North Carolina Senior Living Association

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August 15, 2024

Ms. Taylor Corpening
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Raleigh, NC 27699
Email: dhsr.rulescoordinator@dhhs.nc.gov

Re: North Carolina Senior Living Association Comments to Proposed Medical Care Commission Rules Published June 17, 2024 in the North Carolina Register, Volume 38, Issue 24, pages 1582 – 1623

Dear Ms. Corpening,

I represent the North Carolina Senior Living Association and the many adult care home and family care home members and associate members that comprise the Association. The majority of our members provide care and services to Medicaid beneficiaries and many are family owned and operated businesses, which have been providing care to our seniors and adults with disabilities for decades.

First of all, I would like to say that our Association and its members are extremely disappointed regarding the process that the Division of Health Service Regulation (DHSR) has followed for the rules we are commenting on in this letter. Up to this point, DHSR, on behalf of the Commission, had followed a regular, although at times disorganized, process of reviewing and revising the 10 NCAC 13F rules for adult care homes and the 10 NCAC 13G rules family care homes via the agency's Rules Review Workgroup. By disorganized, we mean that sometimes members of the Rules workgroup would be given less than 24-hours to review proposed rule changes to be discussed at the meeting the following morning and oftentimes, meetings were abruptly cancelled with little notice and no reason and one was left with the impression that the process was disorganized.

Prior to DHSR sending out their April 22, 2024 letter to interested parties regarding the rules which we are commenting, there was little to no discussion regarding emergency and disaster requirements that we now see proposed in 10 NCAC 13F .0309 and 13G .0316 - FIRE SAFETY AND EMERGENCY PREPAREDNESS PLAN. Even though DHSR chairs the Rules Review Workgroup, none of what is being proposed in this Section was discussed in prior meetings and almost immediately after sending out the proposed rules to interested parties, DHSR abruptly disbanded the Rules Review Workgroup, which prohibited any open and frank discussions of the 64 pages of amended rules, many with completely new rule language.

Concerning DHSR's Fiscal Impact Analysis and justification for the new rules for emergencies and disasters under 13F .0309 and 13G .0316, some of the instances they list are not factually correct or otherwise leave out important details where facilities actually took actions to protect their residents. In addition, in the examples cited, where facilities received citations and administrative sanctions, it should be noted that all of these issues were regulated by DHSR within the current regulatory framework and therefore, we believe this nullifies the

need for these unrealistic and onerous regulations the agency is now proposing.

On page 11 of DHSR's Fiscal Impact Analysis of these rules, under Alternatives (to the proposed Fire Safety and Emergency Preparedness Plan rules), DHSR states "…there have been instances where a facility's failure to adequately prepare for an emergency or execute the disaster plan has resulted in death and physical harm to residents, as well as neglect by not providing the care and services necessary to keep residents safe and maintain their wellbeing during an emergency." However, we contend that some of the rules being proposed, specifically, 10 NCAC 13F .0309 and 13G .0316 that require evacuation during drills, is ill advised at best and at worst, irresponsible. Evacuating residents carries significant risks to the residents' health and safety.

In a study published February 2012 in the Journal of American Medical Directors Association - To Evacuate or Shelter in Place: Implications of Universal Hurricane Evacuation Policies on Nursing Home Residents – it was found that evacuation significantly exacerbated subsequent morbidity/mortality.

Another study published in 2024 in the Journal of the American Medical Association - Evacuation and Health Care Outcomes Among Assisted Living Residents After Hurricane Irma, it was found that "…evacuation may be associated with adverse outcomes after a hurricane among AL residents, which should be taken into consideration during emergency preparedness planning."

It should be noted that in March 2021, the Federal Centers for Medicare and Medicaid Services (CMS) issued new Emergency Preparedness rules for certain Medicare certified provider types, which include hospitals, nursing homes and other provider types that typically have more financial and personnel resources and are better equipped to comply with Federal Regulations. It appears that DHSR decided to take the CMS Emergency Preparedness regulations and, without serious consideration of the financial impact and resource impact to adult and family care homes, have essentially copied and pasted them into the new rules text for adult and family care homes, which we argue are not only overly excessive, but we would argue that the majority of providers do not have the money, capacity, and otherwise, resources to comply with these rules. Just to put this in perspective, the existing rules under 13F .0309 and 13G .0316, which have been in place since 2005 and we contend are sufficient, only comprise six (6) rules. The new rules DHSR are proposing span forty (40) rules, many of which have multiple requirements within each rule.

For example, under 10A NCAC 13F .0309 and 13G .0316, the proposed rules will require every adult and family care home in the state to develop an "all-hazards plan", which is directly out of the CMS regulations for Emergency Preparedness for hospitals, nursing homes and other provider types, and are intended to address every conceivable disaster as noted below.

(e) The facility's emergency preparedness plan shall include the following:

(1) An all-hazards plan which includes a basic emergency operations plan, using an all-hazards approach. For the purpose of this Rule, an "all-hazards approach" means addressing the facility's common operational functions in an emergency; the facility identifies and trains staff on tasks common to all emergency events; the facility identifies and trains the primary staff persons responsible for accomplishing those tasks; and the facility identifies how it will ensure continuity of operations, including designating alternate individuals to carry out

those responsibilities and tasks in the event that the primary staff person is not available to do so. The plan shall address the following:

(A) procedures for collaborating with other healthcare facilities and services to include emergency medical services, hospitals, nursing homes, adult care homes when applicable and the community during an emergency or disaster;

(B) a plan for communicating with local emergency management, the Division of Health Service Regulation (DHSR), Department of Social Services (DSS), residents and their responsible parties, and staff;

(C) procedures for collaborating with local emergency management and healthcare coalitions;

(D) provision for subsistence needs for residents and staff, including food, water, medical and pharmaceutical supplies, and equipment including durable medical equipment, medication, and personal protective equipment;

(E) alternate source of energy to maintain temperatures to protect resident health and safety and for the safe and sanitary storage of food and medications, emergency lighting, fire detection, extinguishing, and alarm systems, sewage and waste disposal;

(F) a system for tracking residents and staff;

(G) procedures for sheltering-in-place;

(H) evacuation procedures that provide for safe evacuation of residents, staff, resident family or representatives, or other personnel who sought potential refuge at the facility;

(I) resident identification and resident records;

(J) emergency and standby power systems;

(K) transportation procedures to include prearranged transfer agreements, written agreements or contracted arrangements with other facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to residents;

(L) provisions for addressing potential staffing issues and ensuring staffing to meet the needs of residents during an emergency situation, including the provision of staff to care for residents while evacuated from the facility;

(M) coordination with the local and regional emergency management agency; and

(N) contact information for state and local resources for emergency response, facility staff, residents and responsible parties, vendors, contractors, utility companies, and local building officials such as the fire marshal and local health department.

(2) A risk assessment that identifies potential hazards to the facility. The risk assessment shall be based on the county risk assessment established by the county emergency management agency and the hazard vulnerability assessment established by the regional healthcare coalition. The facility’s risk assessment shall identify the top

three to five risk areas to the facility and its residents and categorize the risk areas by the likelihood of occurrence. For each of the three to five risk areas identified, the facility shall develop a plan which addresses the factors listed in Items (e)(1)(A-N) of this Rule. The following are examples of types of emergencies or disasters that may pose a risk to a facility:

(A) Natural disasters to include a hurricane, tornado, storm, high water, wind-driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm, or drought;

(B) Man-made disasters to include fire, building structure failures, transport accidents, acts of terrorism, active assailant, incidents of mass violence, industrial accidents;

(C) Infrastructure disruptions such as failures to structures, facilities, and equipment for roads, highways, bridges, ports, intercity passenger and freight railroads; freight and intermodal facilities, airport, water systems, sewer systems;

(D) Resident care-related emergencies;

(E) Equipment and utility failures, to include power, water, gas;

(F) Interruptions in communication;

(G) Unforeseen widespread communicable public health and emerging infectious diseases;

(H) Loss of all or a portion of the facility; and

(I) Interruptions to the normal supply of essential resources, such as water, food, fuel for heating and cooking, generators, medications, and medical supplies. For the purposes of this rule “emergency” means a situation which presents the risk of death or physical harm to residents.

(f) The facility’s emergency preparedness plan shall be reviewed at least annually and updated as needed by the administrator and shall be submitted to the local emergency management agency and the local agency designated to coordinate and plan for the provision of access to functional needs support services in shelters during disasters. Any changes to the plan shall be submitted to the local emergency management agency and the local agency designated to coordinate and plan for the provision of access to functional needs support services in shelters during disasters within 30 days of the change. Documentation of submissions shall be maintained at the facility and made available for review upon request to the Division of Health Service Regulation and county department of social services.

(g) Newly licensed facilities and facilities that have changed ownership shall submit an emergency preparedness plan to the local emergency management agency and the local agency designated to coordinate and plan for the provision of access to functional needs support services in shelters during disasters within 30 days after obtaining the new license. Documentation of submissions shall be maintained at the facility and made available for review upon request to the Division of Health Service Regulation and county department of social services.

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COMMENT: there is a formatting error here as (g) appears twice

(g) The facility's emergency preparedness plan shall be made available upon request to the Division of Health Service Regulation, county department of social services, and emergency management officials.

(h) The administrator shall ensure staff are trained on their roles and responsibilities related to emergencies in accordance with the facility's emergency preparedness plan as outlined in Paragraph (e) of this Rule. Staff shall be trained upon employment and annually in accordance with Rule .1211 of this Subchapter. 73 Appendix – Proposed rules Jump to Table of Contents

(i) The facility shall conduct at least one drill per year to test the facility's emergency plan. The facility shall maintain documentation of the annual drill which shall be made available upon request to the Division of Health Service Regulation, county department of social services, and emergency management officials.

(j) The emergency preparedness plan outlined in Paragraph (e) of this Rule shall be maintained in the facility and accessible to staff working in the facility.

Based on the above new regulatory requirements, it appears that DHSR assumes that providers, including small 2-6 bed family care homes, have an endless supply of money and resources available to comply with these new rules. Adult care and family care homes are NOT equivalent to hospitals, nursing homes and other higher level of care provider types.

Below are a few additional comments about the above proposed rules in 13F .0309 and 13G .0316:

1. Paragraph (e) (1) (A) "procedures for collaborating with other healthcare facilities…Emergency medical services, hospitals,…" it is our understanding that a facility in crisis in December 2023, as described on Page 9 of DHSR's Financial Impact Analysis, was not allowed to move residents to a hospital who had swing beds available in an emergency. Therefore,
    a. *How is transfer to any facility other than "like" facility interpreted?*
2. Paragraph (e) (1) (C) "procedures for collaborating with local emergency management and healthcare coalitions.
    a. *Will DHSR impress local county Emergency Management (EM) offices and Coalitions to hold meetings and training on all appropriate changes and expectations by the EM directors?*
        i. *As well as, training the hazard vulnerability assessment established by the county EM department?*
    b. *Will DHSR ensure that there is consistency between DHSR and EM directors?*
3. Paragraph (e) (1) (H) "evacuation procedures that provide for safe evacuation of residents, staff, resident family or representatives, or other personnel who sought potential refuge at the facility;"
    a. *So, facility must now be responsible for providing evacuation for families and others?*

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   b. *Are the facilities now responsible for subsistence and care for family members?*

   c. *This regulation could lead to liability requirements for families by plaintiff's attorneys or adverse actions by insurance companies.*

4. Paragraph (e) (1) (K) "transportation procedures to include prearranged transfer agreements, written agreements,….."

   a. *Based on paragraph (e) (H), this requirement must include "resident family or representatives, or other personnel…". How can we comply with an unknown number? This could double the transportation needs and costs.*

5. Paragraph (e)(2) "A risk assessment that identifies potential hazards to the facility."

   a. *Will DHSR communicate this new requirement to County EM directors and healthcare coalitions and the need to meet with facilities to discuss and assist in assessments for their individual locations?*

6. Paragraph (i) "The facility shall conduct at least one drill per year to test the facility's emergency plan."

   a. *To what event is this drill related? Is a drill required for each of the top five risk areas?*

   b. *To what extent, evacuate to a supporting facility and incur the cost of transportation?*

   c. *Will a tabletop exercise or possible evacuation of building to "on-site" gathering points suffice?*

7. Paragraph (l) "If the facility evacuates residents for any reason, the administrator or their designee shall report the evacuation to the local emergency management agency, the local county department of social services, and the Division of Health Service Regulation Adult Care Licensure Section within four hours or as soon as practicable of the decision to evacuate, and shall notify the agencies within four hours of the return of residents to the facility."

   a. *Who decides if a time period is "as soon as practicable"?*

   b. *Will DHSR have 24/7 on call staff to receive the call?*

8. Paragraph (m) "Any damage to the facility or building systems that disrupts normal care and services provided to residents shall be reported to the Division of Health Service Regulation Construction Section to obtain technical assistance within three hours or as soon as practicable of the incidence occurring."

   a. *Will DHSR Construction Section have a 24/7 on call system in place?*

   b. *Will technical assistance be given on this call?*

   c. *If an onsite visit is required, will that visit be made within 12 hours?*

   d. *Who decides "as soon as practicable"?*

9. Paragraph (n) "If a facility has evacuated residents due to an emergency, the facility shall not re-occupy the building until local building officials have given approval to do so.

    a. *Does this include a situation where the facility was evacuated in anticipation of an emergency, i.e. impending hurricane or forest fire, yet facility is not affected?*

    b. *In situation where the EM director approves return to the facility however; building officials will not come to building for over 24 hours, who mitigates the approval to return? The facility is bearing the cost of alternative housing until the building official makes their visit.*

10. Paragraph (o) "...the receiving facility shall request a waiver from DHSR"

    a. *Will this waiver be able to be received, considered and approved/discussed within two hours, 24/7?*

In summary, as stated earlier, we contend that the proposed new rules for 10 NCAC 13F .0309 and 13G .0316 are unnecessary and the current rules and regulatory framework currently in place are sufficient to address disasters and emergencies in adult and family care homes. Trying to re-write and pass new regulations to address each and every conceivable problem or situation that may occur in a residential setting is both excessive and unnecessary.

Furthermore, if DHSR was so concerned about the examples given on pages 7, 8 & 9 of their Fiscal Impact Analysis, why didn't the agency move to pass temporary or emergency rules after these incidences occurred or similar to what was done with passage of the infection control rules during the COVID-19 pandemic? We contend that none of the examples listed rose to the level of putting in temporary or emergency rules because the current regulatory process was/is sufficient. Furthermore, we believe DHSR's only reason for putting these new rules forth is an effort to regulate adult care and family care homes like nursing homes (which they are clearly not), and, via the back door, make them subject to the CMS Emergency and Disaster Requirements because of an overreactive mindset.

We believe it is not a coincidence that the number of adult care homes and family care homes in North Carolina have declined in the past 10 years. Whereas, in the past, there were nearly 600 family care homes, as of July 15, 2024, there are now only 509 homes. From what we have heard from both adult care and family care home providers no longer in the business is that the regulatory burden, inflationary costs of food, labor and supplies, and lack of sufficient reimbursement, particularly from Medicaid and State/County Special Assistance, has made it next to impossible to operate a home as many providers constantly experience cash flow problems and literally operate paycheck to paycheck. All of this at a time when North Carolina is riding the Silver Tsunami and there needs to be an effective continuum of care for our seniors, including assisted living provided by adult care and family care homes.

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Therefore, we propose that DHSR go back to the drawing table, so to speak, and make an honest effort to work with providers on any proposed changes or amendments to 13F .0309 and 13G .0316. It seems that there should be a risk assessment where facilities work with local EMS to develop a determination of likely risks based on local conditions and the assessments that Local EMS agencies perform. It further seems that DHSR should prepare a common emergency preparedness plan with certain facility-specific and region/ location specific items to be filled in by facilities. Until reimbursement rates and resources increase significantly, there has to be a more uniform approach. Through collaboration and input, we believe that we can arrive with any needed changes that providers can comply with to safely provide care for their residents.

Sincerely,

Jeff Horton

Jeff Horton, Executive Director
NC Senior Living Association

Cc: NC Medical Care Commission members