NEW YORK STATE | Department of Health

Nursing Home Staffing Standards

Public Health Law §2895-b & 10 NYCRR §415.13

Minimum Staffing Level Compliance Reviews

Public Health Law §2895-b

10 NYCRR §415.13

Beginning April 1, 2022 nursing homes must provide at minimum

- Average of 3.5 hours of care per resident per day (HPRD)
- At least 2.2 HPRD by Certified Nurse Aide (CNA) (for 2022 includes nurses in training)
- At least 1.1 HPRD by Licensed Practical Nurse (LPN) or Registered Nurse (RN)

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Public Health Law §2895-b

10 NYCRR § 415.13

- Penalty up to $2,000 per day out of compliance

- May be less than $2,000 per day if the facility can demonstrate, to the satisfaction of the Department, that the specified mitigating or aggravating factors prevented compliance.

Public Health Law §2895-b

10 NYCRR § 415.13

Mitigating or aggravating factors during Quarter

- Extraordinary Circumstances: natural disaster; declared emergency (national, State or municipal); catastrophic event
- Acute Labor Supply Shortage in facility's location as determined by the Commissioner of Health
- Verifiable Union Dispute

Public Health Law §2895-b

10 NYCRR § 415.13

Acute Labor Supply Shortage in facility's location (continued)

- Commissioner's determinations posted on DOH website
- BLS Metropolitan and Nonmetropolitan Area*
- Specified Nursing titles
- Facility must demonstrate to Department's satisfaction
  - Reasonable attempts to procure sufficient staffing
  - Steps taken to ensure resident health and safety

* Federal Bureau of Labor Statistics

Compliance with Staffing Level Requirements

- Determined by the Department on a Quarterly basis

Period	Quarter
January 1 – March 31	1
April 1 – June 30	2
July 1 – September 30	3
October 1 – December 31	4

* Quarter 2 of 2022 is the first compliance review period

- Initial Determination based on review of CMS Payroll Based Journal (PBJ)
  - Published Public Use file for the Quarter
  - Facility's reported staffing hours per day

Compliance with Staffing Level Requirements

DOH methodology for determining compliance

- Calculate quarterly average HPRD for all nursing titles (3.5 HPRD)
- Calculate quarterly average HPRD for specific nursing titles (2.2 & 1.1 HPRD)
- Compare quarterly averages to staffing requirements
- Noncompliance is failure to meet any of the three HPRD requirements (3.5 Total, 2.2 CNA, 1.1 LPN or RN)

Compliance Determination Notifications

Department will send Notification to facility Administrators and Operators (via Health Commerce System Distribution Management System)

- Notice of Compliance:
  - Met all 3 required HPRD
  - No further action
- Notice of Noncompliance - Initial Determination
  - Failed to meet 1 or more of the required HPRD
    or
  - Facility did not appear in the CMS PBJ

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Notice of Noncompliance

Dear Administrator:

The Department's review of the Centers for Medicare and Medicaid Services (CMS) Payroll Based Journal for [Quarter, Year] indicated that [Name of Facility] was noncompliant with the minimum nursing staff requirements established under Public Health Law § 2895-b and 10 NYCRR 415.13. The facility did not maintain the required daily average staffing hours as indicated below:

- *[insert: "Required: 3.5 hours of care per resident per day by a certified nurse aide, registered professional nurse, licensed practical nurse, or nurse aide"*
  - *Actual quarterly average hours of care per resident per day: XX*
  - *Dates of noncompliance: [MM/DD/YY, MM/DD/YY]*
- *[insert: and/or " Required:2.2 hours of care per resident by a certified nurse aide or a nurse aide"*
  - *Actual quarterly average hours of care per resident per day: XX*
  - *Dates of noncompliance: [MM/DD/YY, MM/DD/YY]*
- *[insert: and/or "Required:1.1 hours of care per resident by a registered professional nurse or licensed practical nurses."*
  - *Actual quarterly average hours of care per resident per day: XX*
  - *Dates of noncompliance: [MM/DD/YY, MM/DD/YY]*

If you believe [Name of Facility] can demonstrate mitigating or aggravating factors as set forth in regulation 10 NYCRR 415.13, you may apply for a reduction in penalties using the form found at [*link to web-based form*]. The Commissioner's determination on the existence of an acute labor supply shortage can be found at [*link to Nursing Home Minimum Staffing and Direct Resident Care Spending webpage*].

If you disagree with this determination, you must complete and submit the Redetermination Request form found at [*link to web-based form*].

Penalty reduction and redetermination requests must be submitted within **10 business days**.

Under statute the facility may be fined up to $2,000 per day for each day in the quarter that the facility failed to comply with the minimum nursing staffing requirements. In the absence of the above penalty reduction or redetermination requests, the Department will impose a penalty based on the data available.

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Initial Notice of Noncompliance

Possible further actions:

- Facility Request for Redetermination
- Facility Request for Penalty Reduction due to Mitigating Factors
- Department Referral for Enforcement to Division of Legal Affairs

Facility Request for Redetermination

Facility believes PBJ data or Department Calculation Error

- Must submit Department issued Electronic Redetermination Request form (accessible via notice)
- Must include Department Issued Employee Detail Attachment form
- Subject to requests for further information
- Requires Attestation by Operator or authorized designee
- Must be submitted within 10 business days

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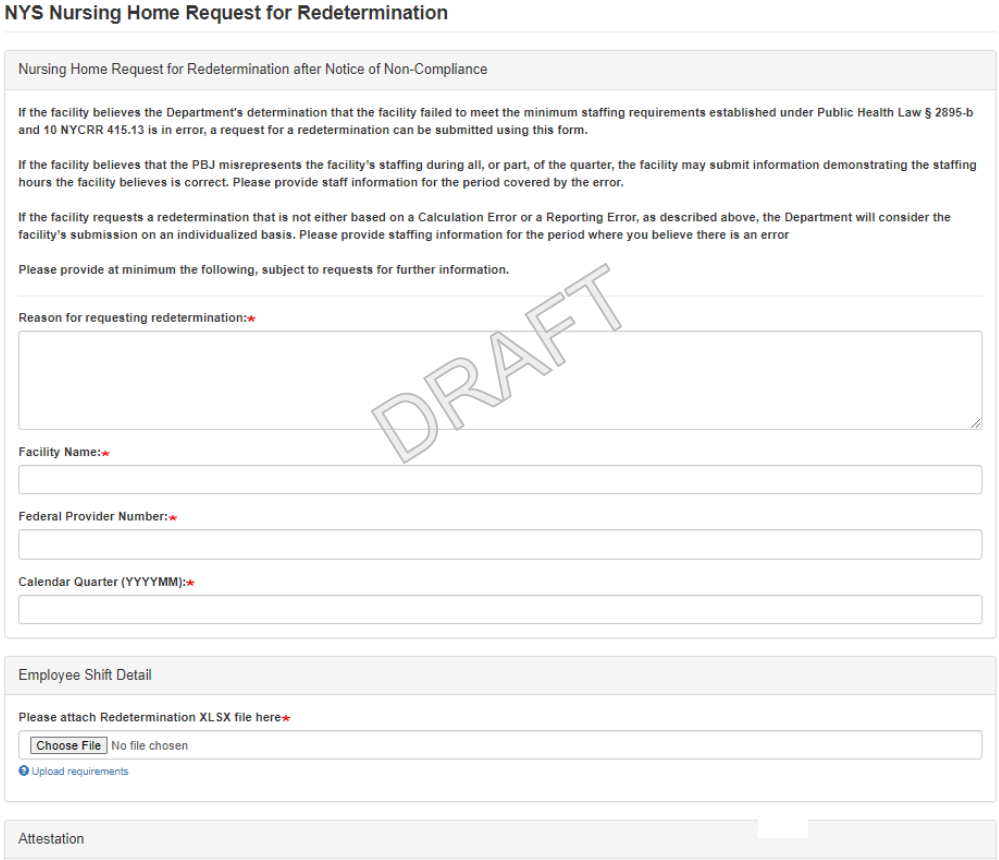
Redetermination Request – Electronic Form



NYS Nursing Home Request for Redetermination

Nursing Home Request for Redetermination after Notice of Non-Compliance

If the facility believes the Department's determination that the facility failed to meet the minimum staffing requirements established under Public Health Law § 2895-b and 10 NYCRR 415.13 is in error, a request for a redetermination can be submitted using this form.

If the facility believes that the PBJ misrepresents the facility's staffing during all, or part, of the quarter, the facility may submit information demonstrating the staffing hours the facility believes is correct. Please provide staff information for the period covered by the error.

If the facility requests a redetermination that is not either based on a Calculation Error or a Reporting Error, as described above, the Department will consider the facility's submission on an individualized basis. Please provide staffing information for the period where you believe there is an error

Please provide at minimum the following, subject to requests for further information.

Reason for requesting redetermination:*

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Facility Name:*

Federal Provider Number:*

Calendar Quarter (YYYYMM):*

Employee Shift Detail

Please attach Redetermination XLSX file here*

Choose File No file chosen

Upload requirements

Attestation

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Redetermination Request – Attachment (Excel)

Nursing Home Request for Redetermination - Employee Detail Attachment

This template must be completed and submitted with the facility's Request for Redermination if the facility believes the Department's determination that the facility failed to meet the minimum staffing requirements established under Public Health Law § 2895-b and 10 NYCRR 415.13 is in error.

The completed template must be submitted through the formal electronic Request for Determination submission. Access to the formal request is provided in the Notice of Noncompliance.

Instructions for:

1. If the facility believes that the PBJ misrepresents the facility's staffing during all, or part, of the quarter, the facility may submit information demonstrating the staffing hours the facility believes is correct. Please provide staff information for the period covered by the error.

2. If the facility believes that the PBJ misrepresents the facility's census during all, or part, of the quarter, the facility may submit information demonstrating the census that the facility believes is correct. Please provide census information for the period covered by the error.

3. If the facility requests a redetermination that is not either based on a Calculation Error or a Reporting Error, as described above, the Department will consider the facility's submission on an individualized basis. Please provide staffing information for the period where you believe there is an error.

Please provide at minimum the following, subject to requests for further information.

→ FACILITY NAME	
→ FEDERAL PROVIDER NUMBER	
→ CALENDAR QUARTER (YYYYQQ)	

→ Please provide the following information for each shift completed by your staff members during the period in question.

WORKDATE	SYS_EMPLEE_ID	EMPLEE_JOB_CD_ID	WORK_HRS_NUM	INCOMPLETE*	CENSUS DATE	TOTAL RESIDENT CENSUS (Occupied Beds)
Please enter the day the staff member worked in the following format: MMDDYYYY	*Please provide the staff member's 'System Employee ID', as typically reported to the CMS PBJ*	*Please provide the Employee Job Title Code for the staff member on that day. - Please only include the number. For example, the employee is a Certified Nurse Aide. Then you would enter 10.* *Please only include staff members working under the following job codes:* *5 = RN Director of Nursing* *6 = RN with Administrative Duties* *7 = Registered Nurse (RN)* *8 = LPN with Administrative Duties* *9 = Licensed Practical Nurse (LPN)* *10 = Certified Nurse Aide* *11 = Nurse Aide in Training*	*Please enter the number of hours the staff member worked on that day. Please enter numbers only. Please enter up to two decimal places* *Example, 2 hours and 33 minutes worked should be entered as 2.6 or 2.55 hours, not 2.33*	*INCOMPLETE** *If the facility has incomplete staffing data for this employee day, please enter a "1" in this field.* *Example, if the facility's data were corrupted or incomplete, regardless of whether it was accident or malice or neither, you would enter "1" here. Otherwise, leave this field blank.*	*Please provide the census date in the following format: MMDDYYYY*	*Please provide number of residents present at the facility as of 12:00 am on the census date.*

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Facility Request for Redetermination

Redetermination on Compliance

- Based on Department's recalculation of actual hours
- Notice of Compliance: Met all 3 required HPRD; No further action
- 2nd Notice of Noncompliance - Redetermination
  - Possible further actions:
    - Facility Request for Penalty Reduction due to Mitigating Factors
    - Enforcement Action

Request for Penalty Reduction

Facility believes can demonstrate mitigating or aggravating factors set forth in 10 NYCRR 415.13

- Must submit Department issued electronic request form (accessible via notice)
- Must provide required information and evidentiary documents (subject to requests for further information)
- Requires Attestation by Operator of facility or authorized designee
- Must be submitted within 10 business days

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Application for Penalty Reduction

- Identifying Information
- Schedule A
- Schedule B
- Schedule C
- Attestation
- Complete

10 NYCRR Section 415.13

415.13 (f)(2)(ii) -- The Department may reduce penalties in a quarter that a facility is non-compliant, if the Department determines, in its sole discretion, that any of the following mitigating circumstances existed during the period of non-compliance.

Please complete the section, providing identifying information for the facility.

Facility ID* | Facility Name* | Medicare Provider ID*

Street Address* | City* | Zip Code*

Compliance Year + Quarter* Please doublecheck Compliance Year and Quarter.

YYYY-Q#

Please enter the year and quarter in YYYY-Q format.

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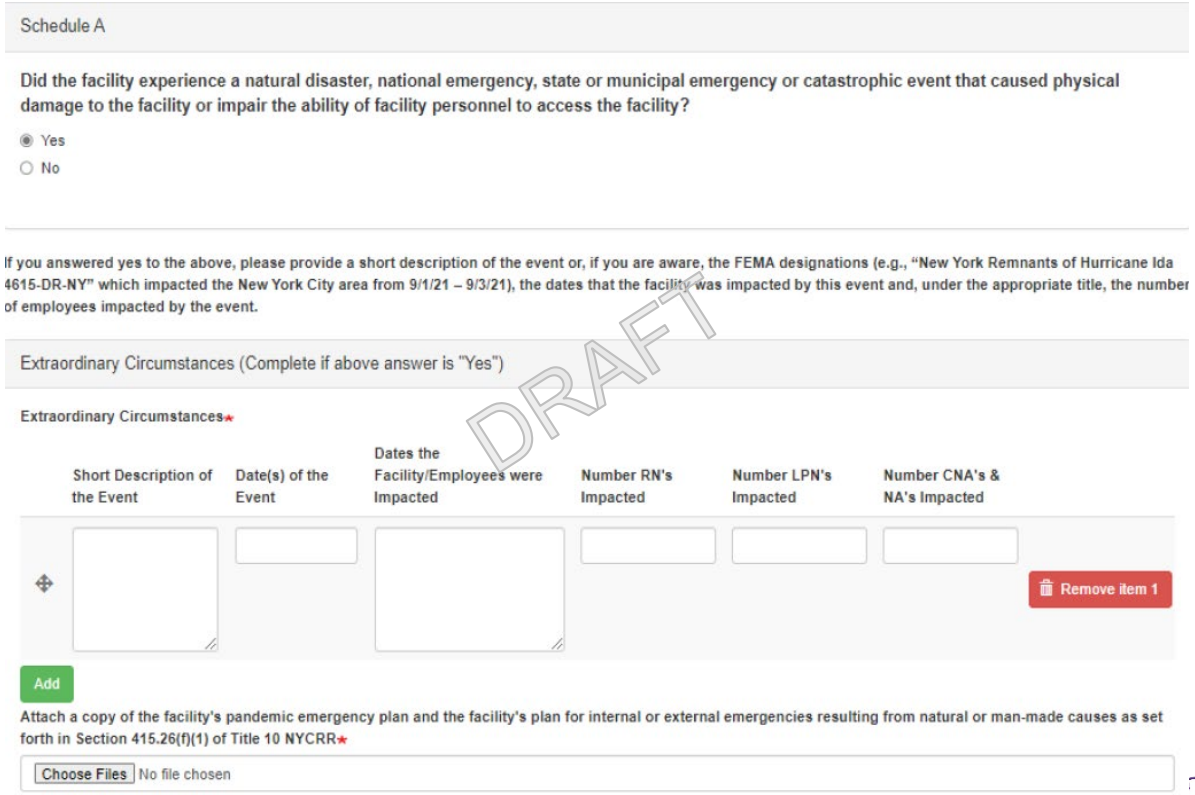
Application – Extraordinary Circumstances



Schedule A

Did the facility experience a natural disaster, national emergency, state or municipal emergency or catastrophic event that caused physical damage to the facility or impair the ability of facility personnel to access the facility?

- (•) Yes
- ( ) No

If you answered yes to the above, please provide a short description of the event or, if you are aware, the FEMA designations (e.g., "New York Remnants of Hurricane Ida 4615-DR-NY" which impacted the New York City area from 9/1/21 – 9/3/21), the dates that the facility was impacted by this event and, under the appropriate title, the number of employees impacted by the event.

Extraordinary Circumstances (Complete if above answer is "Yes")

Extraordinary Circumstances*

Short Description of the Event	Date(s) of the Event	Dates the Facility/Employees were Impacted	Number RN's Impacted	Number LPN's Impacted	Number CNA's & NA's Impacted	
						Remove item 1

Add

Attach a copy of the facility's pandemic emergency plan and the facility's plan for internal or external emergencies resulting from natural or man-made causes as set forth in Section 415.26(f)(1) of Title 10 NYCRR*

Choose Files No file chosen

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Application - Acute Labor Supply Shortage

Schedule B

Has the New York State Health Commissioner determined that there was an acute labor supply shortage of nurse aides, certified nurse aides, licensed practical nurses, or registered nurses in the Metropolitan or Nonmetropolitan area in which the facility is located?

- (●) Yes
- ( ) No

If the facility took steps to ensure the health and safety of the resident population and made reasonable attempts to procure additional staff, please complete the sections below.

Acute Labor Supply Shortage

Pursuant to 415.13 (f)(2)(ii)(b)(3) an acute labor supply shortage shall not serve as a mitigating factor unless the facility has demonstrated, to the satisfaction of the Department, that it has taken steps over the course of the quarter to ensure resident health and safety notwithstanding any labor supply shortage.

Please attach a narrative outlining the steps the facility took to ensure the health and safety of the resident population during the period of non-compliance.*

Choose File | No file chosen

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Application - Labor Supply Shortage

The following section includes eighteen different types of recruiting efforts. Please enter your information for each effort the facility engaged in, provide the date the facility made the attempt to recruit additional staff or if the effort was part of a continuing program, use the implementation date, and under RN, LPN, and CNA/NA check the boxes for the titles that the facility was trying to recruit for. If the space below is insufficient, for example, the facility attended two job fairs but there is only room for one, please attach an additional document and utilize the document to identify the reasonable attempt and provide the requested information. If the facility engaged in recruitment efforts that do not fit into any of the eighteen categories below, please attach an additional narrative describing the recruitment effort, including the dates, the activities involved, and the positions the facility was recruiting for. Upon receipt, the Department will assess and determine if additional information is required.

Reasonable Attempts

When entering information for any reasonable attempt category please complete all fields in the row. Additional attachments are required for many of the options, so please read the instructions in each row carefully.

Type	Date	Notes	RN	LPN	CNA/NA
I. Agency Contract	mm/dd/yyyy	If the facility executed a new contract between the facility and a nursing or temporary agency capable of providing additional staff, please complete the above. Please include the name of the agency under Notes and the effective date of the agreement under Date. Please provide a narrative summarizing the agreement and the reason the facility did not acquire enough staff to bring the facility into compliance and **attach a copy of the agreement between the facility and the agency and include it as Attachment I**.	☐	☐	☐
II. Benefit Increases (for new hires)	mm/dd/yyyy	If the facility increased benefits for potential staff, on a separate sheet, please provide a description of increase, the terms of eligibility, provide the date of change or implementation (under the date) and **attach a copy of the facility's documents outlining the available benefit package for prospective employees that outlines the availability of benefits and include it as Attachment II.**	☐	☐	☐
III. Cash Bonuses (Current & Prospective Employees)	mm/dd/yyyy	If the facility is offering a bonus to employees or prospective employees who bring a candidate to the facility and the candidate is hired (e.g., referral bonus or buddy bonus) or cash bonus to new hires (e.g., sign-on bonus or 90-day bonus). Please provide the date the program became effective and, in the notes, indicate the amount of the bonus. In addition, **attach copies of the materials you use to promote the availability of the bonus to new and/or current employees and include it as Attachment III**.	☐	☐	☐

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NEW YORK STATE Department of Health

Application - Labor Supply Shortage

Type	Date	Notes	RN	LPN	CNA/NA
IV. Job Fairs/Hiring Events	mm/dd/yyyy	If the facility attended or hosted events for prospective employees, please include the date of the event and place the name of the event in the notes section, attach copies of the materials distributed at the event and, if the organizer if not the facility, please attach a copy of the signed agreement or confirmation from the organizer and include the documents as Attachment IV.	☐	☐	☐
V. Online Job Advertisements (General)	mm/dd/yyyy	If the facility posted positions on recognized job search sites (e.g., Indeed) or through general sites (e.g., Google AdWords), please provide the date that the campaign started or the position was posted and, in notes, provide the name of the site or vendor. In addition, please attach copies of the materials of any creative (i.e., the text and visuals) developed for or utilized by the campaign and attach a copy of the signed agreement or confirmation from the vendor and include it as Attachment V.	☐	☐	☐
VI. Online Job Advertisements (Social Media)	mm/dd/yyyy	If the facility's activities included advertisements/sponsored posts on social media via either their own page or working with a third party, please use the date of the initial post as the date and put the name of the social media platform in the notes. In addition, please attach a copy of the facility's agreement with the third party, if applicable, and a copy of the original post and include it as Attachment VI. Please note: If the facility contracted directly with the social media platform (e.g., Facebook, LinkedIn or Twitter), please see "Online (General)".	☐	☐	☐
VII. Partnership (Education Institutions)	mm/dd/yyyy	If the facility worked with educational institutions to link with new graduates and/or provide training to students, hoping that they will consider employment there after graduation, please check the box above and provide the name of the institution in the notes section and, under date, provide the date the relationship began. In addition, please a provide a summary of the working relationship between the facility and the institution and include it as Attachment VII.	☐	☐	☐

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NEW YORK STATE Department of Health

Application - Labor Supply Shortage

Type	Date	Notes	RN	LPN	CNA/NA
VIII. Partnership (Other Healthcare Facility)	mm/dd/yyyy	If the facility established a relationship with another healthcare facility to provide or share staff. Please provide the name of the institution in the notes section and, under the date, provide the date the relationship began. In addition, attach a narrative outlining the relationship between the facility and their partner, a copy of the agreement, and indicate whether the other facility is a related party and include them as Attachment VIII.	☐	☐	☐
IX. Recruiters	mm/dd/yyyy	If the facility hired or contracted with a recruiter to bring potential candidates to the facility. Enter the name of the individual or agency in the notes and use the effective date of the contract or hire date for the date in the field above. In addition, provide a copy of the contract or, if the recruiter as an employee, an overview of the recruiters' activities and include it as Attachment IX.	☐	☐	☐
X. Relocation Assistance (Prospective Employees)	mm/dd/yyyy	If the facility provided cash and/or non-monetary assistance with for an employee that is relocating to the area to work at the facility, please provide the date the relocation assistance plan was initiated. Please provide a summary of the assistance available, including the terms of eligibility, and copies of the materials promoting the availability of the assistance and include it as Attachment X.	☐	☐	☐
XI. Base Salary Increases (Prospective Employees)	mm/dd/yyyy	If the facility increased wages for potential staff, use the effective date of the change for the date above, and provide a schedule outlining the starting salaries before and after the change, by title, and include it as Attachment XI.	☐	☐	☐

NEW YORK STATE Department of Health

Application - Labor Supply Shortage

Type	Date	Notes	RN	LPN	CNA/NA
XII. Sponsoring International Candidates	mm/dd/yyyy	If the facility is sponsoring a new international candidate(s) (e.g., H-1B visas for foreign citizens), please use the date the application was submitted as the date above, identify the candidate in the note, and, attach a narrative that includes the terms of employment and the current disposition of the application and include it as Attachment XII.	☐	☐	☐
XIII. Traditional Advertising (Multimedia)	mm/dd/yyyy	If the facility advertises their available positions using television or radio ads, please use the date the campaign started as the date, please put the name of the vendor or agency in the notes and attach a narrative that includes the details of the media buy and a summary of the messaging and add a copy of the agreement and include them as Attachment XIII.	☐	☐	☐
XIV. Traditional Advertising (Print)	mm/dd/yyyy	If the facility advertises their available positions through newspaper ads, including classifieds, or utilizes mass mailing services, please enter the date the campaign began as the date above and the vendor under the notes. In addition, attach a copy of the advertisement and a copy the agreement or a confirmation notice from the newspaper or vendor and attach it as Attachment XIV.	☐	☐	☐
XV. Transportation	mm/dd/yyyy	If the facility provides assistance getting employees to and from the job (Uber, facility hired a driver and uses the facility's vehicle, paying for out of the area travel), please enter the date that the facility started providing this service and attach a narrative that explains the terms of eligibility and describes the assistance provided and include it as Attachment XV.	☐	☐	☐

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NEW YORK STATE Department of Health

Application - Labor Supply Shortage

Type	Date	Notes	RN	LPN	CNA/NA
XVI. Union Outreach/Programs	mm/dd/yyyy	If the facility worked with employee unions to attract and train new employees, add the date of engagement as the date in the field above, enter the name of the union under the notes, and attach a narrative describing the assistance provided by the union, including the name of the program (if applicable) and include it as Attachment XVI.	☐	☐	☐
XVII. Increased Pay (Overtime, Weekend, or Shift Differential)	mm/dd/yyyy	If the facility increased the additional amount offered to employees who work weekend, holiday, or hard to fill shifts in an attempt to induce employees to work additional hours, use the effective date of the change for the date above, and provide a schedule outlining the pay rates before and after the change, by title and by shift, and include it as Attachment XVII.	☐	☐	☐
XVIII. Education/Training	mm/dd/yyyy	If the facility provided additional training to staff in order to learn new skills or qualify for a promotional position or a certification/license, use the effective date of the program for the date above, and please attach a description of the training, the positions or licenses the employees are training for, and list any accommodations the facility makes for the employee to allow them to engage in the training, and attach the information as Attachment XVIII.	☐	☐	☐

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NEW YORK STATE Department of Health

Application – Union disputes

If a verifiable union dispute between the facility and nurse aides, certified nurse aides, licensed practical nurses, or registered nurses employed or contracted by the facility contributed to the facility's failure to meet minimum staffing requirements, the Department could consider this dispute as a mitigating factor. For the Department to make this determination, please select 'Yes' below and provide the information requested*

- (●) Yes
- ( ) No

Union Dispute (If Yes selected above)

Union Dispute*

Start Date [Required]	End Date (If applicable)	Titles of employees impacted [Required]	Name of the union [Required]	Current Disposition (if ongoing)	
mm/dd/yyyy	mm/dd/yyyy				Remove item 1

Add

Please attach a copy of the facility's Strike Plan*

Choose Files No file chosen

Upload requirements

Please attach a copy of the official written notification from the union, i.e., Strike Notice*

Choose Files No file chosen

Upload requirements

Enforcement Action

All facilities out of compliance are subject to Enforcement

- Penalty of up to two thousand (2,000) dollars per day
  - Progressive penalty per day based on:
    - Level of noncompliance in quarter – Actual daily hours
    - Available data and Department's assessment of application for penalty reduction (if applicable)
    - Frequency of noncompliance – Number of Quarters in Year

Enforcement Action (continued)

Department's Division of Legal affairs will issue Determination

- Notice to facility
- Final penalty amount and mitigating factors considered
- Possible actions

Best Practices

- Quarterly Reporting to CMS
  - Ensure submission by CMS due date
  - Ensure data is an accurate representation of daily staffing levels
- Review today's presentation and maintain relevant records and evidentiary documentation
- Ensure facility Administrator and Operator roles in Health Commerce System are current

Contact Information

Questions: NHSafeStaffing@health.ny.gov