursing home resident, or his or her resident representative, to install an electronic monitoring device in the resident's room or private living unit under certain conditions

The bill allows a non-verbal nursing home resident, or his or her resident representative, to install an electronic monitoring device in the resident's room or private living unit, provided:

1. the resident pays for the device and its installation, maintenance, operation, and removal;

2. the resident and any roommate, or their resident representatives, sign a written consent form, which must be filed with the nursing home within seven days before installing the device; and

3. the resident, or his or her resident representative, places a clear and conspicuous note on the door of the room or private living unit stating that it is subject to electronic monitoring.

Under the bill, any video or audio recording from the electronic monitoring device may be admitted into evidence in a civil, criminal, or administrative proceeding.

Consent Form Content

Under the bill, the resident consent form must include:

1. the signed consent of the nonverbal resident and any roommate or, if either individual is physically or mentally incapable of signing the form, the signature of their resident representative;

2. a waiver of liability for the nursing home for any breach of privacy involving the nonverbal resident's use of an electronic monitoring device, unless the breach occurred because of the unauthorized use of the device or a recording it made by facility staff;

3. the type of electronic monitoring device to be used;

4. a list of conditions or restrictions that the nonverbal resident or roommate may place on the device's use, including (a) prohibiting audio or video recording or broadcasting or (b) turning off or blocking the device's visual recording when the

resident or roommate is undergoing a health care exam or procedure, dressing or bathing, or visiting with a guest (e.g., attorney, partner, ombudsman, or spiritual advisor);

5. an acknowledgement that the nonverbal resident, roommate, or their resident representatives, are responsible for operating the device in accordance with these conditions unless they have a signed written agreement with the nursing home for the facility staff to operate the device, which may include a liability waiver for the facility related to the operation;

6. a statement of the circumstances under which a recording from the device may be disseminated; and

7. a signature box for documenting that the nonverbal resident or roommate, or their representatives, have consented to the electronic monitoring or withdrawn consent.

If a resident representative signs the consent form, the bill requires the consent form to also document:

1. the date the nonverbal resident or roommate was asked if the resident or roommate wants electronic monitoring to be conducted, and who was present when asked;

2. an acknowledgement that the nonverbal resident or roommate did not affirmatively object to electronic monitoring; and

3. the source of the authority allowing the resident representative to sign the consent form on behalf of the nonverbal resident or roommate.

Consent Form Availability

The bill requires the state's long-term care ombudsman, within available appropriations, to make available on the office's website, a downloadable copy of a standard consent form containing all provisions required under the bill.

It requires nursing homes to:

1. make the consent form available to nonverbal residents and inform them and their resident representatives of their option to conduct electronic monitoring of their rooms or private living units,

2. maintain a copy of the consent form in the nonverbal resident's records, and

3. place a notice in a conspicuous place near the facility's entrance stating that some rooms and living areas may be subject to electronic monitoring.

Consent Exceptions

The bill allows a nonverbal resident, or his or her resident representative, to install an electronic monitoring device without submitting a written consent form to the nursing home if:

1. the nonverbal resident or resident representative (1) reasonably fears the nursing home will retaliate against the resident for recording or reporting alleged abuse or neglect by nursing home staff, (b) submits a completed consent form to the long-term care ombudsman, and (c) submits a report to the ombudsman, social services or public health commissioners, or police with evidence from an electronic monitoring device that suspected abuse or neglect of the resident has occurred;
2. the (a) nursing home failed to respond for more than two business days to a written communication from the nonverbal resident or his or her resident representative about a concern that prompted the resident's desire to install an electronic monitoring device and (b) resident or resident representative submitted a consent form to the ombudsman; or
3. the nonverbal resident or his or her resident representative already submitted a report to the ombudsman, social services or public health commissioners, or police regarding concerns about

the resident's safety or wellbeing that prompted the resident's desire for electronic monitoring and the resident or resident's representative has submitted a consent form to the ombudsman.

New Roommate Consent

Under the bill, if a nonverbal resident is using electronic monitoring and a new roommate moves in, the resident must stop using the device unless and until the new roommate signs the consent form, and the resident or his or her resident representative files the consent form with the nursing home.

If a roommate refuses to consent, the bill requires the nursing home to reasonably accommodate the resident's request to move into a private room or another room with a roommate who has agreed to consent to the monitoring. The nursing home must do this within 30 days after the resident's request and only if a room is available and the resident is able to pay any price difference.

BACKGROUND

Current Minimum Nurse Staffing Standards for Nursing Homes

DPH licenses nursing homes at two levels of care: (1) chronic and convalescent nursing homes (CCNHs), which provide skilled nursing care, and (2) rest homes with nursing supervision (RHNS), which provide intermediate care. (Nursing homes generally have been phasing out RHNS beds or converting them to CCNH beds.)

Minimum staffing requirements for CCNHs and RHNS are set by regulation and depend on the time of day, as shown in the table below (Conn. Agencies Reg. § 19-13-D8t(m)).

Table 1: Minimum Nurse Staffing Requirements for Nursing Homes

Direct Care Personnel	*CCNH*		*RHNS*	
	7 a.m. to 9 p.m.	9 p.m. to 7 a.m.	7 a.m. to 9 p.m.	9 p.m. to 7 a.m.

Licensed Nursing Personnel	0.47 hours per patient (hpp)* (28 min.)	0.17 hpp (10 min.)	0.23 hpp (14 min.)	0.08 hpp (5 min.)
Total Nurses and Nurse Aide Personnel	1.40 hpp (1 hr. 24 min.)	0.50 hpp (30 min.)	0.70 hpp (42 min.)	0.17 hpp (10 min.)

Related Bills

SB 973, favorably reported by the Aging Committee, requires the long-term care ombudsman and executive director of the Commission on Women, Children, Seniors, Equity, and Opportunity to seek testimony from family councils on statewide policies, legislative proposals, or regulations on long-term care facility conditions.

sSB 975, favorably reported by the Aging Committee, adds to the nursing home patients' bill of rights, the right to treat their living quarters as their own home, including purchasing and using technology they choose that facilitates virtual visitation with family and others

SB 1057, favorably reported by the Human Services Committee, requires DPH to establish nursing home minimum staffing levels of 4.1 hours of direct care, including 0.75 hours by a registered nurse, 0.54 hours by a LPN, and 2.81 hours from a CNA

sHB 6552, favorably reported by the Aging Committee, allows nursing home residents to use the technology of their choosing that facilitates virtual monitoring or virtual visitation, under certain conditions.

sHB 6595 and sSB 1002, both reported favorably by the Labor and Public Employees Committee, contain provisions that generally require (1) the DPH commissioner to amass stockpiles of PPE (§ 8 in both bills) and (2) LTC providers to maintain an unexpired inventory of new PPE sufficient for 90 days of surge consumption during a state of emergency (§ 10 in both bills).

HB 6634, favorably reported by the Human Services Committee, allows long-term care facility residents to designate an essential support person who may visit the resident despite general visitation restrictions imposed on other visitors and requires DPH to establish a state-wide visitation policy

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute
Yea 32 Nay 1 (03/29/2021)