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VIA ELECTRONIC MAIL

Dear Ms. Wilkerson:

Thank you for providing the American Health Care Association (AHCA) with the opportunity to comment on the draft Survey and Certification (S&C) letter for ICFs/MR, "Protection of Clients Rights—Locked Areas and Supplies."

AHCA is a federation of state associations representing nearly 11,000 non-profit and proprietary long term care providers, including ICFs/MR. On behalf of these providers, we appreciate the opportunity to comment on this proposed clarification letter.

Our general comments include:

- There are aspects of the letter that do not align with current ICF/MR regulation and guidance, as well as other federal/state/local laws, and are therefore inappropriate for inclusion in the document.
- In some facilities, locked areas may be needed for longer than "isolated, temporary use" as not all clients, even with a focused active treatment program, will be able to safely access and use certain items. These long-term, locked areas are also necessary for compliance with certain regulations that ICFs/MR must follow—outside of CMS requirements.
- Asserting that "usual community home settings" allow access to all areas and supplies is inaccurate. On the contrary, these settings have appropriate, restricted access areas to promote safety and security.

Our specific comments and recommendations are below:

Regulatory Inconsistencies

1) The Memorandum Summary states that “locking mechanisms must be supported by assessments, be limited in duration and be employed in conjunction with an active treatment plan....” However, guidance at W195, “Condition of Participation (CoP): Active Treatment Services” recognizes that the CoP is met when staff works to “increase” clients’ skills and independence in functional life areas and that treatment, overall, “promotes” skills and independence. It is clear that current guidance recognizes that some clients may never fully achieve certain skills, which may include having the cognitive ability to distinguish between safe and unsafe materials. Therefore, in certain cases, locking mechanisms cannot be “limited in duration” because client assessments and active treatment plans may reflect that ceasing this practice is too dangerous. This is especially true for clients with PICA, who crave the chalky materials often found in laundry detergent; therefore, these individuals should not have access to laundry supply storage areas for their own safety.

Recommendation:

Facilities should not be cited if specific areas are locked for an extended period of time if the following protocols are in place: assessments and active treatment plans are thoroughly completed and regularly re-evaluated, the specially constituted committee approves of any locked areas, and appropriate consent forms are signed by clients or their families/guardians.

2) CMS states in the letter that “blanket or inappropriate use of locks in the ICF/MR living unit may indicate.... inadequate staffing ratios.” However, the guidance at W158, “CoP: Facility Staffing” states that the CoP is met when “there are sufficient numbers of competent, trained staff to provide active treatment and.... to protect individuals’ health and safety.” As previously stated, despite having thorough active treatment plans in place, some clients may never be able to safely have unlimited access to all areas of the ICF/MR. At W122, “Client Protections,” it states that individual freedoms are “promoted” and that justification is needed for restrictions; this further supports the fact that facilities must balance free access with clients’ safety needs as determined by assessments and active treatment plans. Existing ICF/MR regulations and survey guidance adequately balance clients’ rights with safety. The letter’s direction to “automatically trigger a review of the on-duty staff” if there are locked areas is inconsistent with regulations and is uncalled for.

Recommendation:

Remove from the S&C letter the direction for automatic review of facility staffing levels. There is not an automatic correlation between the use of locked areas and staff resources.

Permanent Locked Areas Are Necessary for Regulatory Compliance

W106 states that the facility must comply with federal, state and local laws. Some of these laws and other regulations (including HIPAA, OSHA, etc.) do require that hazardous materials and medical records be locked. Due to conflicting regulatory requirements, disallowing any permanent locked areas in ICFs/MR is inappropriate and potentially illegal. CMS should not put providers in a position where complying with CMS regulations is in violation with state/local laws or other regulatory requirements.

Recommendation:

As previously stated, CMS needs to include language in the letter that certain areas of the ICF/MR can be permanently locked.

“Usual Community Home Settings” Use Restricted Access for Safety/Security

The S&C letter states that “in the usual community home setting, a person living in the home has free access to all areas and supplies in the home unless another member of the household chooses to restrict access to his/her own personal belongings.” However, the following scenarios should be considered:

- Parents do not provide children—who may not, at certain ages, have the cognitive ability to safely distinguish between safe/unsafe materials—free access to all areas and supplies of the home. If parents did provide such free access, they could be considered negligent. At some ages, these children, even with “training” would not be able to reach a level of safe understanding.
- Locked “supply storage areas” in ICFs/MR have resulted in citations; however, these same storage areas are often locked in community home settings. For example, boiler rooms, dry good supply areas, etc. are often locked in apartment and other residential buildings to prevent injury of residents and theft by outside parties. Placing different expectations on ICFs/MR does not make sense.
- Notably, other healthcare-related settings have locked areas to ensure privacy and to protect property. For example, doctors’ offices and nursing homes have locked office areas where medications and patient files are kept, as well as storage areas for equipment, furniture, seasonal items, etc. Unfortunately, locked areas may also be needed in these settings, as well as in ICFs/MR, to prevent staff access to items.

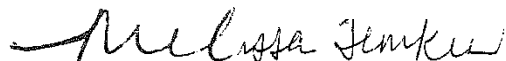
Unlike in private homes, ICFs/MR have medical records, large equipment, and other storage and security concerns; it is clear that there need to be allowances for permanently locked areas in ICFs/MR to sustain general operations. These locked areas are also needed so that, similar to “usual community home settings,” clients’ safety and facility property can be protected per client and family/guardian choice.

Recommendation:

Clarify in the letter that there are areas in ICFs/MR that are not considered the “living area” which can be locked on an ongoing basis. In addition, clarify that, if informed consent documents have been signed, additional locked areas are permissible. These conditions would allow ICFs/MR to protect the unusual and often costly property that is not even part of average households (including medical records and equipment, etc.) as well as items of concern to specific ICFs/MR’s clients and their families/guardians.

AHCA appreciates the opportunity to comment on this draft ICF/MR S&C letter. We encourage you to contact us at any time for additional information or to provide comment on other issues.

Thank you,



Melissa Temkin
Director of Membership and Regulatory Relations

cc: Kelley Leonette
Douglas Thomas
AHCA DD Residential Services Committee