Recommendations on
Personal Care Home Licensing and Enforcement Reform
by the Licensing and Legislative Subcommittee
of the DPW PCH Advisory Committee

March 14, 2002

The Licensing and Legislative Subcommittee of the DPW PCH Advisory Committee met three times, on November 28 and December 14, 2001 and January 8, 2002. The purpose was to address the issues raised by the Auditor General's October 2001 report on "Oversight of Personal Care Homes in Pennsylvania" and other concerns about the licensure and regulation of personal care homes. The group explored the current regulatory and enforcement system to determine what changes should be made in order to ensure the health and safety of personal care home residents.

The Subcommittee included the following participants: Pam Walz (Chair), Community Legal Services; William Gannon, DPW-OSP; Patsy Taylor-Moore, DPW-OSP; Ann Torregrossa, Pennsylvania Health Law Project; Alissa Halperin, Pennsylvania Health Law Project; Christine Klejbuk, PANPHA; Lynn Fosnight, PALA; Beth Greenberg, PANPHA; Dale Laninga, Inter-Governmental Council on Long Term Care; Clarence Smith, CERCA; Pat McNamara, PHCA/CALM; Cindy Boyne, State Ombudsman.

The Subcommittee makes the following recommendations:

I. Licensing:

The subcommittee recommends changes to the licensing process *to ensure that facilities which are out of compliance with regulatory standards do not receive new or renewed licenses.*

Overview of Recommended Licensing Process:

1. Step 1: Facility applies for license. If applying to renew existing license, it will apply 2-3 months prior to expiration of current license.
2. Step 2: DPW makes unannounced inspection visit.
3. Step 3:
   - If facility is in full compliance (meaning no Class I, II or III violations), it will be issued a full license.
   - If facility is in substantial compliance (meaning it has Class III violations and has had an acceptable plan of correction approved), it will be issued a provisional license. If correction of violations is demonstrated prior to expiration of current license, full license will be issued.
   - If facility is in non-compliance (meaning that Class I or II violations exist), no license will be issued unless the facility submits an acceptable plan of correction and provides verification that violations have in fact been corrected prior to the end of the licensure period.

Additional Licensing Recommendations

4. Newly opened facilities which are found in full compliance should be issued a full "new" license (not a provisional license as is currently the practice), with a notation for a six month period stating that the license is "new". DPW should reinspect newly opened facilities within 3 months to check for compliance with requirements which can only be inspected once a facility is in operation and has admitted residents.

5. DPW should differentiate between a new facility license and a full license in providing information to the public. It should be made clear that a facility with a new license has no resident history and that there is thus no measure of its performance on resident-related aspects of the regulations. At the end of the new license period, a facility must be in full compliance in order to get a regular license.

6. Provisional licenses should be issued only in cases where Class III violations exist and the facility has submitted an acceptable plan of correction.

7. DPW should not issue second and subsequent provisional licenses if violations which resulted in the previous provisional license have not been corrected or if the same violations have been repeated. A facility could be issued a subsequent provisional license if new and different Class 3 violations occurred.

8. If a facility which has had four consecutive provisional licenses is not in full compliance prior to the beginning of the next licensing period, no license should be issued.

9. When the Department denies or revokes a license, it should issue an emergency order to relocate residents while any appeal proceeds.

10. The Department should interpret the requirement that applicants for a license be "responsible persons", 62 P.S. §1007, to prohibit transfer of license or issuance of new license for a facility to family members, friends, business associates, etc., where it appears that the purpose of the change in license holder is to avoid licensing action or if it appears that the former owner will continue to have involvement in the facility or business. Regulations should be promulgated to state this explicitly.

11. Licensure inspections should be unannounced and conducted annually.

12. Inspections should include review of whether past violations have been and continue to be corrected.

13. At the inspection visit, opportunity should be provided for the provider to develop a plan of correction (which may be in collaboration with licensing representative) to submit for approval during the visit.

II. Classification of Violations

1. The statutory classification system for violations set forth at 62 P.S. §1085 should be implemented and utilized, and fines should be imposed as required by 62 P.S. §1086.

2. The subcommittee recognized that the existing classification system could be improved to make it more workable, and would like to work with the Department to develop a classification system which would facilitate more effective enforcement action and address the Department's past concerns.

3. The current guidelines for classifying violations in the DPW Procedural Manual for Licensing Staff should be reviewed and amended by a work group including the Ombudsman,

Protective Services and Department staff. The guidelines should direct that in classifying violations, consideration be given to the number and frequency of violations, and the circumstances surrounding and consequences of violations.

4. After revision, the guidelines should be added as an appendix to the regulations in order to increase consistency of enforcement and certainty about the penalty for a particular violation.

5. The statutory provision at 62 P.S. §1085 should be amended to provide that a violation which "**has caused or** has a substantial probability of causing death or serious mental or physical harm to any resident" constitutes a Class 1 violation.

6. The term "serious mental harm" in 62 P.S. §1085 (defining Class 1 violations) should be interpreted to include the harm resulting from abandonment or financial exploitation.

7. The Department should enforce compliance with 62 P.S. §1057.3(a)(4), which requires that each resident be provided by the administrator with notice of any Class 1 or 2 violations which remain uncorrected after five days.

III. Fines

1. Fines should be imposed for failure to comply with a plan of correction or for false documentation of compliance with a plan of correction.

2. There should be a rebuttable presumption that a violation still exists (resulting in the continued imposition of fines) unless and until the provider demonstrates that it has been corrected. Notices of violations or of imposition of a fine should state that the fines will continue to accrue each day until the facility demonstrates to the Department that the violation has been corrected. Any revision of the personal care home regulations should explicitly state this presumption.

3. In certain circumstances, fines should be imposed irrespective of whether the violation(s) have been corrected. If the provider fails to correct the violation, additional fines should be imposed. The Department should seek the statutory change which appears necessary to implement this recommendation.

IV. Plans of Correction

1. For a plan of correction to be considered acceptable, it should address how the facility will correct the root cause of the violation and not just the resulting symptoms. For example, if a facility is cited for having bulging cans of food, the plan of correction should not just state that the bulging cans will be thrown away, but also provide a system for ensuring that the facility does not have bulging cans in the future (e.g., provider will check the cans at periodic intervals).

2. When a plan of correction is submitted, the Department should promptly determine and notify the provider whether it is acceptable as a tool which, upon implementation, will bring the facility into compliance.

3. The Department should facilitate the joint development of plans of correction by providers and licensing representatives, as well as approval, at the time of an inspection.

4. Once a plan of correction has been approved, the provider must demonstrate implementation of the plan and provide verification to the Department that compliance has been achieved. This must take place before expiration of a license in order for the license to be

renewed and within the time frames for correction set forth in 62 P.S. §1086 in order to avoid a fine.

5. When a violation recurs after having supposedly been resolved by a plan of correction, requirements for further plans of correction should be more prescriptive and stringent in order to ensure that the violation does not recur. For a first violation, the provider should determine how s/he will achieve compliance. The proposed plan of correction must reflect the provider's understanding of the health and safety risks posed by the violation. If there is a recurrence of the violation, the Department will direct what steps the facility must take in its plan of correction. The steps outlined in the first plan of correction should not be considered sufficient the second time because they failed to achieve sustained compliance.

6. The Department should develop uniform acceptable corrective measures for each type of violation which facilities can select on a first violation and which facilities will be required to follow on a subsequent violation. These measures should include protocols for correcting the violation, the anticipated effect on residents, and time frames for completion.

7. The Department should promptly respond to a request for approval of a plan of correction (we recommend within 2 to 3 business days).

8. After the above changes are implemented, supervisory-level staff within the Department should oversee approval of plans of correction for an initial period of time in order to ensure uniformity.

9. Demonstration that a violation has been corrected shall be consistent with the nature and seriousness of the violation and may include: revisit by inspector (should be required for all Class 1 and 2 violations), submission of receipts or photographs, or certification by the administrator.

10. Failure to meet deadlines for compliance with plans of correction should result in revocation of full licensure status. There may be situations in which compliance is not within the provider's control (e.g., getting physician's signature). In such cases, proof of acceptable efforts to comply (e.g., copies of certified letters sent to physician requesting the signature) should be treated as compliance. If, at next inspection, the violation is still uncorrected (e.g., physician signature still not obtained), more strenuous efforts will be expected of the facility (e.g., facility may be required to change to a more responsive house physician).

V. Appeals

1. A facility's appeal of a license revocation or denial of license renewal should not permit the facility to continue business as usual (admitting new residents, ongoing poor care and/or conditions) for long periods of time, as is currently the case. Where a facility appeals the loss of its license, the Department should take the following actions as necessary to protect the residents:

a. appoint a master pursuant to 62 P.S. §1057.1(b);

b. seek an injunction against new admissions or continued operation of the facility pursuant to 62 P.S. §1055; and

c. oppose any request for supersedeas.

2. The subcommittee has been informed that the Department considers an adverse licensing action only a "recommendation", not a "decision", until BHA has denied the provider's appeal. The result of this interpretation has been that the Department assumes that it cannot halt

a facility's admissions or operation until the matter has gone to Commonwealth Court, a step which currently takes years to reach. The subcommittee disagrees very strongly and questions the legal basis for this interpretation. A revocation or denial of a license is a decision of the Department, giving the Department the right and the duty to prevent further harm to residents while an appeal is pending. To this end, the Department should in appropriate cases relocate residents, ban new admissions and oppose supersedeas from the moment it revokes or denies renewal of a license. Supersedeas should not be granted during administrative appeals or at the Commonwealth Court level unless the provider can show a substantial likelihood of success on the merits.

3. BHA should make PCH appeals a top priority where residents are still in the facility. Hearing decisions should be issued within 90 days of the filing of an appeal, and reconsideration requests to the Secretary should be decided within 60 days.

4. The Department's Office of Legal Counsel needs to have adequate staff dedicated to PCH issues to be able to handle appeals with reasonable promptness.

5. Appeals should not routinely be settled with poorly performing providers, as currently appears to be the case. Settlements should only be used if they a) are specific as to what will be required from the provider and b) the terms are enforceable by the imposition of financial and/or licensure consequences if the provider does not comply.

6. To avoid giving an advantage to non-compliant providers, any settlement agreement must require the provider to do more than simply comply with the regulatory requirements which they were supposed to comply with in the first place; the provider must offer additional efforts above and beyond the baseline requirements.

7. All settlement agreements should provide that the facility waives the right to appeal citations for violations of anything they promised to do or not to do in the settlement agreement.

8. In licensing action appeals involving the worst actors, the Department should coordinate efforts with Protective Services and ombudsmen and seek amicus briefs from consumer advocates to help educate the courts about the harm caused by egregiously bad PCHs.

9. Providers who appeal fines are required to submit the assessed penalty, up to a maximum of $500, to the Department for placement in an escrow account. A higher payment, dependent on the severity of the violation, should be required in order to cut down on frivolous appeals. An escrow payment should also be required in appeals of license revocations.

10. The statute or regulations should be clarified to provide that a reviewing court should not sustain an appeal on the ground that the facility, although out of compliance at the time it was cited, is now in compliance unless the facility can show by a preponderance of the evidence that its procedures, policies and staff resources do and will continue to ensure full compliance in the future.

VI. Disclosure of Information to the Public

1. The public needs more and better information about PCHs in order to make knowledgeable decisions. Accordingly, the following should be added to the Department's web site: a) which facilities have secured unit waivers, b) whether the reason a facility has a provisional license is that it is new or that it has been reduced from a full license, c) number of consecutive provisional licenses a facility has had, d) types of violations found in recent

inspections, e) plans of correction, and f) information about the facility's legal entity.

2. Any changes to the licensing and enforcement process should be communicated to providers and consumers in a timely manner and should be memorialized in the DPW Procedure Manual for Licensing Staff and/or Department bulletins. These operating instructions should be available to the public.

3. All inspection and redacted complaint reports should be made available as public records, especially monitoring records during cease and desist and other litigation.

4. When residents are relocated by the Department, they should never be placed into facilities with less than full licensure status.

5. Referral sources (hospital social workers, etc.) need more information about the licensing status of facilities.

VII. Department Administrative and Technological Resources

1. The Department should resolve coordination problems between OLRM and the Office of Social Programs which have led to delays in the scheduling of inspections and completion of the licensing process. Notification of upcoming license renewal and inspections should be sent to providers sufficiently in advance to allow time for the license application to be returned, inspections to be conducted, and plans of correction to be submitted and implemented prior to the end of the licensing period.

2. For renewals of licenses, the Department should explore creating a presumption that the provider intends to reapply. Facilities would be required to have their pre-licensure survey and census ready and available during the last three months of the licensure period so that they are prepared when inspectors arrive.

3. Licensing offices should be allocated sufficient staff and resources to carry out their functions effectively.

4. Licensing staffing levels should reflect growth or decline in the size of the industry, with staffing in each regional office determined taking into consideration the region's facility demographics, number of beds in each facility, concentration of facilities with high numbers of complaints, geographic distance between facilities which licensing representatives must travel, and presence of special needs populations. We recommend that a licensing representative should never handle more than 60 homes, with 50 being preferable.

5. Delays in entering licensing status changes into computer systems have created delays in the licensing process and confusion. Adequate technological resources should be made available to provide for "real time licensing".

6. The Department should use technology and photography to demonstrate and provide evidence of violations to support its actions in appeals.

VIII. Complaint System

1. Licensing representatives are not adequately trained in investigative techniques and do not necessarily possess the skills needed to investigate complaints. In addition, licensing reps tend to develop a cooperative relationship with the facilities they license which may interfere with their ability to investigate a complaint with objectivity. The subcommittee therefore recommends that separate complaint investigation teams be created, composed of different staff

than the licensing reps. It is recommended that the teams be multi-disciplinary, including members with different knowledge bases.

2. Complaint investigations should take place in accordance with the DPW Procedure Manual for Licensing Staff, which sets forth different time frames depending on whether a complaint involves an immediate threat, a potential threat, or no threat. For the purpose of determining which of these three categories is applicable, the facts alleged should be taken as true.

3. Complaint investigations should focus not just on the individual circumstances of the complainant, but also on whether a systemic problem may exist which threatens harm to additional residents. For example, even if the complainant is hospitalized, consideration should be given to whether the facts as alleged reflect a threat to other residents who are still in the facility. If so, the complaint should be considered an immediate or potential threat even though the complainant is no longer in the facility.

4. The Department should create protocols articulating what steps a complaint investigation should include, how it is to proceed and at what point it will be considered completed. The protocols should specify the types of individuals who should be interviewed. All person with information pertinent to the complaint should be interviewed. This may include other residents, family, physicians and others. Investigators should make sure to speak with enough people to get both sides of the story. Interviews should be conducted confidentially. Where residents' rights violations are alleged, confidential interviews should be conducted with other residents in order to determine whether the alleged violations are occurring.

5. The Department should develop criteria for circumstances in which a complaint investigation may be performed by telephone and those in which there should be a site visit.

6. Site visits for complaint investigations should be unannounced except where immediate telephone contact with the provider is needed to avert an imminent risk to residents.

7. The Department should follow up after the investigation to verify that the conditions complained of have been corrected. Depending on the circumstances, this follow-up could take the form of calling the resident back to check whether the problem is resolved, making a site visit to verify compliance, etc.

8. The Department should notify the complainant in writing of its investigation findings, whether the complaint was founded, and any resulting actions which will take place.

9. During licensing inspections, attention should be paid to issues which have been the subject of complaints in a facility.

10. The Department should utilize a data base to track complaints better. Specifically, the Pennsylvania Automated Complaint Tracking System (PACTS) should promptly be made available to licensing staff. Complaint records should document, in a retrievable form, the nature of each complaint, actions and follow-up monitoring performed by the Department, and issues to be monitored at the next inspection.

IX. Waivers, Immobile Residents

1. No regulation which address the health, safety or well-being of residents (including residents' rights) should ever be waivable.

2. The Department should adopt the Personal Care Home Advisory Committee's

previous recommendations concerning waivers.

3. The Department should promulgate regulatory requirements for facilities housing immobile residents, including cognitively impaired residents. The areas which should be addressed in regulation include increased staffing, appropriate training and activities, environmental needs of physically immobile and cognitively impaired residents, ease of egress for emergency evacuation, and fire safety.

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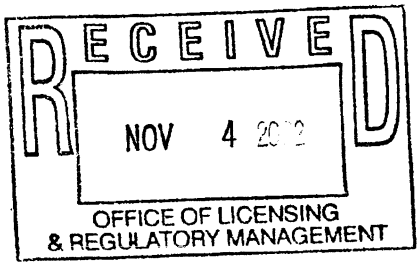
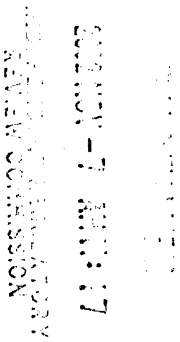


COUNTRY MEADOWS®
Retirement Communities

November 1, 2002



Teleta Nevius
Department of Public Welfare
316 Health Welfare Building
P.O. Box 2675
Harrisburg, PA 17101-2675

RE: Proposed Personal Care Home Regulation Comments

Dear Ms. Nevius:

Country Meadows (George M. Leader Family Corporation), representing approximately 2200 beds in the State of Pennsylvania respectfully submits the attached comments on the draft personal care home (PCH) regulations.

We have attached a document that identifies the areas of concern in relation to our facilities and, in some areas, other known providers in the state.

We are aware of the DPW Advisory Committee and the Subcommittee Task groups who have been working long hours with all interested parties involved, to create common ground ideas in response to the initial draft which was provided in the Spring of 2002. We would encourage continued discussions with all interested parties going forward until such time that the final proposal is made.

We are supportive of all recommendations set forth in the document submitted by CALM including the general observations and comments dealing with:

- Economic or fiscal impact;
- Protection of the public health, safety and welfare and the clarity, feasibility and reasonableness of regulation;
- Questions as to the regulation representing a policy decision of such a substantial nature that it requires legislative review.

Country Meadows Home Office • 880 Cherry Drive • Hershey, PA 17033
Phone: (717) 533-2474 • Fax: (717) 533-6202 • www.countrymeadows.com

In closing we appreciate this opportunity to comment and look forward to continuing this collaborative effort.

Sincerely,

Michael Leader, CEO Country Meadows

David Leader, COO Country Meadows

Michelle Hamilton, Vice President of Operations

Suzanne Owens, Vice President Operations

Lee Tinkey, Vice President of Operations and Quality Assurance

Cc: Robert E. Nyce, Executive Director IRRC
Members of the Senate Public Health and Welfare committee
Members of the House & Human Services Committee
Other Interested Parties

Response to proposed DPW regulation 2600 from Country Meadows

Section of regulation in question	Comments regarding concerns in regulation	Suggested change to regulation
2600.27 Quality Management	This is too prescriptive in its verbiage and could also be overwhelming to smaller providers	We recommend that the facility be able to determine what quality management means to their facility based on size and levels of care. Such a determination may or may not include the areas stated in proposal.
2600.41 Residents Rights (u) reason resident can be asked to leave PCH (x) regarding stolen or mismanaged resident money	(u) We feel there needs to be an addition to the reasons provided to ensure the rights of others as well. (x) It is a concern that not all residents or families may be accurate as it relates to their finances.	(u) Add "Violation of house rules and/or violation of other residents rights" (x) We feel the words "proven to be" must appear in the sentence so as to protect the provider and residents.
2600.59 Staff Training Plan	We feel the detail to which this proposal goes is far too cumbersome for all providers and will not result in a higher quality of care – this was also discussed in the DPWAC task force and agreed to be excessive.	Keep the first paragraph with the same modifications as explained by CALM and delete 1 through 4.
2600.60 Individual Staff Training Plan	Same as above	Delete the entire section
2600.130 Smoke Detectors and Fire Alarms (F)	Testing <u>all</u> smoke detectors and fire alarms monthly – the amount of noise and volume of work involved in a large building does not equal the benefit.	Change "at least monthly" to once "annually".
2600.61 Nutritional Adequacy (f) Therapeutic diets shall be followed and documentation retained on resident record	We feel that a facility can not <u>assure</u> that a resident will follow a therapeutic diet since they also have rights that contradict this portion of the proposed regulation.	We suggest that any special diets be made <u>available</u> for residents, but that the facility not be held responsible if they do not follow it.

Response to proposed DPW regulation 2600 from Country Meadows

Section of regulation in question	Comments regarding concerns in regulation	Suggested change to regulation
2600.201 Safe Management Techniques (a) use of positive interventions (b) specific quality improvement for this item	The items mentioned in 2600.201 (a) are appropriate methods in dealing with behaviors, but it is uncertain as to how DPW would regulate this area for compliance.	We suggest that 2600.201 (a) be reconsidered as an actual regulation and 2600.201 (B) be totally eliminated.
2600.225 Initial Assessment and the Annual Assessment (a) 72 hour required time period for assessment	Based on the data required under 2600.225 (a) and (b), 3 days may not be enough time to fully complete – even in a nursing facility 5-7 days are given to accumulate such data.	We recommend that 5-7 days be the appropriate time frame to complete the information requested in the proposed regulation for the initial assessment.
2600.225 continued (b) coordination of persons in attendance at service plan meeting (c)documentation of efforts to involve resident or family in service plan (e) documentation of why family or resident would not sign service plan	These proposed regulations are excessive and do not relate to the accuracy or the quality of the service plan. Items such as these related to documentation of a non-direct care activity only provide more possible areas of non-compliance due to the inability to control all parties involved.	We recommend that these items be removed from regulation. If a facility wishes to go to this extent it should be their decision and not a regulation.
2600.231 Door locks and alarms (l) building standards	There is no language regarding grand fathering of current facilities.	Indicate in 2600.231 (i) that such items will be grand fathered.
2600.239 Programming Standards for Secured Units (l) activity programming expectations	The proposed regulations are very general and would be very difficult to measure compliance. Too subjective of a decision for the surveyor to determine with consistency.	Subparagraph (l) should be eliminated .

14-475 (636)

Original: 2294

CITY OF PHILADELPHIA

OFFICE OF THE MANAGING DIRECTOR
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Managing Director

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November 1, 2002

Teleta Nevius
Director
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Commonwealth of Pennsylvania
Department of Public Welfare
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Harrisburg, PA 17105-2675

Dear Ms. Nevius:

This letter is being written with regard to the proposed Personal Boarding Care Home regulations.

The Philadelphia Behavioral Health System would like to thank you for the opportunity to comment on the proposed regulations, and we are pleased that the Department of Public Welfare has decided to insure needed improvements in the Personal Care system.

The Philadelphia Behavioral Health System has also worked in close conjunction with the Coalition for Personal Care Home Reform, and we fully support their recommendations in response to the proposed regulations (submitted under a separate cover).

Thank you for your time and your consideration of these comments and recommendations. If you have any questions, please do not hesitate to contact Mr. Thomas J. O'Hara, Mental Health Administrator, at 215-685-5469.

Sincerely,

Michael J. Covone
Deputy Commissioner

MJC:MH/kr

Attachment

cc: Estelle B. Richman
Nancy Lucas
Judith W. Dogin, M.D.
Margaret A. Minehart, M.D.
Sandy Vasko
Thomas J. O'Hara

Philadelphia Behavioral Health System

The following are the comments of the Philadelphia Behavioral Health System in regard to the proposed Personal Care Boarding Home regulations:

1. **Licensure and Enforcement**

We support annual inspections of all personal care homes, not every three years. See our specific comments on section 2600.3 and 2600.11 below.

2. Annual health exam and assessment.

As a result of this summer's personal care home closures in Philadelphia, we have seen many instances where residents are not getting the healthcare services they require and their health needs are going unattended, it is critical that the annual health exam be performed by an independent doctor of the resident's choosing. Too often a PCH has a "home doctor" who provides all the care and completes all the resident evaluations and never finds a person inappropriate for that PCH, no matter how great their care needs have become. It is also essential that the resident have the right to have an assessment of their needs completed by an independent assessor. The Area Agency on Aging performs these assessments regularly.

At issue here is the reality of conflict of interest. A "home" doctor is unlikely to find a resident inappropriate for the PCH. A home assessor may find that a person requires less care than would an independent assessor (who is not the one getting paid for providing the care).

We also believe that PCH residents should have a bi-annual psychiatric exam performed by an independent psychiatrist. This is crucial in light of the number of residents with an MH diagnosis. It is also critical because many residents get placed on MH medications by "home" doctors where such a medication may not be prescribed by a provider less interested in controlling resident behavior. Residents in some homes have been intentionally overmedicated. See our specific comments on section 2600.141.

3. Medications

We feel very strongly that medications be administered to pch residents by a specially trained medication technician with proven competency. Presently, direct care staff with no educational requirements and no training are causing numerous medication errors in PCHS/ALRS. The onus must be placed on responsible, trained staff to insure that resident medications are taken as prescribed, and that all refusals or adverse reactions are noted and reported to doctors.

It is our recommendation that DPW adopt a Medication Technician training like those DPW uses in the MR and MH realms and that they allow properly trained med techs to administer medications in PCHs. Consumers and advocates would like to be assured that those who administer or assist in self-administration are capable and competent to do so.

4. The Mental Health Consumer as Resident

The regulations fail to adequately recognize the needs of the mental health consumer as resident. While residents with cognitive impairments will, we hope, be protected in the new secured units, inadequate protections exist for residents with mental health diagnoses. For example, there is no requirement that residents with MH diagnosis have annual psychiatric visits and evaluations, just physical health evaluations. This should be added. Additionally, there should be recognition of the need to insure that homes that serve residents with MH must be familiar with the MH system and must link residents to local MH/MR authorities.

Below are section by section comments. These pertain solely to areas for which we suggest further revision to the draft proposed regulations. **For all areas of the regulations upon which we are not herein providing comments, we offer our strongest possible support for their retention as is, and without diminution in response to comments from providers.**

2600.3 – Inspections and licenses or certificates of compliance

An annual inspection requirement must be reinserted here and for 2600.11.

Thus, we suggest that 2600.3 and 2600.11 be consolidated. The new 2600.3 should read:

(a) "An authorized agent of the Department shall conduct an **unannounced** on-site inspection of a personal care home at least annually"

(b) "A certificate of compliance shall be issued to the legal entity by the Department if, after an inspection by an authorized agent of the Department, it is determined that **the personal care home is in full compliance with all requirements and** that the requirements for a certificate of compliance are met.

(c) In addition to the annual inspection, the department shall inspect as often as required by 62 P.S. 211(I) and more often as necessary.

(d) Where a violation is found, submission and compliance with an acceptable plan of correction followed by actual verified correction of violations shall be required to achieve full compliance for licensure purposes. Only a plan of correction that clearly articulates the facility's understanding of the reason for the violation, the impact or consequences of the violation and which specifically corrects the present violation and provides a process to ensure that there will not be future violations shall be accepted by the department.

(e) **An applicant for a license for a new facility shall, if in full compliance with all regulatory requirements that can be met prior to admitting residents, receive a "New Facility Full License". An applicant that is found to have violations shall not be issued a new facility license until the facility is in full compliance.**

(f) **All homes shall have adequate fiscal resources to pay utilities, staff, insurance, taxes, etc. prior to licensure.**

(g) All homes shall have an adequate amount of liability insurance or bond to cover negligence and theft.

2600.4 – Definitions

The term "cease and desist" is not defined in these regulations. Because it is used and may not be clear to consumers and providers, it must be defined.

2600.5 – Access requirements.

Local MH/MR Authorities should be provided access to Personal Care Homes in order to assess and serve persons with mental health/mental retardation.

GENERAL REQUIREMENTS:

2600.11 – Procedural Requirements for Licensure or Approval of Homes.

Given the vulnerable, isolated population residing in PCHs and their dependency on the PCH for more of their needs, it is necessary that onsite inspections of PCHs occur at least annually. As written, 2600.11(b) is unacceptable. To require inspections to take place **only** once every 3 years entirely contravenes the goal of the regulations, to insure health, safety, and welfare, and the goal of inspection, to insure compliance with regulations.

As a matter of policy, all personal care homes must be inspected for licensure compliance through annual unannounced inspections. Where a personal care home has demonstrated full compliance with all regulations for three consecutive annual licensure inspections, we encourage the use of abbreviated or inferential inspections. However, there should not be any year in which a facility does not receive a complete compliance inspection until it has demonstrated a pattern of good practice.

The requirement of an annual inspection must be maintained and improved upon.

2600.16 - Reportable Incidents

It is essential that any Reportable Incidents be immediately brought to the attention of the Department and all others, as required by law AND that any of these items prompt immediate onsite investigations by the Department, and, where appropriate referral to the Ombudsman. This essential investigation component has been excluded from the proposed regulations.

Additionally, family members or legal representatives must be notified of Reportable Incidents and the personal care home must be required to swiftly provide family members or legal representatives with this notice.

It should not be up to the home to determine whether deaths are suspicious. There is a **glaring** conflict of interest in asking them to report the deaths that are due to abuse, neglect, malnutrition, etc. As a result, it is essential that the department require the home to report **ALL** deaths. The report can be on a one page standard fax or e-mail-able form so that the department can review the death and cause of death for anything suspicious. The same is true for hospitalizations. Any treatment at a hospital or medical facility should be reported in addition to any serious injury, trauma or medication error. The way it is worded, it could mean that serious physical injury, trauma or medication error only need to be reported if they required treatment at a hospital or medical facility. Thus we suggest that the language of 2600.16(a) be changed as follows:

(a)(1) A death of a resident **and the cause as placed on the death certificate, including whether** due to accident, abuse, neglect, homicide, suicide, malnutrition, dehydration, or other unusual circumstances."

(3) Take out all of what was there at (3) and insert: **Any healthcare situation requiring treatment at a hospital or medical facility, not to include routine healthcare visits.**

Additionally, the initial unusual incident reporting must be done by immediate technology tools only, such as phone, fax, or e-mail.

Thus, we suggest that 2600.16(c) be revised as follows: (c) The home shall immediately report **to 24 hour hotline, by phone, fax, or e-mail** ... We also suggest that 2600.16(g) should be added and should state: (g) **The home shall inform the family members or legal representatives by phone of residents of the occurrence of an unusual incident affecting their single resident or of an unusual incident affecting all residents. This shall be done within 24 hours of the occurrence.**

2600.18 Applicable health and safety laws

This section should be revised to make clear that PCHs are expected to be in compliance before a license will be granted as well as throughout licensure. Thus this section should read:

"A personal care home shall be in compliance with **all** applicable Federal, State, and local statutes, ordinances, and regulations, especially those statutes or regulations pertaining to fire and panic, public health, civil rights, and protective services **prior to and throughout licensure. Failure to be in compliance with any other applicable law will amount to a violation of this section."**

2600.24 Tasks of Daily Living

Need to articulate that PCHs should assist in shopping for clothing, personal items, etc. Need to include obligation to assist in obtaining needed medications.

One critical task of daily living is the securing of healthcare. All too often, PCHs meet this obligation by having a "home doctor" come in. Some require the resident to use that home doctor. PCHs are not medical facilities. Physical and Mental Health care should be provided off-site in the offices of licensed physicians and clinicians. If services are allowed on-site, oversight by DPW is imperative and must include regular (annual) review of medical and psychiatric billing, review of records, necessity and appropriateness of the services provided.

2600.32 (or 2600.42 in PA Bulletin version) - Specific Rights

Need to add:

(aa) A resident shall have the right to choose his own healthcare providers from those within his own health insurance plan and the facility shall help the resident arrange care through his insurance plan.

(bb) A resident has the right to reasonable accommodations of his disabilities.
(cc) A resident has the right to receive assistance in applying for public funding if private funding is exhausted.
(dd) A resident has the right to reside and receive services with reasonable accommodation of individual needs and preferences, except where the health or safety of the individual or other residents would be endangered.

2600.57 – Administrator training and orientation

This section is an improvement over current regulations. We are pleased to see that the administrator and staff will be required to completed an appropriate amount of competency-tested training. However, the regulations fail to make clear several critical elements. Specifically:

(a) and (b) The trainer needs to be a person with appropriate training and background in the area on which he/she is training. Especially in the training areas such as Mental Illness, Alzheimer's/Dementia, etc. Thus, (a) and (b) should be revised to state that the Department-approved training **provided by an appropriately trained person or agency.** In all circumstances, the Department approved training should be developed with input from stakeholders as to what are best practices, etc.

Residents Rights are not specific to Mental illness and gerontology and should not be listed as a training area under these but as its own critical training area. Likewise, mental illness, mental retardation, and gerontology are three wholly separate areas and should not be collapsed into one.

Thus we suggest that (c) be revised as follows:

(2) First Aid training, **accessing healthcare services through Medical Assistance and other insurance companies,** medications, medical terminology and personal hygiene...

(6) **Overview of** Mental Illness, **mental retardation, substance abuse, dual diagnoses,** and gerontology, which shall **be provided by trained specialists and which shall** include, but not be limited to:

(i) ~~residents rights~~

(ii) care for persons with **mental illness, mental retardation,** or dementia/cognitive impairments

(iii) ~~care for persons with mental retardation~~

(iv) symptoms, medication side effects, and behaviors of major mental illness (i.e. schizophrenia, schizo-affective disorder, major depression, bi-polar disorder and personality disorders), mental retardation, aging, and dementia/cognitive impairments.

(v) community and healthcare services, programs, and systems available for persons with mental illness, mental retardation, etc.

(vi) Confidentiality laws.

(vii) De-escalation techniques and interventions.

2600.58 – Staff Training and Orientation

MH/MR training must include at least one trainer with the condition or who has a family member with the condition, which is the subject of the training. Additionally, the training must include where to obtain additional supports.

Section 2600.81 Physical accommodations and equipment

The current language in the proposed regulation should become new subsection (a). This language is too generic and provides no guidance to personal care home operators or staff. Thus, we recommend the additional language set out below.

A new subsection (b) should be added with the following language

"Personal care homes designed or built after March 13, 1991 shall comply with the accessibility requirements of the Fair Housing Amendments Act, 42 U.S.C. 3601, et seq., including the regulations thereunder found at 24 C.F.R. Part 8."

A new subsection (c) should be added with the following language:

"No personal care home shall discriminate against any persons with disabilities, including persons with physical mobility impairments, in the provision of equal housing opportunities or other services in a personal care home."

2600.101 – Resident Bedrooms

While we are pleased that the department has increased the space each resident gets to call her own for residents in single rooms and for residents with disabilities (where a doctor indicates a need for space), this is not enough. It has long been noted that the space afforded a resident is less than that afforded in a prison cell. Simply put, (a), (b), and (c) should all be consolidated to simply state that **"Each resident shall have 100 square feet of floor space measured wall to wall, including space occupied by furniture."**

In 2002, it is time to no longer force 4 strangers to live together in tiny spaces. For any new construction, new additions, or increase in census, bedrooms should have no more than 2 to a room (although 1 would be truly preferable). With occupancy only at 68%, there are adequate beds available to cover 2 to a room. Thus, (d) should read:
(d) **For facilities built or space or beds added after the effective date of these regulations,** no more than **2** ~~4~~ residents shall share a bedroom **and only by choice. For facilities, wings, and licensed capacities in place prior to effective date of these regulation,** no more than 4 shall share a bedroom.

RESIDENT HEALTH:

2600.141 – Resident health exam and medical care

It is imperative that the resident's annual health examination be performed by her own primary care physician and not by a "home" doctor. Similarly, there must be a bi-annual psychiatric evaluation at minimum every two years to insure that mental health needs of residents are being met.

Where the doctor's own assessment calls for regular doctor's visits and health examinations more frequently than annually, these must be obtained by the home.

It is critical that the home be obligated to insure that the resident gets needed healthcare. Saying, as is said in proposed (b) that a resident shall have access to medical care and that the home shall help arrange this if the resident needs this is not the same as requiring the home to know and recognize when a resident needs medical care and to insure that the medical care is obtained. This must be inserted in the final regulations. (b) should also provide that the facility shall assist residents in accessing dental and psychiatric care, if needed. Replace the second sentence with **"The home shall assist any resident to the degree necessary to ensure that medical needs are being met. The assistance shall consider the resident's desires and be a least intrusive as possible, but may require comprehensive assistance."**

2600.142 - Physical and behavioral health

In (a), medical/physical or behavioral health service needs should be included in those to be addressed in the support plan.

MEDICATIONS:

2600.181 - Self-Administration

As discussed below, it is a concern that the proposed regulations continue the current regulations' dangerous practices concerning "self-administration" of medication. Providers, advocates and regulators are all well aware that residents who cannot distinguish between their medications and do not know the correct doses or purposes of their medications have their medications administered to them every day by untrained PCH direct care staff. The notion that the staff person is merely "assisting in self-administration" by handing the pills to be taken (after the staff person has consulted the bottle as to the dose and counted it out) is a fiction. A medication administration training program is desperately needed to ensure that trained, qualified staff are present in personal care homes to administer medications safely.

Subsection (e) takes a step in the right direction by attempting to define when a resident is capable of self-administration. It is unclear, however, whether this subsection is describing a resident who is capable of self-administering medications without assistance (and who could therefore store their medications in their own room) or one who needs assistance from staff. In addition, it is not clear what the "examples" given in the last sentence are meant to be examples of. The "examples" all address whether the resident is physically capable of ingesting

or applying a medication, not whether he or she can understand the purpose and dosage, etc. of the medication, which the previous section addresses. This provision must make clear that a resident who is capable of placing a pill in his mouth and swallowing but has no idea what the purpose of the medication is not "capable of self-administering medication".

ENFORCEMENT:

2600.251-253 – Enforcement

The Department of Public Welfare's appointed advisory board, the Personal Care Home Advisory Committee, unanimously recommended numerous mechanisms for improvement to the Department's enforcement that could be accomplished within the statutory scheme. None of these have been included in this section. The recommendations of the PCHAC should be included.

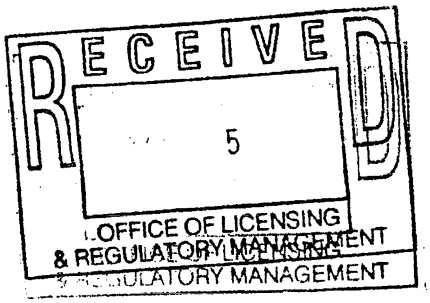
In addition to this items proposed by the PCHAC subcommittee, we believe that Multidisciplinary monitoring team(s) (to include a doctor/nurse, L&I, psych and aging professionals from (MH and Aging) provider agencies, advocates, consumers) should be created to perform all licensing inspections, to include record reviews, clinical reviews, client interviews, etc. Expanding the expertise beyond that of current OSP staff is recommended to review and adequately address the range of specialized needs that consumers require. This team should be involved in the License Revocation Recommendations. This team should also review and approve any Correction Plans generated as a result of License deficiencies.

Also, Local entity(s) must approve safety-related issues in the Correction Plan. If the provider does not comply with the more substantive findings of the local L&I, OSP will suspend and/or not renew license as well as require relocation of all consumers. Provider must report all local L&I violations to OSP monitoring staff within 2 working days. OSP will notify local L&I of all violations of PCH regulations.

Because the PCHAC subcommittee did not address this, the regulations should also include specifics about closures. In recent months, several closures involved several hundred residents. The Department must formalize its multidisciplinary relocation protocol and address this in the regulations.

14-475 (513)
SAME Commenter as #4, 8, 12, 23, 92, 93, 163, 167, 294 and 466

Original: 2294



Carmella's House
P.O.Box 73
Crabtree, PA.
15624

Friday, Nov.1,2002

Commonwealth of PA.
Dept. of Public Welfare
P.O.Box 2675
Harrisburg, PA.
17105-2675

Dear Teleta Nevius,

I am compelled at this time to write my thoughts, and opinions regarding the Proposed Chapter 2600 Regulations as published on Oct.5,2002 in the "PA.Bulletin".I am requesting that my letter be considered my public comment. I've been involved in the work submitted by the Westmoreland Personal Care Home Administrators Association. I have carefully read every comment made, line by line to every page of Chapter 2600. I am in complete and full agreement with all written comments. Please count those comments another time for me personally, as that would save submitting over 150 pages of the same to you.

I own and operate a very small, 8 bed home in Westmoreland County. Statistically speaking, our county is the third highest out of 67 counties in the Commonwealth. There are 84 homes which serve about 2063 residents & 364 SSI.Over the past 2 years, due to the imminent threat of the changing regulations, I have come to know many of my competitors throughout this county. I now consider my competitors to be my constituents. They are a wonderful group of very hard working and compassionate people. I can and do highly recommend their services. I am proud to be a part of the "Westmoreland group"„as well as NAPCHAA.

I have been actively involved in every step of these proposed regulations,since the first day that I became aware of them. Precisely, since March 29,2001 when they were introduced in Harrisburg at the DPW Advisory Committee. At that early point in time, when they were called "the draft of the Adult Residential Regulations Project", DPW mailed a copy to every PCH in the State. Every home received the playtoy...the draft.

I am extremely alarmed and upset by the fact that the DPW has not sent this published version of the proposed Chapter 2600 Regulations to every PCH within the Commonwealth. You have not even so much as sent a letter,nor a postcard, to alert the homes of the movement forward. I find this to be deceitful, and this silence very negligent to the lives of over 2000 residents, their families, as well as the 84 remaining providers. Quite frankly, I am appalled. As my licensing Dept., I trusted you, and I expected more from you!!!
The PCH providers throughout the Commonwealth deserve to know what is about to turn their lives and businesses upside down, Theydeserve to know and they deserve a chance to react!!!

There are 3 major theories of WHY'S for the reasons behind these drastic proposed regulations.
(1)To line PA.up for Medicare/medicaid monies.
(2)To eliminate the "bad" homes.
(3)To destroy the small businesses.

Over the past 1½years, I have always said that those 3 reasons were far-fetched ideas. That the purpose of change is to improve what we have, to raise the standards, and improve the quality of care for all of our residents. Now that I have reviewed these proposed regulations, I am coming to the conclusion that my benevolent thoughts were quite far-fetched!

I need to respond to each of the 3 theories.

(1) Whoever said that the providers-the home owners want federal funding?!! Whoever said that would be the direction that we would want to go? Whoever said that we wanted to mix with the federal government?

I went into <u>private business</u> because of 25 yrs. of experience with Medicare, and JAHCO. I went into <u>private</u> business to get away from the absurd amount of paperwork. I could have easily ventured into a home health care business, but what I really wanted to do was take care of people, not paperwork. I wanted to follow my calling to do hands-on, quality care...I wanted a personal care home.

(2) The "bad" homes that you are going after with such a vengence are such a small %. Estimates are less than 10% of all PCH are "bad".Such a minute % does not warrant this major change that you're proposing.

The advocates and the Ombudsman represent hideous conditions which need to be changed immediately!Those conditions are an embarassment to all of us, they hurt all of us. They're a slap in the face to the entire PCH profession, and to humanity, and to those of us who believe in a higher power. The "bad" homes need to be aggressively dealt with.

The "bad" homes need to be dealt with through <u>enforcement</u>, not through over-regulating.

Now, I'm in a crises situation--a delimma because you folks want to change the regulations, and to change them beyond what is prudent and reasonable. YOU ARE GOING TO UPSET THE APPLECART, JUST TO GET RID OF A FEW BAD APPLES.

(3) Carmella's House was just established about 4¼ years ago. It took me 12 years to get what I wanted. 12 years of savings, 12 years of planning, and 12 years to talk my husband into "going for broke" to chase a dream.Everything that I am worth is in my 100+ yr.old building. Everything that I do is for my family,my extended family of residents, and my colt. We work 16-18 hrs. per day, without any days off since we began our business.I cannot complain, because I love what we are doing. It's an old-folks Bed & Breakfast, a geriatric kibbutz, a communal living, which offers many rewards...in the form of hugs and good laughs.

I do everything willingly. We've worked hard to create my vision-to build my small business.

OLRM seems to be on a mission to wipe out the industry. An analogy would be to treat the cancer by giving the chemotherapy

which kills all the cells-both the good and the bad cells. These proposed regulations are going to weaken and destroy the entire profession. That nauseates me!

For the record of public comment, I must also add some overall, general statements.

(1) COST-The proposed Chapter 2600 regs. will have a detrimental economic impact on our residents and their families. It will raise the cost of care to such an exorbitant amount that few will be able to afford. Residents who are on a fixed income will loose this option of lifestyle.

PCH's will not be able to accept an SSI resident for $30/day when it will cost in excess of $300/day to care for a resident after the proposed regulations are instituted.

(2) HOME CLOSURES THROUGHOUT THE COMMONWEALTH-Exorbitant increases in the cost to do business will force many homes to close their doors. The income from the resident's room and board will not begin to pay for these regulations.

Costs include: paperwork & wages to complete excessive paperwork
alterations to the buildings
additional staff which may include licensed personnel
cost of training - orientation and 24hrs./annual training for all employees and volunteers.This cost is compounded by the expense of hourly wages while training, as well as hourly wages for a second employee to cover the floor.

(3) CHANGE FROM A SOCIAL MODEL TO A MEDICAL MODEL-This infringes on the residents' right to choose where he/she wants to live.It is forcing a philosophical change of lifestyle on a frail society of residents. It is stripping them of choices.

We feel that our residents thrive in the social settings that our PCH provide, and that many will perish in a medical setting.

Chapter 2600 is heavily laced with Medicare regulations that have been extracted from the nursing homes. It's disheartening to see that the nursing home administrators have had more of an impact on this chapter than the PCH administrators.

WE DO NOT WANT TO BE MINI NURSING HOME JR'S!!

(4) OVER-REGULATING-There are over 20 seperate policies and procedures and 59 seperate required documentations. This amount of paperwork will NOT ensure the health, safety, and welfare of our residents. It will actually have an adverse effect of less care and significantly higher cost. Staff will be buried in paperwork.

(5) OVER-REGULATION **WITH LESS INSPECTIONS**-75% of PCH will be inspected every 2 years, some every 3 years, and some every year. This does NOT add up to protecting our residents. Is Auditor General Robert P. Casey, Jr. or the advocates from the PA.Health Law Project aware of this?

(6) ENFORCEMENT- Every complaint that has been brought to our attention by the Auditor General Casey, the advocates, and the Ombudsman fall into 2 categories for resolution: Either they

are so horrific that they become a criminal matter which is a POLICE issue, or they could be handled appropriately by current Chapter 2620 IF the DPW inspectors had support from the State to do their job completely BY ENFORCING REGULATIONS!

(7) THOSE WHO KNOW THIS PROFESSION **WERE NOT CONSULTED** about what good regulations should include. Those who know best are the residents and their families, providers, and inspectors.

Out of all this turmoil, a few positive things have developed. We had to step back and take a long,hard look at our profession. We have recognized several needs that might have an effect on the health, safety, and welfare of our residents. We need to raise our standards by offering more educational training sessions to the caregivers.But the training needs to be economically feasible.

We need to improve our medication delivery systems so that lay staff throughout the Commonwealth can safely give medications. WCPCHAA & NAPCHAA are developing and piloting a medication training program. We are proactive to find solutions.

We need enforcement of the regulation. We realize that our weakness is also your weakness.

We have more years in the developing of our small business than you do in the developing of Chapter 2600. Everything that I have done; everything that I own; and my future is at stake with Chapter 2600. IT IS UNACCEPTABLE.

MY SUGGESTION: To keep Chapter 2620, but add some addendums to enhance our profession,like some training and med.tech.program.

Please try to understand the implications that Chapter 2600 will have on residents, their families, providers, small businesses, as well as the DPW inspectors. The inspectors will also be buried in paperwork.

I'm also including some letters from families, and a petition of 93 names from interested persons in my community.

I will continue to participate at every given opportunity, until the end. I will plan to attend the Dec.11 statewide stakeholder meeting.

Please keep me informed of any other developments.

PLEASE DO NOT DESTROY THE ENTIRE ORCHARD FOR A FEW BAD APPLES!!

Thank you,

Elgin Panichelle

Elgin Panichelle, R.N.,Adm.
Carmella's House

Original: 2294

14-471 (451)

ALZHEIMER'S ASSOCIATION

Someone to Stand by You

ALZHEIMER'S ASSOCIATION

Pennsylvania Public Policy Coalition

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Alzheimer's Association
Delaware Valley Chapter
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(215) 561-2919

Regional Offices

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Laurel Mountains Region
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Northeastern Region
Kirby Health Center
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Wilkes-Barre, PA 18701
(570) 822-9915

November 1, 2002

Teleta Nevius, Director
Office of Licensing and Regulatory Management
Department of Public Welfare
Room 316 Health and Welfare Building
P.O. Box 2675
Harrisburg, PA 17120

Dear Ms. Nevius:

Attached please find the comments of the Alzheimer's Association's Pennsylvania Public Policy Coalition on the draft personal care home regulations issued by the Department of Public Welfare.

As advocates for the more than 270,000 Pennsylvanians with Alzheimer's disease, we know that most personal care homes in the Commonwealth are doing their utmost to provide residents with decent, safe, and sanitary shelter and a good quality of life. However, recent tragedies such as the Alterra situation in Bucks County serve to underscore the need for statewide standards, inspections, and enforcement.

Administrators and staff of the vast majority of personal care homes are as anxious as we are to identify and eliminate situations in which the health and safety of residents is threatened. We appreciate the Department moving forward with these regulations and look forward to working with you on their successful implementation.

If we can be of service to you in areas such as dementia specific training, please feel free to contact us.

Sincerely,

Diane M. Balcom, Chair

CHAPTER 2600 PERSONAL CARE HOME REGULATIONS

GENERAL REQUIREMENTS

§2600.15. Abuse reporting covered by statute.

§2600.16. Reportable incidents.

Comment: Reports generated under these two sections are important for the Department; however, we would recommend providing copies of the reports to residents and their designees.

RESIDENT RIGHTS

§2600.31. Notification of rights and complaint procedures.

Comment: Paragraph (a) of this section uses the term "advocate" for the first time, which is not defined in section 2600.4. Does this mean an attorney, an attorney-in-fact, or any designee with the resident's best interests in mind?

§2600.32. Specific rights.

Comment: This section articulates a very thorough list of rights. We particularly appreciate the freedom from restraints and excessive medication. However, while it is notable that the regulations prohibit discrimination by personal care homes based on sexual orientation, the regulations themselves discriminate based both on sexual orientation and marital status. The word "family", which is used throughout the regulations in terms of receiving notice and being involved with the resident's support plan, is defined to exclude unmarried partners of either gender. Similarly, the regulations indicate in section 2600.229(c)(3) that a personal care home secured unit resident's "spouse or relative" is entitled to move in with him or her without having to undergo a medical assessment. This could be addressed either by adding a definition of "spouse" to section 2600.4 that includes unmarried partners, or by adding the words "or designee" after each use of the word "family" and clarifying the language on spouses and relatives moving into a personal care home.

We also recommend additional language in or following subsection (c), which calls for treating residents with dignity and respect. An example of residents' dignity should be the right to be clean and dry, and have incontinence needs addressed. Similarly, an example of residents' respect should be the right to have any wounds received treated promptly by a trained medical provider, regardless of their cause.

§2600.33. Prohibition against deprivation of rights.

Comment: Paragraph (a) states that residents, "shall not be deprived of their civil rights". "Civil rights" are generally interpreted as those stemming from the Civil Rights Act of 1964, the

Americans with Disabilities Act of 1990, and title IX of the Education Reform Act of 1972, namely race, national origin, gender, age, handicap, or religious preference. Since section 2600.32(a) confers additional specific "rights" above and beyond those generally required by law, perhaps this section would be clearer if it said "residents shall not be deprived of their rights as stated in section 2600.32(a)."

SUBCHAPTER B - STAFFING

§2600.55. Exceptions for staff qualifications.

Comment: Paragraph (a) may be worded a little too generally in its waiver of qualification requirements for staff hired prior to the effective date of the regulations. Some requirements, such as age or supervisory ability, can be made up with time and training, including on-the-job training. However, others, such as freedom from dependence on drugs or alcohol, should not be waived simply because the staff person was already working in a personal care home when he or she developed the dependency.

§2600.57. Administrator training and orientation, and §2600.58. Staff training.

Comments: The lists of training topics in these sections are thorough, particularly for administrators. However, with so many training areas, dementia care topics are unlikely to receive more than a few of the initial 40 hours required for administrators, and even less in annual refresher training. The Alzheimer's Association is uniquely qualified to provide this type of training and, generally, the minimum curriculum we offer is eight hours for direct care staff.

The key skills needed in the personal care home setting include, among others, the ability to: identify when a resident may be developing Alzheimer's or some related dementia; work with the resident's loved ones, attending physician, and other experts to reach a diagnosis and the resident's acceptance of it; revise the resident support plan appropriately to allow someone in the early stages of Alzheimer's to remain in the residence; provide assistance with activities of daily living when the resident doesn't understand basic instructions; work with appropriate experts to develop a secured unit for the resident, or assist the resident in identifying alternative living arrangements; and develop appropriate strategies for addressing wandering, access to portions of the home that may become a hazard to the resident, such as the kitchen, and interaction between the affected resident and other residents of the home. These are not topics than can be covered in an hour or two. We would welcome an opportunity to work with the Department in developing a standard curriculum for administrators and direct care staff.

PHYSICAL SITE

§2600.99. Recreation space.

Comments: While standards for secured units are covered in section 2600.229(a)(2), it is notable that wandering may be an indication to staff that an existing resident is developing Alzheimer's or a related dementia. Even personal care homes without secured units should have a plan in place for ensuring that regular access to outdoor recreation doesn't lead to lost residents.

FIRE SAFETY

§2600.121 – 133.

Comments: The definition of "immobile" in section 2600.4 includes persons who cannot understand instructions. Given this, it would seem that a fire safety plan should include specific provisions for ensuring that immobile residents have staff assigned to them on every shift who would be responsible for their safe egress, that local fire officials are notified of the presence of residents who might not understand what is happening, and that immobile residents' access to flammable materials in the home is limited.

RESIDENT HEALTH

§ 2600.141. Resident health exam and medical care.

Comments: It would be preferable for a health examination to occur prior to admission, to avoid situations in which someone in the early stages of dementia moves in only to be asked to leave because the home is unable to accommodate his or her future needs for a secured unit. In addition, an evaluation of the resident's cognitive abilities should take place more frequently than once per year. We would recommend at least every six months, or upon any significant change in the resident's condition or other triggers similar to those used in section 2600.225 for resident assessments.

We also would recommend adding the word "timely" before the phrase "medical care" in paragraph (b). Residents with wounds or other need for medical attention should receive it promptly.

§2600.145. Supervised care.

Comments: This section states that, "A resident in need of services that are beyond services available in the home in which he resides shall be referred to the appropriate assessment agency." As discussed previously, knowing when and to whom a referral should be made requires training both in making the referral and in getting the resident to accept it.

NUTRITION

Comments: This subchapter is very thorough in its direction of how many meals and snacks to offer, and the content of each. However, the proposed regulations do not fully address nutritional adequacy among a population where dementia may cause them to forget to eat or not want to eat. In fact, section 2600.164 prohibits force feeding. Some type of intervention, or at least notice to a resident's loved ones or physician, should be required if a resident exhibits a significant unintended weight loss, such as 5% in a 30-day period or 10% in a 180-day period.

TRANSPORTATION

§2600.171. Transportation.

Comments: A resident in the early stages of Alzheimer's may need transportation to a doctor's appointment or may just wish to travel with other residents to a local shopping mall or movie theater. Additional staff would be needed in this event, to ensure that the resident with dementia got where he or she needed to go and back again, while still providing sufficient oversight of other residents on the trip.

In addition, this is another area where additional training should be provided for drivers or other staff so they can effectively assist the resident with getting in and out of the vehicle, getting to appointments, and the like.

MEDICATIONS

§2600.181. Self-administration.

Comments: While we recognize an overall shortage of health care professionals and skilled workers in long-term care, particularly in rural and inner-city areas, we are very concerned about ensuring the competence of staff assisting personal care home residents with self-administration of medications. Given the relatively high percentage of PCH residents who have undiagnosed dementias, it is critical that residents have the support they need to ensure their health and safety. We recommend a two-step process:

- personal care homes should be required to develop a written policy on administration of medications and assistance to residents with self-administration, which should be provided to all residents' physicians and dentists; and

- physicians and dentists with notice of a personal care home's lack of on-site qualified staff (meaning a licensed physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse, or licensed paramedic) should be required to review a minimum of two weeks' drug administration records prior to making any changes in a PCH resident's prescriptions.

In addition, we strongly support the regulations' requirement for training PCH staff in helping residents with self-administering medications.

SERVICES

§ 2600.229. Secured unit requirements.

Comments: This section is critically important, and its organization is much improved from the first draft circulated on the Department's web site. Still, some of the provisions of this section are duplicative of other provisions elsewhere in these draft regulations, making it sometimes unclear whether this section is intended to supplement or supplant the rest of the personal care home regulations. For example, paragraph (h) states that residents of secured units are considered to be mentally immobile. But, the definition of "immobile resident" in 2600.4

includes, "difficulty in understanding and carrying out instructions without the continual and full assistance of other persons". It would seem that the statement in section 2600.229(h) is duplicative, unless the real intent was to limit the mental aspects of the "immobile resident" definition only to the provisions of section 2600.229.

Training in the areas articulated in this section obviously is very important to a facility that holds itself out as offering a secure environment for people with cognitive impairment. However, all current personal care home residents should be viewed as having the potential to develop dementia. The incidence of Alzheimer's disease increases dramatically after the age of 70, and is nearly 50% in people over age 85. This training should be provided at least to all administrators, and preferably to all direct care staff, as well.

Paragraph (j) still needs some work, in form and substance. We note that 60 days notice prior to becoming operational is not the same as getting approval or obtaining additional licensure prior to becoming operational. There should be some acknowledgement from the State that the home meets the requirements of this section before it is permitted to hold itself out to the public as being able to accommodate the needs of persons with Alzheimer's disease.

In addition, subparagraph (1) talks about providing notice to the Department when a PCH initially begins operating a secured unit. Subparagraph (2) discusses providing notice of changes made to secured units already operating. Subparagraph (3) articulates a list of items to included "in the written notification" (emphasis added), without specifying whether that's the written notification of intent to open a secured unit, or the written notification of intent to make changes in a functioning secured unit, or both.

Finally, we would recommend that an additional certificate or special license be issued to homes with secured units that comply with this section. Such a certificate would assist the loved ones of persons with Alzheimer's disease in quickly identifying a suitable personal care home. It also would allow the Alzheimer's Association to quickly identify personal care homes that may be interested in enrolling residents in the "Safe Return" program, a program that helps wandering Alzheimer's sufferers get home safely.

ENFORCEMENT

§2600.253. Revocation or non-renewal of licenses.

Comments: Paragraph (c), relating to relocation, is unclear. It appears to offer the Department's assistance in relocating residents only if the PCH in which they're currently living failed to apply for a license in the first place. When a license has been revoked for cause, the paragraph says that residents shall be relocated, but it does not indicate at whose expense or whether Departmental assistance would be available. Certainly it would seem that the urgency associated with revocation for cause would argue for residents getting help from the Department.

#14-475
(355)

Original: 2294

2002 NOV -4 PM 3:36

REVIEW COMMISSION

467 Mt. Tabor Road
Coal Center, PA 15423
November 1, 2002

Teleta Nevius
Fax 717-705-6955

It is my understanding that if the proposed new regulations regarding personal care homes in Pennsylvania pass, some serious financial damage will be done to many personal care homes. This financial burden will naturally be passed on to the residents of those homes and their families.

My aunt, Mary Matz, is a resident of Hallsworth House in Charleroi, PA. She receives excellent care, and professional medical help is on call, and available whenever needed. The proposed new regulations are unnecessary, and furthermore are damaging to families like us. If you make the cost of personal care prohibitive, you will force many residents into unsafe and unhealthy environments. What's your point?

Candace Bernier

Candace Bernier

W 724-229-0785
H 724-483-2883

14-475 (631)

Original: 2294

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF AGING
555 Walnut Street - 5th Floor
Harrisburg, Pennsylvania 17101-1919

November 1, 2002

Teleta Nevius
Director
Office of Licensing and Regulatory Management
Department of Public Welfare
PO Box 2675
Harrisburg, PA 17105-2675

Dear Ms. Nevius:

Enclosed are comments from the Office of the State Ombudsman in the Department of Aging in response to the proposed personal care home regulations -- 55 PA Code Chapter 2600 -- published in the PA Bulletin, October 5, 2002.

Initially my office had the opportunity to participate in meetings to formulate the first draft. We are pleased that many comments offered during that process have been incorporated into the proposed regulations. We also recognize and appreciate the time and effort expended by many parties to improve the regulations and enhance protections for consumers who are residents of personal care homes.

We would like to comment and reinforce the positive additions to the regulations concerning initial and annual assessments, development of support plans, quality management, increased administrator and direct care worker qualifications and training requirements, provision of personal care services 365/24/7 and resident protection language added to transfer, discharge, refunds, and termination notification.

Overall, we support the finalization of these regulations with the noted revisions attached. I must, however, reiterate our concern and disagreement to allow for less than annual inspections and the omission of requiring unannounced visits. Our experience in all licensed long-term care facilities demonstrates that conditions can change rapidly for various reasons.

If the intent and mission of licensing and enforcement is to ensure the health and safety of residents, the Commonwealth must provide such assurance through annual inspection of all facilities. Our entire ombudsman network feels very strongly about this issue. I encourage you to reconsider.

I also request that the Department of Public Welfare give due consideration to the recommendations of the subcommittee of the Personal Care Home Advisory Committee on enforcement that were submitted on January 10, 2002.

On behalf of all ombudsmen, I thank you for the opportunity to comment on these proposed regulations as we all strive to protect the rights and ensure a high quality of care and life for residents of personal care homes.

Sincerely,

Cindy Boyne

Cynthia Boyne
State Long-Term Care Ombudsman

CB/pas

Enclosure

2600.2 Scope

(b) add "exclusively" after operated and before by

2600.3 Inspections and Licenses or Inspections of Compliance

(a) add "annual" before on-site inspections

(b) replace "the" with "all" requirements

2600.4 Definitions

Direct Care Staff – add provides "personal care" services

Financial Management – add to the end of the first sentence ", or when a resident requests such assistance and the request is documented in the resident's records."

IADL – add "(vi) securing health care"

Long-Term Care Ombudsman – in the first sentence replace "An agent of" with "A representative of the Office of the State Long-Term Care Ombudsman in"

2600.5 Access Requirements

(a) add "at any time" after license and before and

2600.11 Procedural Requirements for Licensure or Approval of Homes

Anything less than annual on-site inspections for all licensed facilities is not appropriate. Our experience has shown that conditions can deteriorate rapidly for various reasons. In addition, all inspections should be <u>unannounced</u>.

2600.15 Abuse Reporting Covered by Statute

(a) need to include neglect and add penalties for failure to report

(b) add immediately "investigate" and implement a plan "for removal of alleged perpetrator from residents"

require submission of plan of "remediation" rather than supervision

2600.16 Reportable Incidents

(5) add "or elopement from a secured unit for any time."

Add "(19) Injury of unknown origin requiring medical treatment."

(c) add to first sentence "and to the responsible party or legal representative of the resident."

2600.18 Applicable Health and Safety Laws

Replace "comply" with "be in compliance"

Add "to obtain and following issuance of a certificate of compliance."

2600.19 Waivers

(a) add request for a waiver of a specific requirement only in exceptional circumstances. Waiver request must provide justification.

(c) in the first sentence add "resident responsible parties, resident legal representatives, and the local Ombudsman"

(e) in the first sentence add "resident responsible parties, resident legal representatives, and the local Ombudsman"

(f) in the first sentence replace "a periodic" with "annual"

2600.20 Resident Funds

(4) in first sentence delete "if available"

(6) replace "personal needs allowance" with "funds"

(9) in second sentence add "or designated representative"

(10) in the first sentence add "contact."

"and surrender upon request all resident's estate"

(11) in the first sentence replace "within 30 days of" with "before or upon departure due to" add "voluntary closure", resident decision to leave with appropriate advance notice.

(12) add emergency relocation, voluntary closure

2600.24 Tasks of Daily Living

(9) add "and medications"

2600.26 Resident-Home Contract: Information on Resident Rights

(6) add "voluntary departure from facility"

(11) add "based on needs identified in the assessment and addressed in the support plan

2600.27 Quality Management

Add abuse/neglect reporting protocols

2600.28 SSI Recipients

(e) Does the word "clothing", in the second and third sentences, obligate the home to provide clothing to the SSI recipients?

2600.29 Refunds

(a) Thirty days is an unreasonable amount of time to provide refunds

in the second sentence replace "discharge" with "upon departure."

in the last sentence replace "within one week" to "upon departure"

(d) in second sentence replace "within 30 days of death" with "upon request by the estate" after and

(e) replace "discharge" with "departure"

2600.31 Notification of Rights and Complaint Procedures

(a) add lodge complaints with "PCH, Department, and/or Ombudsman"

(g) replace "14" with "7"

last sentence add phone numbers "of all the above"

(i) add "receive assistance as identified in assessment/support plan." Include accessing prescriptions.

(w) We do agree with providing the right to appeal the items in this section. We do question the ability of the home to establish appeal procedures that would be fair and objective. DPW should establish an appeal process that provides for third party impartiality but preferably not utilizing the formal process of DPW's Hearing and Appeals. Add, resident must be permitted to continue residence in the home pending outcome of appeal.

(2) add "(aa) A resident has the right to reside and receive services with reasonable accommodation of individual needs and preferences, except where the health or safety of the individual or other residents would be endangered."

2600.53 Qualifications for Administrators

Add "(5) Administrator must have minimum of high school or GED."

(k) Administrator must meet all requirements prior to serving as an Administrator.

2600.54 Direct Care Qualifications

(2) or have comparable life experience and demonstrate ability to pass State designed literacy competency test

(5) Direct Care Staff must meet all requirements of this section prior to serving as direct care staff

2600.57 Administrator Training

(a) replace "and administered ..." with "provided by an appropriately trained person or agency. The Department needs to ensure standardization and that appropriate topics are addressed by individuals knowledgeable in subject areas. Current practice of some trainers using valuable

training time to essentially "rally against DPW, PDA or others" is not acceptable training.

(c) add "recognizing signs/symptoms of abuse/neglect and reporting requirements

2600.101 Resident Bedrooms

(d) replace (4) with (2) bedrooms for more than 2 may occur only if by resident choice.

Existing facilities can be grandfathered in.

2600.102 Bathrooms

(c) replace (15) with (6)

(e) add "each"

2600.104 Dining Room

(1) add "or as noted in the resident's support plan" after illness

2600.141 Resident Health Exam and Medical Care

(1) Physician completing may not be in any way affiliated with the particular PCH. Resident must be given choice and right to use personal primary physician.

(b) delete wording and add "The home shall ensure that all residents have access to medical care and provide assistance in obtaining such care when needed."

2600.161 Nutritional Adequacy

(b) add and "alternative" drink

add "(h) A snack consisting of food and drink shall be offered to all residents no more than 4 hours past the evening meal."

2600.162 Meal Prep

(c) replace 14-16 with 12-14

2600.164 Withholding Food

Add (d) residents with cognitive impairment will receive assistance/monitoring to ensure they receive adequate nutrition and hydration

2600.181 Self-Administration

This regulation is regularly violated by many homes on a daily basis. The requirements are adequate as a standard. The problem lies with the home that allows untrained, unauthorized staff to pass and administer medications. Enhanced enforcement with sanctions may help discourage the abuse of this section.

2600.226 Development of the Support Plan

(a) replace "15" with "72 hours"

(c) revise – "Documentation of family involvement with resident consent in the development of the support plan shall be kept."

(d) add "All"

2600.227 Copies of Support Plan

Add "and all involved in development/provision of the support plan. Current plan must be maintained in the resident's record.

2600.228 Notification of Termination

(a) add receive assistance "from the facility"

(f) add "or if the Department has initiated legal action", the

delete "except in the case of an emergency"

add "Under no circumstances may the legal entity, administrator or staff interfere with relocation efforts."

2600.229 Secured Units

Criteria need to be developed re: type of admission, staffing requirements, DPW oversight, etc., with input from person with Alzheimers/dementia expertise.

Regular monitoring of facility's compliance with established criteria must be conducted by DPW.

2600.240 Notification to Department

Add "(4) No residents shall be moved into a secure unit until all required documents have been received and approved by the Department, the Department conducts an on-site inspection, and the Department issues a certificate of approval to operate a secure unit."

2600.241 Mobility Standards

(c) replace "30" with "7"

2600.251 Classification of Violations

Must be enforced statewide

2600.252 Penalties

Must be enforced statewide

2600.253 Revocation or Non-Renewal

Must be enforced statewide

Original: 2294

#14-475 (401)

AARP Pennsylvania

November 1, 2002

Teleta Nevius
Director, Office of Licensing and Regulatory Management
Department of Public Welfare
Room 316, Health and Welfare Building
Harrisburg, PA 171201

Dear Ms. Nevius,

AARP is writing regarding the publication of proposed rulemaking for the Department of Public Welfare in the October 5, 2002 Pennsylvania Bulletin.

The proposed regulations for Personal Care Homes contain important changes that will help consumers. There are still shortcomings in these regulations, however. AARP shares the concerns of other advocacy and consumer organizations that have commented on these proposed regulations and hopes you will seriously consider these concerns.

AARP also has a serious concern with the overall scope of these proposed regulations. Today in Pennsylvania, countless facilities advertise themselves to consumers as "Assisted Living Facilities." The services offered by these facilities range from the simple to the extravagant, and the costs associated with these services can be modest or very high. At the same time, other facilities continue to identify themselves as "Personal Care Homes." These facilities also offer different services at different costs to consumers.

Consumers naturally think there is a difference between Personal Care Homes and Assisted Living facilities. But all facilities that are known as Assisted Living or Personal Care are covered under one set of rules in these proposed regulations. And nowhere in these proposed regulations is the term "assisted living" acknowledged.

Many states have now defined the concept of assisted living. AARP feels that true assisted living facilities should offer a level of care beyond what is offered by personal care homes, and beyond what is required by these regulations. But there is a place for personal care homes in the growing field of long-term care in Pennsylvania. Some of the regulations proposed by the Department may cause difficulties for smaller personal care homes – difficulties that could be avoided if larger assisted living facilities were regulated separately.

AARP also considers these proposed regulations on this issue ill-timed. The General Assembly has had legislation under consideration that would define assisted living and

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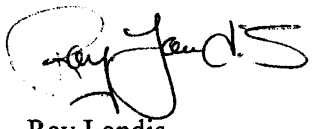
James G. Parkel, President | William D. Novelli, Executive Director and CEO | www.aarp.org

establish a framework for regulations. This legislation passed the House of Representatives and is pending in the Senate. It seems prudent for the Department to delay consideration of their proposed regulations until it is determined whether the General Assembly will address the assisted living question. In addition, the pending change of Administrations should factor into this issue.

AARP urges the Department of Public Welfare to revise these proposed regulations to include the concept of assisted living. Assisted living facilities are a reality in Pennsylvania, and a definition and regulatory framework for these facilities, which are different than personal care homes, should be established.

Sincerely,



Ray Landis
AARP State Legislative Representative

14-475 (1080)

RECEIVED

PETITION

Dear family and friends of the elderly. Recently the Department of Welfare proposed 149 pages of regulations. These regulations will put many small personal /assisted living facilities out of business. These regulations can be found on the Pennsylvania Bulletin printed this past Saturday. If these regulations go through, the cost in the homes will increase approximate 40% per home.in addition to the cost already. At this point in time, many of us ignore the fact we are aging. Many of our parents, uncles, aunts, have already experienced some physical or mental conditions. The question for all of us is where are we going to go when we age? We would appreciate you and any members of your family or friends to sign this petition. We will make sure they are hand delivered to the proper organization in Harrisburg.

Thank you in advance in this cause.

NAME	ADDRESS	PHONE
Susan A Nelson	163 Spring Grove Rd, Pgh PA	(unlisted)
Jim Durkan	180 Penn Lear Dr, Monroeville PA 15146	
Lanaine Halfeder RN	3044 Leechburg Rd. Lower Burrell 15068	
Camille [illegible]	100 Carriage [illegible] Pitts Pa. 15239	
Robert J [illegible]	2923 Amy Drive South Park, PA 15129	(unlisted)
David P Crowley	1112 Holmes St McKees Rocks PA 15136	
Melissa Kondroski	401 Lawnwood ave, Pgh Pa 15227	
Rita Mason	502 Lenox Ave Pgh PA 15221	
Latasha Washington	1449 Foliage St Pgh PA 15221	412-244-9901
Mary Ann [illegible]	1808 Patricia Lane N. Versailles PA	823-2385
Derek Hassim	North Versailles PA	488-6065
Sherry Waring	Northside	412 23# 9373
Eric Brown	Greentree	344-5452
Dana Kline	100 Bryn Mawr ct	412 271-2488
[illegible]	544 Chicora St.	412-823-6407
Christopher Krebs	2730 Evergreen Ln Imperial	724-695-8455
Ketosha Lewis	5 Edinburgh Dr Pgh Pa	412 [illegible]-8474
C Kerns	7439 McClure St Pgh Pa 15218	
[illegible] Watkins	1715 Weiler st	412-829-2562
[illegible]	731 Braddock Rd	412 247-2542
[illegible]	229 Thornridge Dr	
Dorothy Edelman	224 Emeline St	
Constance Ruffing	243 Berner Rd. Pgh Pa 15221	

Original: 2294

14-475 (726)

Dennis L. Raraigh
329 Sarver Road
Sarver, PA 16055
724-353-1529

Independent Regulatory Review Commission
333 Market Street
Harrisburg, PA 17101

Dear Sirs,

I am writing to you concerning the pending changes in the regulations on personal care homes. I am very familiar with personal care homes because my mother has lived in one for the last eight years. While living in a personal care home, my mother has received excellent care and has always been happy living there. I am greatly concerned that if these new regulations were to pass, living in a personal care home may no longer be possible for her. I certainly understand the need for personal care homes to be regulated. These new proposed regulations will increase the cost of living in a personal care home a considerable amount. This will force many small homes out of business. The minimum estimated increase in my mother's rent would be $900 per month. That means it will no longer be affordable for my mother to live there. I am not sure were my mother would be forced to live it would be very difficult for my 65 year old father to care for her in his home. Likewise, it would be a struggle for my sister or I to care for her in our homes. My mother lives in a home that is close to her family. Would my mother be forced to move into a larger home away from her immediate and church families? Would she be forced into a nursing home setting? That would be ridiculous because my mother does not need this kind of care. Stop for a moment and think about that. How would you feel if a loved one of yours were faced with that?

Using plain common sense, these regulations make very little sense. Some of the proposed regulations are stricter than the regulations that nursing homes and hospitals must follow. Why? I do not understand this. The current regulations have not been strictly enforced in recent years. If the current regulations are not fully enforced now, then how do you expect to enforce three times the current regulations?

The new regulations will greatly affect the lives of the residents of this commonwealth. I urge you to give careful consideration to this. I am not only asking you to fight for Pennsylvania's best interests, but my family's as well.

Sincerely,

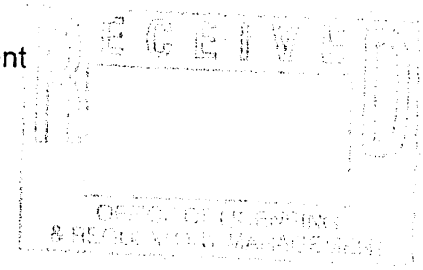
Dennis L. Raraigh

Dennis L. Raraigh
A concerned citizen and son

14-475 (710)
"SAME Commenter
as #484"

MENTAL HEALTH ASSOCIATION
OF SOUTHEASTERN PENNSYLVANIA
The Bell of Hope

Department of Public Welfare
Office of Licensing and Regulatory Management
Teleta Nevius, Director
Room 316 Health and Welfare Building
P. O. Box 2675
Harrisburg, PA 17120



Dear Ms. Nevius:

I am writing on behalf of the Mental Health/Aging Advocacy Project of the Mental Health Association of Southeastern Pennsylvania with regard to the latest draft of the Department of Public Welfare's Personal Care Boarding Home (PCBH) Regulations, as published on September 30th. Our organization consists of older adult mental health consumers, and advocates in Southeastern Pennsylvania.

While some improvements have been made in this latest draft we are concerned about the following issues:

1) Don't eliminate the previous requirement that homes be inspected at least once per year could make more homes unsafe. We are well aware that homes that closed down this year were inspected under the current regulations and still had substandard and dangerous conditions. How would inspect less help improve standards? We strongly feel that by eliminating annual inspections many older adults Moreover we believe that annual inspections should be unannounced Regulation 2600.11 as well as 2600.3, relating to Inspections and licenses or certificate of compliance must reflect this.

2) Make sure training be done by appropriate personnel and include all necessary areas.
I applaud the improvements that have been made in the area of administrator and staff training. These should help improve resident care and staff retention for a population that is sicker and frailer than when the first regulations were made. What will be important is to make sure the training is done appropriately and is valuable. This is especially true in the areas of mental health and dementia. We support making sure that Training needs to be done by qualified persons. Thus, in regulation 2600.57, (a) and (b) should be revised to state that the Department-approved training be provided by an appropriately trained person or agency.

1211 Chestnut Street, 11th Floor • Philadelphia, PA 19107 • 215.751.1800 • Fax: 215. 636.6300
Website: www.mhasp.org • Email: mha@mhasp.org

We also believe that certain vital areas of training have been left out. While we recognize that the staff is not involved in treatment, they need to be aware of symptoms of mental illness and dementia. Therefore we believe (c) of 2600.57 should include the following areas of training: how to access healthcare services through Medical Assistance and other insurance companies, specific training on symptoms and behaviors of major mental illness (i.e. schizophrenia, schizo-affective disorder, major depression, bi-polar disorder and personality disorders), mental retardation, aging, and dementia/cognitive impairments.

We urge the department to develop a manual for training based on the best practices available in the commonwealth.

3) Don't take away the requirement to help residents get health and mental health services. Previous regulations required homes to obtain health services for a resident. As many residents are older and frailer this becomes even more crucial now. Regulation 2600.141 should require homes to assist residents in accessing health, dental and psychiatric care when needed.

4) Insure that secured units are safe and assessments made every six months. As advocates for older adults with mental illness and dementia we are concerned that the proposed regulations, because of some important omissions, may not provide necessary safeguards for residents who may be admitted to secured units. First of all the process for gaining permission (2600.229) for a secured unit leaves out any inspection by DPW. This must be changed. These residents are the most vulnerable to mistreatment and abuse.

Second, as you know that there are many forms of dementia and many of the symptoms could be caused by other physical or mental health problems. They may not be able to report symptoms or express pain etc. Additional training hours should be spelled out. Also assessments need to be every six months in order to insure that further deterioration or improvement is determined.

These issues are salient and need to be addressed. I thank you for your efforts to improve living situations for residents of personal care homes.

Sincerely,

Tom Volkert

Tom Volkert
Director of Mental Health/Aging Advocacy

Cc: Hon. George T. Kenney, Jr.
Hon. Frank L. Oliver
Hon. Harold Mowery, Jr. Chair
Hon. Timothy Murphy, Vice Chair
Hon. Vincent Hughes, Minority Chair

Original: 2294

14-475 (453)

PROPOSED RULEMAKING
DEPARTMENT OF PUBLIC WELFARE
[55 PA. CODE CHS. 2600 AND 2620]

PERSONAL CARE HOMES

COMMENTS AND OBSERVATIONS

LIZA'S HOUSE PCH

P.O. Box 191
Danielsville, PA 18038
TEL: 610-760-1970
FAX: 610-760-8868

NOVEMBER, 2002

Wayne C. Watkins, MBA, CMC
President
Watkins Concepts Company
Consultant to Management, LIZA'S HOUSE

CONTENTS

EXECUTIVE SUMMARY

Discussion:

Thank you for the opportunity to provide input into this proposed rulemaking, 55 PA. CODE CHS. 2600 and 2620, development process. The quality of input would be improved with more time to digest the proposed regulation and reevaluate our initial comments and observations.

It is difficult to find sufficient quality time for a comprehensive study and evaluation of the PROPOSED RULEMAKING 2600. Providing quality care to our residents is and remains our first priority. However, remaining in business and turning sufficient profit to remain in business is essential for us to fulfill our first priority of quality care for our residents.

A "Process Dictated" drop dead time of November 4, 2002 is rapidly approaching for final comments on the PROPOSED RULEMAKING. The criticality of this time line requires a direct approach in addressing this critical issue. While a lot of hard and dedicated good work has been done, and much progress made, much remains to be done. The focus on this PROPOSED RULEMAKING has recently shifted from quality of product to meeting some arbitrarily determined time line. This shift in focus leads to bad rulemaking. There is not enough time to review and assess impact of changes, updates and modifications to the PROPOSED RULEMAKING since the March 7, 2002, draft regulation was put out for comment.

This PROPOSED RULEMAKING VERSION is a significant improvement over the March 7, 2002 version, but it still falls fall short of realistic and practical implementation by the Provider. As written, the PROPOSED RULEMAKING is:

- **cost prohibitive.**
  - **For the 30 resident average Personal Care Home, an investmet in systems development of $145,580.00 and an ongoing annual operating cost of $371,642.00 on a current income projection of $720,000.00.**
  - **The annual operating cost increase is 51.6% of current income.**
  - **The increased operating costs must be passed on the the resident and that equates to roughly $1,000.00 per month increase, an increase most personal care home residents or their families can not absorb.**
  - **This is an industry impact cost of $260,000,000.00 system development cost and an annual ongoing operating expense increase of $664,000,000.00.**
- **filled with red flags.**
- **would put most small and medium providers out of business.**
- **significantly raise the costs on the few surviving large 'institutional' facilities, significantly increasing their cost and pricing all but the most affluent of the senior community out of the personal care home option.**

- **not ready nor worthy of the department to forward for review and enactment.**

Options:

Three basic courses of action are available:

1. Extend the "Process Imposed" drop dead date to let the current ongoing process have a couple more passes to try and resolve more of the unacceptable provisions and prohibitive costs imposed.
2. Stop the PROPOSED RULEMAKING process and reassess 2620, the current regulation which has served the Personal Care Home sector quite well for many years.
3. Steamroll the PROPOSED RULEMAKING through and either **be shot down is flames** at the legislature hearings **or force many small and medium homes to close and put thousands of dependent elderly out of their homes.**

Recommendations:

Adopt course of action 2, stop the Proposed Rulemaking process and reassess 2620 for enhancements.

The second recommended option is course of action 1, with the concern is the quality of the product, with a parameter that the PROPOSED RULEMAKING be realistic, affordable, and responsible, not adherence to an artificial time line and irresponsible social engineering.

OVERVIEW

While reading the PROPOSED RULEMAKING, and thinking about the real world of the provider, I am reminded of a noteworthy passage. I do not know the author of these thoughts so I can give proper credit. I just wish they were mine rather than simply agreeing with them.

"The Man in the Arena"

It is not the critic who counts, nor the one who points out how the strong man stumbled or how the doer of deeds might have done better. The credit belongs to the man who is actually in the arena, whose face is marred with sweat and dust and blood; who strives valiantly; who errs and comes short again and again; who knows, the great enthusiasms, the great decisions, and spends himself in a worthy cause; who, if he wins, knows the triumph of high achievement; and who, if he fails, at least fails while daring greatly, so that his place shall never be with those cold and timid souls who know neither victory or defeat.

The Provider is 'The Man in the Arena." The PROPOSED RULEMAKING, DEPARTMENT OF PUBLIC WELFARE,[55 PA. CODE CHS. 2600 AND 2620],PERSONAL CARE HOMES, (2600) outcome should support 'The Man in the Arena' rather than make the job more difficult! **The provider is not only the man in the arena, (s)he is the number one advocate for the resident. We not only empathize with their needs, we actually satisfy their needs. We know that without residents, we are out of business.**

The following critical comments are based on more than 40 years experience as a senior manager and management consultant. I made my living for 30 years doing this kind of work, for large, medium and small enterprises. I am 1 of about 2,000 Certified Management Consultants in the country. I feel I have a solid background and knowledge in the management process, and Personal Care Homes are private businesses, not government agencies.

The summary assessment of the introductory paragraphs contained in the Internet posting of 2600 are very interesting and deserve objective assessment.

:

dBackground: focused on process timeline, not outcome, and **dominated by inputs from ADVOCATES, who have no responsibility or liability for home operations, incidents, costs or outcomes.**

Resident Rights: 2600.41, 2600.42, and 2600.43 are over kill. **Should be scrapped and retain current provisions of 2620.**

Administrative Training and Orientation: 2600.57 **lacks cost justification for the impact** of these requirements. What is the projected cost increase on small and medium sized homes that employ an independent administrator to oversee their faciliy?

Staff Training and Orientation: 2600.58, **lacks cost justification for the impact these mandated requirements.** Trainee and trainer time expenses, before the facility can even expose the new hire

to the residents, is prohibitive. The interactions between the new hire and the residents are the critical factor to determine if the new hire will remain and be successful in this field. **To be forced to absorb about 4 weeks of trainer time and new hire staff time wage costs then find out the new hire is not a satisfactory candidate is a very poor cost management decision.**

Safe Management Techniques: 2600.501. This is an interesting concept, but is this new concept and requirement appropriate for PCH? **This is a skill needed in handling MH/MR consumers**, that also have State funding. I do not know the frequency or density of such residents in PCH homes. This information should have been factored into the cost benefit analysis, data which is lacking. This process is a change of mind set type training, not a couple hours in the class room. To be successful in changing an individual's mind set and method of interaction with other individuals requires at least three weeks of intensive indoctrination and oversight, a training cost that would be difficult for small and medium size homes to absorb.

Development of the Support Plan: 2600.226. This is a management **time intensive undertaking** as envisioned. The time required to get everyone together, to then get every one to agree on the care plan, and then have them sign off of the document is prohibitive for small and medium care homes to absorb. Even in large homes, the time involved is probable cost prohibitive. While this is envisioned as a once a year plan, to include updates, in reality this will probable be required twice a year per resident and involve about 8 hours of administrator time per resident for the initial plan and 6 hours for each update, sign offs are tough.

Medication Administration:

- 2600.181-2600.188, **very few PCH residents can meet the standards of 2600.181(e) for self administration.**

- 2600.186(2) **implies the PCH making a diagnosis of drug side effects for altered physical of mental condition. We are not permitted to diagnose, this is an invitation to disaster and litigation.**

- 2600.186(3) **implies responsibility on the PCH, this is a professional decision we are not qualified to make. The responsibility for this decision is with the Pharmacy and or Physician, not the PCH.** Yet the resident has the right to take any medication (s)he wants, when (s)he wants, and in the quantity (s)he wants. Families have the right to bring in any outside PRESCRIPTION, OTC or CAM medication, put them it in the resident's room, and the resident can consume them at their option, yet the PCH remains liable for any adverse outcomes. How about a little authority to intervene and manage this risk?

Personal Care Home Providers: The claim that "the Department gave careful consideration to the effect the regulations will have on the costs of providing and receiving services" IS NOT TRUE. The overview of the cost benefit analysis would be a failing grade for any Business 101 high school class project. As a management consultant for over 30 years, if any of my staff had produced such an incomplete, inaccurate and misleading document, even in draft, I would have fired them. A magnitude cost impact projection for the average

size personal care home shows hundreds of thousands of dollars annually, per home. See cost impact section below.

FIXED	ANNUAL	INCOME
$ 145,850.00	**$ 371,642.00**	**$ 720,000.00**

PERCENT OF INCOME; **51.6%**

ANNUAL COST PER RESIDENT **$ 12,387.00**

MONTHLY COST PER RESIDENT **$ 1,032.00**

PROJECTED COST IMPACT ON 1,786 LICENSED PERSONAL CARE HOMES

$ 260,488,100.00 **$ 663,752,612.00**

General Public: **"There will be no costs to the general public as a result of this proposed rulemaking." IS A FALSE STATEMENT. It is the result of an ineffectual cost/benefit analysis, if indeed one was made. This proposed rulemaking will substantially increase the costs of doing business in the PCH. The slim, if any, profit margins of the PCH will not permit absorbing the costs and these costs must be passed on to the private sector, the general public that is currently paying for PCH services. The projected cost impact on an average size personal care home is hundreds of thousands of dollars annually, per home. See cost impact section below.**

FIXED	ANNUAL	INCOME
$ 145,850.00	**$ 371,642.00**	**$ 720,000.00**

PERCENT OF INCOME; **51.6%**

ANNUAL COST PER RESIDENT **$ 12,387.00**

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PROJECTED COST IMPACT ON 1,786 LICENSED PERSONAL CARE HOMES

$ 260,488,100.00 **$ 663,752,612.00**

Paperwork Requirements: The statement that there is no reasonable alternative to the increased paperwork is not true. From many years of productivity control and improvement experience, **most well run departments were accomplished from the notebook in the hip pocket of the foreman, not the elaborate Total Quality Management Procedure Manuals** we developed and implemented. Once the total burden of these proposed paperwork systems is felt, the next logical step is to introduce computerization and electronic data collection technology, which will permit monitoring via remote location. These processes, which I have also developed and

installed, are definitely cost prohibitive for small and medium sized PCHs, but will give greater "oversight. and supervision" to the regulators. Is that the true objective? I have trouble finding any cost savings or tangible benefits to offset these procedure documentation and records keeping costs.

2600, does not yield the outcome desired as stated in 2600.1. 2600, as presented, runs a great risk of forcing many small and medium homes out of business. Costs will be forced up to the point that only the most affluent dependent adults can affordthe option of placement in the Personal Care Home environment.

RED FLAGS

The PROPOSED RULEMAKING introductory comments **failed to mention several RED FLAGS to the Personal Care Home.**

- In 2600.288, **risk management decisions on who can reside in the home and who can be terminated from the home are removed from the Administrator/Owner and vested in undefined State Agencies and Physicians, none of whom bear any responsibility or liability for outcomes in the home.** Wait until the insurance industry digests the impact of this. If we think insurance is high now, God help us! **Will we be getting immunity for litigation claims as part of this deal?**

- Please define Advocate: **Anyone can present themselves as an advocate, on any subject. In 2600, they have absolute power because they lack any accountability or responsibility.** There are already sufficient legitimate, responsible and qualified advocates identified in 2620. All other advocates, not listed by name in 2600, should be required to register with and be accredited by the Department before they can interject themselves into the decision making, risk management, and cost containment efforts on behalf of the PCH residents.

- **A whole new hidden, unknown and undefined set of requirements and costs are imposed by providing for the "special needs' of residents.** A new term "special needs" has been introduced, from somewhere, in 2600.56(a), impacting staffing requirements, for which the provider must accommodate. What is the definition of "special needs"? Is this the concept of "special needs" as envisioned for severely retarded or handicapped individuals?All of our residents have "special needs" or they would be in independent living.

- **The clarification of Medications Prescribed for Self Administration 2600.181.(e) excludes almost everyone in Personal Care and many in Independent Living.** These guidelines exclude anyone with even Mild Dementia, Severe Arthritis, Vision Impairment, Stroke paralysis, and a number of other conditions quite common in the elderly. This requirement will require an LPN to pass meds on all shifts and be on call overnight for PRN medication assistance. Is this reasonable? It is cost prohibitive for a small and medium sized home.

- **Medication Administration: 2600.186(2) implies the PCH making a diagnosis of drug side effects for altered physical of mental condition.** We are not permitted to make a diagnosis. This is an invitation to disaster and litigation.

- **Medication Administration: 2600.186(3) implies responsibility on the PCH, this is a professional decision we are not qualified to make.** The responsibility for this decision is with the Pharmacy and or Physician, not the PCH. Yet the resident has the right to take any medication (s)he wants, when (s)he wants, and in the quantity (s)he wants. Families

have the right to bring in any outside PRESCRIPTION, OTC or CAM medication, put them it in the resident's room, and the resident can consume them at their option, yet the PCH remains liable for any adverse outcomes. How about a little authority to intervene and manage this risk? This is an invitation to disaster and litigation.

- **Quality Management, the procedures dictated in 2600.27 are only the tip of the ice berg. Many other paragraphs mandate written procedures. A rough estimate of the number of procedures required is one hundred to one hundred-fifty.** This represents roughly one year to a year and a half research, development, testing, and implementing time for management or an outside consultant. Then if the procedures exist, there must me an operations audit, presumably by the department, and to properly audit that number of procedures would take a couple days annually. This would pose an undue burden on the facility and the department alike.

- **Staff training requirements for a small or medium size personal care home exceed the requirements for a CNA**. Universal workers must be skilled in many functional areas, not specialized as a CNA. And the PROPOSED RULEMAKING dictates a whole new set of specialized qualifications that are not required of aides in NH or Hospital environments.

- **Competency testing, presently undefined and lacking standards.**

- **Time limitations and competing priorities, for a provider, preclude an in-depth assessment and response to the PROPOSED RULEMAKING in this rush to enactment framework.** I know this list is not complete. More time will be required to digest the PROPOSED RULEMAKING and make an informed assessment and projection of the total impact on the provider and the resident.

MAGNITUDE COST IMPACT PROJECTIONS

To make a magnitude cost projection, in this situation, is fraught with danger. Information necessary to make a valid analysis, like a final regulation, size of the home, quality of the people involved, existing policies and procedures, et.al., is lacking. **It would take a three week assessment, per home, to develop a reasonably accurate estimate and project outline/plan of action on a project of this size**. Having fair knowledge of the range and scope of work involved, and **projecting the average home at 30 residents** (the total residents in PCH divided by the number of PCHs), **with 12 Universal Care Giver Staff, and an annual income of $ 720,000.00**, I will plunge boldly where the department feared to go.

2600.26. Resident-home contract: information on resident rights. The projected cost to rewrite our contract to incorporate all the new provisions of 2600 is 40 administrator hours at $ 37.50 per hour or **$ 1,500.00** management development time, **$ 2,500.00** for legal review. and 2 hours of management time , $ 75.00 per resident & family to review and activate the new contract x 30 residents for the hypothetical average PCH or **$ 2,250.00**

FIXED	ANNUAL
$ 6,250.00.	

2600.27. Quality management and 2600.264. Policies, plans and procedures of the personal care home. The best magnitude guess on the number of procedures required for the hypothetical average personal care home is 125. I will venture a rough estimate is 15 months of management, administrator, or independent small consultant time to analyze, develop, test, rewrite and implement this number of procedures as specified in this proposed rulemaking. At a conservative estimate of $ 2,000.00 per week cost for this project development for 65 weeks, that is a **$130,000.00** up front, fixed cost. Additionally there would be a fixed cost for iniitial staff training time, estimated two weeks per staff (estimate 12 total staff for a 30 resident PCH X an estimated average of $400.00 per week cost to the PCH X 2 weeks [12 x 2 x $400.00]) of **$ 9,600.00**, required and oversight and supervision of the implementation and learning process. Without the analysis I am unable to give a reasonably accurate estimate of staff time for data entry and management time for data review on a weekly basis, as a rough guess, lets use 10 minutes per resident per day, or 5 hours total data entry, and 30 minutes a day management review for compliance. That equates to $ 50.00 data entry costs per day expense to the PCH and $ 18.75 management costs per day, a total of $ 68.75 per day or **$25,100.00**. Then there would need to be an annual maintenance and update process estimated at 2 to 3 weeks, for an annual ongoing cost of **$5,000.00.**

FIXED	ANNUAL
$ 139,600.00	**$ 30,100.00**

I have trouble finding any cost savings or tangible benefits to offset these procedure documentation and records keeping costs. Please help me out here so I can do a better cost/benefit analysis.

2600.53. Staff titles and qualifications for administrators, The impact of this change in

background and qualifications will reduce the number of people who can qualify as Personal Care Home Administrators. The simple law of Supply and Demand shows that with fewer people in the pool that can become an Administrator, the higher wages they can demand and receive. The approximate compensation for an Administrator now is $ 60,000.00-75,000.00 per year, to the home. It is reasonable to project an ongoing $ 10,000.00-15,000.00 per year increase in home expenses to hire an administrator. I will use a figure of **$ 12,500.00** for my cost/benefit projections.

	FIXED	ANNUAL
		$ 12,500.00

2600.54. Staff titles and qualifications for direct care staff. You are requiring they receive training and be qualified in more areas than the typical CAN job description requires. The simple law of Supply and Demand shows that with fewer people in the pool that can become a personal care home care giver, and have more training and higher skill levels, the higher wages they can demand and receive. The approximate compensation for a care giver now is $ 10.00 per hour. It is reasonable to project an ongoing increase of $ 2.00 per hour expenses to the home to hire and retain a care giver. This equates to an increase of payroll costs of $ 4,160.00 , per care giver per year. With the theoretical home of 30 residents and 12 care givers used in the magnitude cost benefit analysis, this added payroll cost represents an added cost to the home of **$ 49,920.00** per year.

	FIXED	ANNUAL
		$ 49,920.00

2600.56. Staff Ratios. Based on the undefined requirements of the **'special needs'** requirements, I have no way to estimate the cost impact on the average home. **It could range from no impact to an astronomical number.**

2600.57. Administrator training and orientation. This requirement for 24 hours of annual training for the administrator is a 4 fold increase over current requirements. This equates to roughly 4 days of administrator's time per year. Estimating administrator's daily payroll costs to the business are about $300.00. Travel and meals for time getting to and from the training location, estimate an average of $ 50.00. Estimated average cost of a day's training program, $ 100.00. That equates to a daily cost of $ 450.00., current administrator training costs. As in the proposed rulemaking, the cost for 4 says will be $ 1,800.00, a net increased cost of **$ 1,350.00** annually.

	FIXED	ANNUAL
		$ 1,350.00

2600.58. Staff training and orientation.
The time required for a trainer and new hire to complete all the topics listed in (a) and (c) is estimated to take four weeks. With the hypothetical home of 30 residents and 12 universal care giver staff used for other projections, you would have to have a trainer full time, doing nothing but training, testing and certifying of new hires. While the administrator theoretically can do this, that is not a practical alternative as the administrator has other duties to perform, like running the

business. The trainer will have to be experienced and highly qualified, perhaps a nurse will be required for this position. The 12 universal care staff have a turnover rate of around 80% per year, approximately 8 fully qualified employees must be replaced each year. To get a fully qualified new hire, you have to put 3 in training, that is about 24 per year. Projecting a training class starting each month, and a small and medium size home can not wait an average of 6 weeks to replace a care giver that leaves, nor can you afford to hire extra people to cover such losses. Doing a rough magnitude cost/benefit analysis to satisfy these training requirements before the new hire actually gets to meet the residents:
Annual compensation cost of a Trainer **$ 45,000.00**.
Annual compensation cost of new hire trainees ($ 12.00 per hour, average 3 weeks per trainee, estimated 24 people entering training per year) equals **$ 34,560.00**, on going.
This is an annual investment (cost) of **$ 79,560.00** to the home before new hires can provide unsupervised direct resident care in any particular area.

FIXED	**ANNUAL**
	$ 79,560.00

(e) The annual number of non OJT mandated training hours for Personal Care Givers is 12. . This equates to roughly 2 days of administrator's time per year. Estimating a care givers daily compensation costs to the business are about $80.00. Travel and meals for time getting to and from the training location, estimate an average of $ 50.00. Estimated average cost of a day's training program, $ 100.00. That equates to a daily cost of $ 230.00. The cost for 2 days for 8 staff, or 16 staff training days will be **$ 3,680.00**. The benefit of these mandated training hours is directly dependent on the content of the training program. I have been to some where they should have paid me to attend.

FIXED	**ANNUAL**
	$ 3,680.00

2600.59. Staff Training Plan. For a staff training plan to be of any value, it would have to be updated at least quarterly, an undue cost and time burden on small and medium size personal care homes, and removing hours of care from the residents. A order of magnitude cost calculation, per planning cycle, for the hypothetical average PCH home of 30 residents and 12 FT universal care giver staff projects 4.0 management hours per staff for diagnostic tool design, data collection, interviews, analysis and plan preparation, and 2.5 hours per universal care giver to complete the diagnostic, information and feedback interviews, and input into the plan preparation to develop and maintain this plan annually.

• 48 management hours at $ 37.50 per hour:	$ 1,800.00
• 48 universal care giver hours at $ 12.00 per hour:	576.00
Total costs to develop the staff training plan per cycle:	$ 2,376.00

If updated quarterly, the annualized cost would be: **$ 9,504.00**

FIXED	**ANNUAL**
	$ 9,504.00

2600.60. Individual Staff Training Plan. With ongoing resident population mix changes and

staff turnover, individual staff training plans would have updated at least quarterly, an undue cost and time burden on small and medium size personal care homes, and removing hours of care from the residents. A order of magnitude cost calculation, per planning cycle, for the hypothetical average PCH home of 30 residents and 12 FT universal care giver staff projects 3.0 management hours per staff for diagnostic tool design, data collection, interviews, analysis and plan preparation, and 2 hours per universal care giver to complete the diagnostic, information and feedback interviews, and input into the plan preparation to develop and maintain this plan annually.

- 36 management hours at $ 37.50 per hour: $ 1,350.00
- 24 universal care giver hours at $ 12.00 per hour: 288.00

Total costs to develop the staff training plan per cycle: $ 1,638.00

If updated quarterly, the annualized cost would be: **$ 6,552.00**

FIXED **ANNUAL**
$ 6,552.00

2600.181. (e) Self Administration. is unreasonable and would exclude most PCH residents, in fact independent living residents, from self administration of their medications if they have mild dementia, poor eye sight, arthritis, or many other common ailments of the elderly. This restriction will force each PCH to hire three full time medications staff that do comply with the provisions of 2600.181(b). These persons do not usually participate in the other tasks required in giving ADL assistance. This is a potential significant cost increase, estimated at ($17.50 per hour x 120 hours/week x 52 weeks per year) **$ 109,200.00** to the small and medium sized PCH.

FIXED **ANNUAL**
$ 109,200.00

2600.201. Safe management techniques. To properly train anyone in these coping strategies requires a basic alteration in the individual's mind set. Under optimum conditions, that is a total controlled environment, it takes 3 weeks to begin to achieve a functional change in an individual's mind set.

Projecting a magnitude cost for the training and follow-up:
Initial training, Annual:

- (15 days per staff (15) X $ 12.00 per hour X 8 hours a day) $ 21,600.00
- (1/2 half trainer, same time @ 17.50 per hour) 15,750.00

Total initial costs per staff: $ 37,350.00

Maintenance training, Annual:

- 12 staff X 52 hours per year X $ 12.00 per hour: $ 7,488.00
- trainer X 52 hours per year/staff (12) X $17.50 per hour: 10,920.00

Annual maintenance costs per staff: $ 18,408.00

FIXED **ANNUAL**
$ 55,758.00

2600.226. Development of the support plan. The support plan, as described, requires much management involvement, coordination and commensurate costs.

Cost projections:

•	Management time per support plan (8 hours @ $ 37.50):	$ 300.00
•	Average 1.5 Support Plans required per resident per year based on 30 residents in the hypothetical average home (45) gives a projected annualized cost of:	**$ 13,500.00**

FIXED	**ANNUAL**
	$ 13,500.00

2600.288. Notification of termination. Risk management decisions on who can reside in the home and who can be terminated from the home are removed from the Administrator/Owner and vested in undefined State Agencies and Physicians, none of whom bear any responsibility or liability for outcomes in the home. Wait until the insurance industry digests the impact of this. If we think insurance is high now, God help us! Will we be getting immunity for litigation claims as part of this deal? **I have no way to estimate the cost impact on the average home, It could be an astronomical number.**

CURSORY OVERVIEW MAGNITUDE COST IMPACT

FIXED	**ANNUAL**	**INCOME**
$ 145,850.00	**$ 371,642.00**	**$ 720,000.00**
PERCENT OF INCOME;	**51.6%**	
ANNUAL COST PER RESIDENT	**$ 12,387.00**	
MONTHLY COST PER RESIDENT	**$ 1,032.00**	

PROJECTED COST IMPACT ON 1,786 LICENSED PERSONAL CARE HOMES

$ 260,488,100.00	**$ 663,752,612.00**

GENERAL COMMENTS:

There has been no information presented to explain the perceived necessity to rewrite regulation 2620 into 2600. We may or may not like the present 2620 Regulation. There are parts that in my opinion should be amended to reflect current knowledge, experience and conditions. 2620 has provided sufficient oversight for most facilities to provide quality care to dependent elderly, throughout Pennsylvania. In fact, from the provider's point of view, and for that matter from an objective assessment, 2620 as is, is far superior to the PROPOSED RULEMAKING 2600, as proposed. Why do you want to throw out the baby with the bath water?

What is the desired outcome of the PROPOSED RULEMAKING:

- **to deny personal care home services, namely a safe, humane, comfortable and supportive residential setting for dependent adults who require assistance beyond the basic necessities of food and shelter but who do not need hospitalization or skilled or intermediate nursing care, to all but the most affluent of the dependent adults?**

- **to force between 30 and 50% of Personal Care Home owners out of business? Many of these homes are family owned businesses in which the family has their total wealth and future at risk. To force them to close their doors and into liquidation/foreclosure is unworthy of the Department.**

- **to mandate that the Personal Care Home industry be forced from a social model to a medical model?**

- **to force large enterprise management methods and controls on small and medium, Mom and Pop, Personal Care Homes?**

- **to remove dependent elderly from their unique local community environment where they find the encouragement and assistance they need to develop and maintain maximum independence and self-determination, and concentrate them in large, sterile, regimented, institutional, quasi-medical compound?**

What are the objectives, Bench Marks, performance criteria, measurable variables, et. al., of the PROPOSED RULEMAKING? This is the keystone of the Quality Management method, and this information is noticeably absent. We see the strong influence of the Quality Management philosophy, a concept, that if adopted, will quickly overload the abilities of small and medium size facilities to comply and be in permanent non compliance.

2600.1 Purpose sets forth a "clear vision" of what the PROPOSED RULEMAKING 2600 is intended to accomplish. However, lacking clear measurable goals against which to measure outcomes, 2600 will be interpreted differently by the various stakeholders. Being as objective

as possible, from a provider's perspective, 2600 is not a balanced regulation. It gives all the rights and authority to the resident. state agencies and doctors, without commensurate responsibility or liability, and gives all the responsibility and liability to the provider, without commensurate rights or authority.

There was no in-depth, realistic of comprehensive cost benefit analysis for this proposed rulemaking. The pitiful efforts put forth are an insult to all providers, an affront to the regulatory decision makers and unworthy of the department, in short, a disgrace. Someone failed to generate cost input data, in fact they even failed to identify all areas where costs to the provider or department would be incurred. It must be remembered, added costs will have to be passed onto the resident and their designated representatives. The cost benefits analysis presented here would receive a failing grade in high school business 101 if submitted as a class project. **In my 30 years of consulting, have never seen such a pathetic cost benefit analysis, even as a first working draft. I would fire any staff and project manager that provided such a shoddy presentation, staff work, and blatant misrepresentation of the impact on the dependent elderly is unacceptable.**

PROPOSED QUALITY MANAGEMENT

Quality Management, the procedures dictated in 2600.27 are only the tip of the ice berg. Many other paragraphs mandate written procedures. A rough estimate of the number of procedures required is one hundred to one hundred-fifty. This represents roughly one year to a year and a half research, design, development, testing, and implementing time for management or an outside consultant. Then if the procedures exist, there must me an operations audit, presumably by the department. **To properly audit that number of procedures could take a week, annually. This would pose an undue burden on the facility and the department alike.**

Quality Management sounds good, but it is **an exercise that quickly gets out of control.** It feeds on itself and becomes all consuming. You are a slave to the paperwork audit trail, and quality output actually suffers. I have had years of designing and implementing these programs in far more simple environments, manufacturing and assembly lines, and they create nightmares in those highly structured environments. Total quality management program minimum requirements call for:

- specific measurable goal definition.
- performance standards.
- monitoring requirements.
- evaluation standards.
- assessment criteria.
- corrective follow up action plans.
- follow-up procedures.
- effectiveness assessment.

Everything needs to be documented in procedures manuals. These procedures are to be detailed, to include variations of the procedure and exceptions to the rules. This logically leads to Statistical Quality Control (SQC) so a Continuos Improvement Program (CIP) can be implemented to bring about Zero Defects (ZD), a logical program goal. Similarly for inventory, cost control and scheduling, a Just In Time (JIT) program becomes logical for control of all consumable items, to include medication. Are these logical extensions, based on TQM experience, appropriate for Personal Care Homes? Not in our experience. We do not have time to take away from resident care and services and to have staff increases to perform these administrative tasks would not be possible if we are to remain in budget. The paper work burden in developing and maintaining these volumes of procedures are a very heavy burden to impose on any organization, especially the small or medium size Personal Care Home.

I have trouble finding any REDEEMING VALUE, cost savings or tangible benefits to offset these procedure documentation and records keeping costs..

PARAGRAPH SPECIFIC COMMENTS AND OBSERVATIONS

26000.1 Purpose:

The purpose, as stated in 2600.1 appears to be a good purpose statement. Unfortunately, the totality of 2600 does not support the purpose as defined.

Unfortunately, the impact of implementing 2600, as written, will change the basic nature of the personal care home from a social environment model to a medical institution model. Added costs and requirements could force small and medium size personal care homes out of the market. 2600, as written, could deny personal care home services, namely a safe, humane, comfortable and supportive residential setting for dependent adults who require assistance beyond the basic necessities of food and shelter but who do not need hospitalization or skilled or intermediate nursing care, to all but the most affluent of the dependent adults. This could remove dependent elderly from the local community environment that provides the encouragement and assistance they need to develop and maintain maximum independence and self-determination, and concentrate them in large, structured, institutional, quasi-medical environment.

2600.3 Inspections and licenses or certificates of compliance

(a). as reads "..... will conduct an on-site inspection ....." should read "..... will conduct an announced on-site inspection .....".

conflicts with 2600.11(c).

2600.4 Definitions:

2600 definitions are an improvement over the March draft. There still remains a couple terms, that have significant impact on implementation and execution of 2600 that must be defined.

ADD:

Advocate -- Are the Advocates listed in 2600.5. Access Requirements?

Assault: What constitutes an assault, particularly a reportable assault under 2600.16.(a).(9). There are multiple levels of physical assault, such as: slapping, pushing, shoving, banging chairs, hitting, biting, scratching, punching, kicking, etc. Where do we draw the line?

Special Needs: (I have no idea what is intended by 2600. I am unable to offer substitute language without clarification.)

Fire Safety Expert: (Include this training in the Administrator's Training Course and have all Administrators tasked as the fire safety expert in their facility? You could give a one year grace period for current administrators to receive this training and certification, sponsored by the DPW

PCH Regional Offices every six weeks during that year grace period)?

2600.16 Reportable Incidents.

(a) (9) As reads "Any physical assault ....." should read "Any significant or willful physical assault with the intent to inflict injury or that does cause injury to another .....".I find it hard to believe the department has time to worry about reactive slaps, and minor pushes over chair location, seating intrusions, or child like responses to petty misunderstandings and arguments that are an occasional part of the daily interactions of living in any communal living environment, like a family.

2600.26 Resident/home contract; information on resident rights.

(d) This requirement is unreasonable. It requires a commitment on resources beyond the control of the home. Recommend this section read "The basic, in-house provided needs, addressed in the resident's support plan shall be available to the resident 365 days a year. Needs addressed in the resident's support plan provided by outside resources are subject to their availability and can not be guaranteed to be available 365 days a year."

* See MAGNITUDE COST IMPACT PROJECTIONS, above.

2600.27 -- Quality management.

(b)The specific items mentioned in (b) do not include many other procedures mandated in 2600. The agency should not become involved in the details of managing the provider's operations. Mandated management systems without agency funding, responsibility, or accountability is clearly an unacceptable. It is an inappropriate intrusion into management responsibility. Implementing Total Quality Management systems imposes an undue reporting and documentation requirement that, even in the best of conditions, can not be meaningfully maintained and accurate. Too much time would be taken away from resident care and devoted to questionable or pencil qualification documentation.

(b)(5) -- remove mandate for councils. The quality of councils is directly dependent upon the qualifications of the chair, and I doubt if small and medium size facilities can afford to provide an adequately qualified and educated chair. Lacking these qualified chairs, councils tend to degenerate to bitching sessions and finger pointing exercises. **The provider should determine if they elect to use this tool in an attempt to improve the quality of services and care in their facility. Its use should not be dictated by the agency.** A more effective and affordable alternative is a scheduled weekly/monthly open door policy to talk with the administrator or designee by the resident, Power of Attorney, or Designated Representative. Simply being open and available during family visiting time provides a wealth of vital feedback information.

* See MAGNITUDE COST IMPACT PROJECTIONS, above.

RESIDENT RIGHTS

2600.41 -- Notification of rights and complaint procedures

(a). What a negative way to start a residency.

Talk about highlighting the negative! I understand there are isolated cases of abuse and poor management/care practices in the industry, but the tone of this presentation makes abusive situations the norm. It still says the provider is a slime ball and only the advocates are looking out for the best interests of the resident. If the department believes that is the case, simply close all PCH facilities now.

A one (1) paragraph explanation as in 2620.61 is sufficient.

Recommend this section be deleted or alternatively the one paragraph, 2620.61(8), be substituted.

2600.42. Specific rights.

(e) as reads ".....shall have private access....", change to read ".....shall have reasonable private access....."

(i) as reads "....shall receive assistance in accessing medical...." change to read "....shall receive assistance in informing their designated representative of the need for medical.....".

(j) as reads ".....shall receive assistance in attaining clean....." change to read ".....shall receive assistance in selecting, from family provided or donated clothing, clean....."

(l) add "except for contra ban items, as defined in the home rules, such as tobacco, illegal drugs, weapons, fire generation devices, pornographic materials, etc."

(n) as reads ".....right to request and receive assistance.....", change to read ".....right to request and be directed to resources providing assistance.....". To expect the home to actively search for another place for a resident's voluntary relocation is unreasonable. That is like asking Super Fresh to call my shopping list to ACME or Giant to be filled. The provider can not become a case manager for the resident, that is a clear cut conflict of interests.

(u) ADD:
(4) The Administrator or Designee Certifies on the Personal Care Home Standardized Screening Instrument - Part 1, that the resident's needs cannot be met or Exclusionary Factors apply and is not appropriate for this personal care home.
(5) Disruptive behavior or altered mental status that disturbs tranquil home environment of other residents.

(y) Delete, duplication of 2600.20.(b).(2)

(z) Delete, a Physician orders the residents medications, we are not in the diagnosis and

prescribing cycle.

While we are engaged in this elaboration of specific rights, we might add:

(y) The resident has the right to refuse his medications.

(z) The resident has the right to refuse to eat.

(aa) The resident has the right to refuse to take fluids.

(ab) The resident has the right to disrobe when and where they please.

(ac) The resident has the right to tell the staff to go pound salt without fear of retribution or discipline.

(ad) The resident has the right to pick his nose at the dinner table.

(ae) The resident has the right to spit on the floor.

(af) The resident has the right to refuse personal cleanliness, health and hygiene activities at the home.

(ag) The resident has the right to use vulgar and profane language and gestures at any time.

and the list goes on.

There is nothing wrong with the current 2620.31 statement of resident rights. Some of the items contained in 2600.42 are already addressed in other sections of this draft regulation, for example access to resident information, non-discrimination policies, search and seizure, et. al..

2600.43. Prohibition against deprivation of rights -- DELETE, This section is not needed. These provisions are incorporated throughout 2600, and established principles of law.

2600.53 Staff titles and qualifications for administrators.

* See MAGNITUDE COST IMPACT PROJECTIONS, above.

2600.54 Staff titles and qualifications for direct care staff

(2) - Desirable qualification for staff, but not realistic. We try to hire over 21 with HS or GED, but the labor pool does not always permit achieving these goals. Finding qualified staff, using current minimum qualifications, is hard enough without further reduction of the size of the available labor pool, in fact, 3 of the last 9 people I interviewed did not meet this GED criteria, but two of these three had many years experience in the health care and assisted living career fields. Many of the people now seeking work in the Personal Care/Assisted Living field in this

area are coming from sewing mills that have been forced to shut down. Many of these people are hard working, responsible, mature, caring individuals that do not have their HS Diploma or GED, and have been out of school more than 20 years. What is your option by not letting them seek work in this field, to put them on Public Assistance? There is no evidence that shows someone with a GED can deliver better care as a Universal Care Giver than someone that does not have that piece of paper. What is more important is the nuturing heart, quality, maturity and motivation of the individual.

* See MAGNITUDE COST IMPACT PROJECTIONS, above.

2600.56 -- Staff ratios .

(a). A definition of "Special Needs" is required. All or our residents have special needs or they would not be here. If you are using this term in the sense of MH/MR "Special Needs", that is not the nature and scope of our business. People with those "Special Needs" belong in facilities that can service their needs. Lacking basic information, we are unable to guestimate the cost impact on providers and residents from this RED FLAG. There is no way to know what staffing impact this will have.

2600.57 Administrator training and orientation

(b).(1) as reads "Fire prevention and emergency planning" change to read "Fire Safety Expert Certification".

* See MAGNITUDE COST IMPACT PROJECTIONS, above.

2600.58. Staff training and orientation.

This entire section, as written, is unacceptable and unrealistic for small and medium size Personal Care Homes that use universal care giver staff. **We do not have the luxury of putting someone through a month long training program and testing before they can provide unsupervised direct resident care in any particular area.** That is a luxury that even the largest of homes can not afford, let alone a small or medium size personal care home.

* See MAGNITUDE COST IMPACT PROJECTIONS, above.

We believe in education and upgrading qualifications, however, we have to continue to provide care and service for our dependent elderly residents. A more reasonable training and orientation requirement before a new hire can perform direct resident care is necessary. A more realistic requirement would be 16 shadowing hours with an experienced and qualified care giver before providing resident care, is doable. Having a huge up front investment cost before a new hire faces the test of resident care is unrealistic and unacceptable. A six month period to accomplish this mandated training, as in 2620 is more reasonable, and more effective training. The new hire will remember more of the training materials, and have the advantage of practical reinforcement during the training process. Also, more training topics have been added to the list, and it may

actually take longer to complete the mandated training.

(i) delete the restriction "in personal care homes serving 20 or fewer residents". Fire safety training is far too important a safety consideration to wait for an indefinite period for a fire safety expert to be available to conduct this training. I agree with the current requirement to have this fire safety training completed within 30 days of hiring, but it is just not practical to have an outside fire safety expert come in to train one or two people, especially when the main part of the training is the in house specific requirements, design, and features..

(j) DELETE as reads "in personal care homes serving 20 or fewer residents"

2600.59 Staff Training Plan

This is unrealistic and not cost justified in small and medium size care facilities. The high staff turnover ratio makes the plan obsolete as soon as it is completed, thus a waste of time. I have developed comprehensive training plans for large and small organizations, and they are difficult to develop and maintain. I know the theory of Total Quality Management, but it must be modified to attain what is possible, not dictated by unrealistic and impossible paper work maintenance systems. Resident population care and current staff training requirements change with each resident's arrival or departure. Individual resident needs requirements are not constant as the maintenance of a production line or and accounts receivable system. Training requirements for universal workers is an ongoing change process.

* See MAGNITUDE COST IMPACT PROJECTIONS, above.

2600.60 Individual Staff Training Plan

This is no need for an annual written individual staff-training plan, appropriate to each individual's skill level with a specific plan to identify the subject areas and the training resources needed to satisfy that individual need. Resident population care and current staff training requirements change with each resident's arrival or departure. Individual resident needs requirements are not constant as the maintenance of a production line or and accounts receivable system. Training requirements for universal workers is an ongoing change process.

* See MAGNITUDE COST IMPACT PROJECTIONS, above.

Time requirements to write and keep updated meaningful individual annual staff training plans presents a heavy administrative burden on small and medium size facilities. We do not have, nor can we afford, the luxury of a full time administrative training professional.

2600.85. Sanitation.

(f) DELETE -- This is an area of responsibility of the Zoning Authority. It is an unnecessary requirement. If such certification is not made by the SEO, permits are not issued.

2600.98. Indoor activity space.

(f) as reads "If more than one living room or lounge area is available in the home, the largest shall have a working television.", should read "The television viewing room will be sufficiently large so residents can enjoy watching television in comfort."

2600.100. Exterior conditions.

(b) DELETE-- as reads "recreational areas", surely you can not expect the home to remove all snow from the total property.

2600.101. Resident bedrooms,

(r) DELETE -- as reads "The resident shall determine what type of chair is comfortable." This is an unrealistic requirement to place on the provider. There is never any guarantee that what a resident finds comfortable today he will find comfortable tomorrow. Do you expect the provider to pay for a game of musical chairs? We recently had a resident that went through 4 different chair styles, currently available in the house, before he selected the one he wanted, and it was not appropriate for his condition. He wanted a deep, rocking recliner, which he could not get out of. He needed a straight, high back wing chair so he could be a one person, moderate assist transfer. The home should have input as to the furniture used by the resident as part of the care plan, high bed vs. low bed, recliner vs. straight back chair, etc.

2600.102 Bathrooms

(f) DELETE-- "soap", this is a personal choice item and should be the individual's responsibility.

(g) The home should not be responsible for providing personal grooming items. Those are items of personal choice and are the responsibility of the resident, Power of Attorney or Designated Representatives to provide. If the responsible parties do not or can not provide personal grooming items, these items can be provided by the home and the cost billed to the resident, as addressed in the resident agreement or home rules.

(i) as reads "in all of the bathrooms." should read "in all of the community use bathrooms."

2600.103. Kitchen areas.

(e) as reads "weekly" change to "quarterly". Our replenishment plan is based on economic considerations, twice a week for some items, weekly for others, bi-weekly for another group of products, and monthly for others. a A weekly inventory of all food items is an unwarranted intrusion into cost management decisions.

2600.105. Laundry.

(g) as reads "from all clothes." change to read "from all clothes dryer filters.' I don't think a little

lint on M. Z's. skirt is a fire hazard that will cause her to spontaneously combust..

2600.107. Internal and external disasters.

(b).(5). Is this practical? What do we do about medications prescribed for a specific number of days, like antibiotic? What about shelf life on medications. What about medications that can be changed and or discontinued. This can be an added cost to the resident.

2600.126. Furnaces.

(b) DELETE the first sentence and replace with "A professional furnace cleaning company or trained maintenance staff persons shall clean the furnace at least annually. ....."

2600.132 Fire Drills

(f) Unrealistic requirement. If you are moving people to a fire safe area, through a horizontal exit, there frequently is only one passage through the fire wall. There is no way to use an alternate exit route short of taking them outside then bring them back into another part of the building, and that does not make sense.

2600.141. Resident health exam and medical records.

Is the provider going to be cited when Doctors do not provide listed information, such as (a)(6)immunization history, (a)(7)contradicted medications, (a)(7)side effects, et. al.

(a)(8) DELETE-- This information should be on Doctor orders, not the medical evaluation.
(a)(9) DELETE-- Personal Care Homes do not perform medical procedures which require written consent.

(a)(10) DELETE -- While I would like to have this information, this provision violates the resident's confidentiality rights.

2600.161 Nutrition

(g) as reads ""available and offered to the resident at least every 2 hours." change to "available to the resident upon request."

2600.181 Self Administration

(a) as reads "..... resident the medication at the prescribed times." change to " ..... resident the medication as prescribed by the physician."

(e) The criteria set forth for self-administration precludes most personal care home residents, in fact many people in independent or at home living environment fail the criteria for self-administration. Most people with even mild dementia, moderate to severe arthritis, stroke, or

vision problems, poor nutrition, depression, to name a few conditions fail to satisfy the listed criteria. These restrictions will force each PCH to hire three full time medications staff that do comply with the provisions of 2600.181(b). These persons do not usually participate in the other tasks required in giving ADL assistance. This is a potential significant cost increase, estimated at ($12.00 per hour x 120 hours/week x 52 weeks per year) $ 75,000.00 per year to the small and medium sized PCH.

26000.182. Storage and disposition of medications and medical supplies.

(b) and (h) are redundant, recommend (b) be deleted and (h) substituted in its place.

2600.186 Medication records

(b)(2) This is an unrealistic requirement for the provider. Where do we get information on all possible side effects for OTC and CAM when the pharmacy refuses to send information on possible side effects of prescription medications? Why do we need to have all this supporting documentation when we can not diagnose or determine that a specific medication is causing an altered physical or mental state? This is an expertise beyond the realm of the PCH.

(b).(3). An inappropriate requirement for the PCH, this is a check to be made by specific qualified professionals like Physicians and Pharmacists. For the provider to make this check would be a quantum leap in liability with disastrous effects on insurance rates..

2600.201. Safe management techniques.

These are MH/MR and Secure Ward intervention strategies. They are not required in most PCH environments unless there are real changes where we are forcecd into mandated admission and retention residency requirements, to include 'assigned" or 'allocated' MH/MR patients by some undefined agency. Are people who require these intervention strategies appropriate for personal care, or do they belong in specialized facilities? The potential liability and ensuing litigation prospects is overwhelming!

* See MAGNITUDE COST IMPACT PROJECTIONS, above.

Adding this specialized skill set may be cost prohibitive and it will increase compensation levels demanded. This is a skill set that most CNA's do not have, they have a "lip service" orientation, but they have not assimilated the changes in their mind set.

Is this really necessary? If so, why is it not listed with other mandated training?

2600.223. Description of services.

(b) Is this really necessary? Another hidden documentation requirement for Quality Management. It would help if the department had pulled all of these requirements together into one location, or would that more clearly reveal the magnitude of the impact of the procedure and documentation

requirement? As an exercise, just try to flow chart this requirement to get an appreciation of the magnitude of impact on time from this little sentence. The cost benefit analysis for this is included in the total documentation projection of 6 months of full time, uninterrupted effort by the administrator or independent consultant.

2600.225 Initial intake assessment and the annual assessment

(b) Austin Powers faces Mini Me, providers now face Mini MDS (Minimum Data Sets, the bane of Nursing Homes). Both scenarios bring drama and problems, and litigious probabilities in the real world.

(d)(2) as reads " ..... the review shall be completed and updated on the current version." change to " ..... a new updated assessment shall be completed and put into the resident's record." Pen and ink changes to official records can be dangerous and subject to abuse. From a legal point of view, it could prove disastrous in an investigation or trial.

2600.226 Development of the support plan

This whole requirement is a massive time consumer, taking time away from the primary task of the small and medium care provider. There is an expression in industry, "It is an example of the suites making work for us and providing job security for themselves."

(b) Who has final decision authority on support plans contents? The provider or a committee? The provider shoulders the responsibility and liability, not the committee. Most of the listed interested parties have no direct responsibility or liability, and in many cases no realistic understanding of what the problem, condition or situation really is, or what assistance is available or possible

* See MAGNITUDE COST IMPACT PROJECTIONS, above.

2600.228 Notification of termination

(b) as reads "as certified by a physician." change to read "as determined by the administrator." The administrator has the responsibility of risk management in their facility, not some physician, who may or may not know the facility and or the resident involved. It is unacceptable to shift the decision making responsibility for such risk management to an individual who has no responsibility or liability for such decisions. **I have no way of projecting the impact of this RED FLAG regulatory directive on insurance costs, but it will be a magnitude change.**

* See MAGNITUDE COST IMPACT PROJECTIONS, above.

(h).(5) DELETE -- There is no public funding to pay for personal care in Pennsylvania..

2600.251 as reads "Classifications of violations" change to "Compliance discrepancies".

Replace section with:

There are two classifications of compliance discrepancies: Violations and Administrative Errors.

(a) Classification of violations: Copy in current 2600.31

(b) Administrative errors, minor administrative violations, which have no adverse affect upon the health, safety or well being of a resident. Administrative error compliance discrepancies may be corrected on the spot or documented as corrected within 24 hours and have no adverse affect on the facilities ability to obtain a full and regular license on the renewal date, if corrected with in the approved time period.

2600.262. Penalties.

ADD: (k). There shall be no penalties for administrative errors corrected within 24 hours of discovery and have no adverse effect upon the health, safety or well being of the residents.

2600.263. Revocation or nonrenewable of licenses.

ADD: (h). If the provider has corrected all known and cited deficiencies cited by the department, prior to the expiration of the current license, and is in full compliance at the time of license renewal, the department will issue the provider a full license.

2600.264. Policies, plans and procedures of the personal care home.

This is a restatement of the Quality Management requirement. The department should not become involved in the details of managing the provider's operations. Mandated management systems without agency, funding, responsibility, or accountability is clearly an insertion by over eager advocacy groups. It is an inappropriate intrusion into management responsibility. Implementing Total Quality Management systems imposes an undue reporting and documentation requirement that, even in the best of conditions, can not be meaningfully maintained and accurate. Too much time would be taken away from resident care and devoted to questionable or pencil qualification documentation.

Nov. 1-02

Original: 2294

I'm writing to you because of the new regulations your want to put on Personal Care Homes.

My husband Franklin Engle is in a Personal Care Home not a Nursing home. He resides at Colonial Garden Personal Care home located at Butler, Pa. It is certified by the V.A. I think that says alot.

My husband has made his home there for five years. He is doing very well under the care of Linda Mueller the owner of the home and the wonderful help and care of her staff. The home is very clean, comfortable, very well managed. My husband is well taken care of, I'm very much satisfied as I want the best for him.

If the new regulations go through alot of small homes will have to close. Welfare would have to help residents pay more for nursing home care and it would be very upsetting for residents to adjust, meaning more hospital stays to.

Please stop these new regulations from going through.

Sincerely
Betty Engle
R.D.# 7 Box 150
Mt. Pleasent, Pa.
15666

#14-475 586

RECEIVED
OFFICE OF LICENSING
QUALITY MANAGEMENT

Original: 2294

#14-475 (588)

Dear Department of Public Welfare,

I am an employee of /Oyears at one personal care home. A home that can truly be called a home. A home for our residents, their families, community members and lastly the other employees and myself. This home was built by the owner's family, one of which resides here. It has an environment that thrives on "family". Why do you want to change what has been built here? Why should this be a nursing facility? The people here need help with the tasks of daily living; they enjoy their time interacting with the others. They would not function in a "facility"; they truly love the environment here, the social time, the holidays and the everyday events of living. The people in our home are comfortable here; they "live" here.

Our administrator/owner has funded any training that we obtain throughout the year. They rely on their income for this sort of training. We have several SSI recipients living in our home. Will you be raising the SSI amounts so the cost will remain a benefit for us? Or perhaps your department will be funding these training hours? Training can be beneficial, and I would be willing, but 24 hours seems unnecessary and out of reach.

As an employee and caretaker to many residents I cannot imagine the devastation in closing the doors of so many personal care homes in our area. The people that I care for truly love it here. These regulations that I have learned of seem only to be benefiting some other government department, certainly not the elderly residents who deserve to live comfortable in a warm loving environment, these are the people who have put us here, these are the people who worked hard in this world and have retired, these are the people who deserve a helping hand. It seems as though you want a medical facility, why would you do that to someone who only needs the help of a daily task? Why would you take away my income and my family security?

Thank you for your time.

Karen Eltkin
R.R. 1 Box 340I Braun Road
Rural Valley, PA. 16249

Copies of this letter are being forwarded to:
State Public Health and Welfare Comm.
Independent Regulatory Review
House Health and Human Services Comm.

14-475 (695)

November 1, 2002

Department of Public Welfare
Teleta Nevius
Room 316 - Office of Licensing and Regulatory Management
Health and Welfare Building
POBox 2675
Harrisburg, PA 17120

Ms. Nevius;

As the Administrator of Pocono Lutheran Village, an assisted living facility in East Stroudsburg, I am concerned regarding proposed changes in the regulations and expectations in our industry. I have followed, with interest, the attempt to build increased accountability and responsibility into our care delivery by the DPW, and I applaud this effort. However, it is imperative that the expectations be both realistic and achievable, with the ultimate focus on how what we do will affect our residents.

Please review the attached suggestions. If at any time, you are seeking committed and sincere membership on any committees regarding Personal Care regulations, please know I would happily and enthusiastically serve and work hard on this process.

Thank you for the opportunity to respond.

Sincerely yours,

Punki Rusiloski

Madeline "Punki" Rusiloski, RN, Administrator
Director of Residential Services

2600.60. INDIVIDUAL STAFF TRAINING PLAN

A written individual staff training plan for each employee, appropriate to that employee's skill level, shall be developed annually with input from both the employee and the employee's supervisor. The individual training plan shall identify the subject areas and potential resources for training which meet the requirements for the employee's position and which relate to the employee's skill level and interest.

COMMENT: All staff need to be trained to meet minimally the requirements of their job Description. All other training will be as required in 2600.58

RECOMMENDATION: All staff will attend required inservice training sessions as developed by the personal care home.

2600.105. LAUNDRY

(g) To reduce the risks of fire hazards, the home shall ensure all lint is removed from all clothes.

COMMENT: Is the intent that lint shall be removed from all clothes or from the clothes dryer.

RECOMMENDATION: Lint shall be removed from all dryers after each use.

2600.161. NUTRITION ADEQUACEY.

(g) Drinking water shall be available to the residents at all times. Other beverages shall be available and offered to the resident at least every two hours.

COMMENT: Offering residents drinking water or other beverages every two hours is inappropriate in a personal care home setting.

RECOMMENDATION: Drinking water and other beverages are available for residents Twenty-four hours daily as requested.

2600.181. SELF-ADMINISTRATION.

A home shall provide residents with assistance, as needed, with medication prescribed for the resident's self-administration. The assistance includes helping the residents to remember the schedule for taking the medication; storing the medication in a secure place and offering the resident the medication at prescribed times.

COMMENT: The regulation does not reflect who can provide the assistance, as needed, for the residents self-administration nor type of training required. Competency based training module not noted in regulation.

RECOMMENDATION: A state approved competency based training program for all direct care staff who provide residents with assistance, as needed, with medication prescribed for the residents self-administration.

2600.54. STAFF TITLES AND QUALIFICATIONS FOR DIRECT CARE STAFF

(1) Be 18 years or Older
(2) Have a high school diploma or GED
(3) Be of good moral character
(4) Be free from medical condition, including drug or alcohol addiction that would limit the direct care staff from providing necessary personal care services with reasonable skill and safety.

COMMENT: Regarding point: (1) In the proposed regulations, volunteers are considered "direct care staff". We would not have the ability to have high-school age volunteers due to the 18 years or older criteria. Including younger volunteers enhances programming and encourages intergenerational interaction that would not exist with this regulation in effect.

RECOMMENDATION: Direct care staff shall be 16 years of age or older. Regarding point (2) recommend to drop GED or High School Diploma. This should be considered "preferred" but not required.

2600.56 STAFFING

(b) If a resident's support plan indicates that the resident's personal care service needs exceed the minimum staffing levels in subsection (a), the personal care home shall provide a sufficient number of trained direct care staff to provide the necessary level of care required by the resident's support plan. If a home cannot meet a resident's needs, the resident shall be referred to a local assessment agency or agent under 2600.225 (e) relating to initial assessment and the annual assessment).

COMMENT: needs more clarity

RECOMMENDATION: More specific regulation needed in regards to clarity of assessment tool.

2600.58. STAFF TRAINING AND ORIENTATION

(a) Prior to working with residents, all staff including temporary staff, part-time staff and volunteers shall have an orientation that includes the following....(extensive listing follows)

COMMENT: Although training for all staff is important, extensive training of volunteers in the same manner is not reasonable. We will have no volunteers if this regulation is in effect.

SUGGESTION: Depending on the "volunteer" job responsibility, training should be the responsibility of the facility director utilizing volunteer job descriptions.

(c) Training direct care staff hired after ____. The blank refers to the effective date of adoption of this proposal.) shall include a demonstration of job duties, followed by guided practice, then proven competency before newly-hired direct care staff may provide unsupervised direct care in any particular area. Prior to direct contact with residents, all direct care staff shall successfully complete and pass the following competency-based training including the following specific job duties and responsibilities:

COMMENT: According to this regulation, agency staff and volunteers would be considered direct care staff and fall under this training requirement. Agency staff could not be utilized. Volunteers would not volunteer for the required training.

RECOMMENDATION: A provision needs to be made for agency staff usage. Do not include volunteers under direct care staff.

(e) Direct care home staff shall have at least 24 hours of annual training relating to their job duties. Staff orientation shall be included in the 24 hours of training for the first year of employment. On the job training for direct care staff may count for 12 out of the 24 training hours required annually.

COMMENTS: 24 hours is excessive and cost of training will be high.

RECOMMENDATION: A minimum of 12 hours of annual training is recommended for direct care staff.

2600.57 ADMINISTRATOR TRAINING AND ORIENTATION

(a) Prior to initial employment at a personal care home, an administrator shall successfully complete an orientation program approved by the Department and administered by the Department or its approved designee.

COMMENTS: It would be difficult for most people to complete an orientation program prior to being employed.

RECOMMENDATION: "as an administrator" should be added after "Prior to initial employment *as an administrator*.....

(b) Prior to licensure of a personal care home, the legal entity shall appoint an administrator who has successfully completed an passed a Department approved competency-based training that includes 60 hours of Department approved competency-based training, and has successfully completed and passed 80 hours of competency-based internship in a licensed home under the supervision of a Department-trained administrator.

COMMENT/SUGGESTION: Regulation needs clarification of "competency-based training".

(e) An administrator shall have at least 24 hours of annual training relating to the job duties, which includes the following:....(a list follows)

COMMENTS: More clarity needed as to what exactly must be included in the total hours of annual training.

RECOMMENDATIONS: An administrator shall have at **least 12 hours** of annual training relating to the job duties, which includes the following: .....The recommendation would also include excess training time to be carried over to the following year.

2600.4 DEFINITIONS

Direct Care Staff

(i) A person who assists residents with activities of daily living, provides services or is otherwise responsible for the health, safety and welfare of residents.

COMMENT: This definition is too broad and will encompass nearly every staff member of a personal care home. For example, the maintenance staff that shovels the sidewalks is responsible for the health and safety of the residents.

(ii) "The term includes full and part time employees, temporary employees and volunteers"

COMMENT: The inclusion of volunteers in this definition is unreasonable due to the proposed training from direct care staff. The inclusion of volunteers in the direct care staff would cause facilities to lose volunteers who visit homes to do activities, etc.

SUGGESTION: Volunteers that act as direct care staff should to be addressed separately from volunteers who visit occasionally to assist with special events, etc.

2600.27 QUALITY MANAGEMENT

(a) The personal care home shall establish and implement quality assessment and management plans.

(b) At minimum, the following shall be addressed in the plan review:

(1) Incident reports
(2) Complaint procedures
(3) Staff training
(4) Monitoring licensing data and plans of correction, if applicable
(5) Resident or family councils or both

COMMENT: Clarification is needed on (b-2) in regards to complaint procedure. If this is interpreted to mean documentation of every complaint of every magnitude it would create an enormous amount of paperwork and consume a substantial amount of time.

2600.42 SPECIFIC RIGHTS

(i) A resident shall receive assistance in accessing medical, behavioral health, rehabilitation services and dental treatment.

COMMENT: Clarification is needed as to what measures are considered "assistance in accessing ... treatment". If this is interpreted to mean financial assistance this could have a substantial negative financial impact on the facility.

SUGGESTION: Keep current regulation (2630.33) which states "PCH shall provide residents with assistance with ... securing transportation... making and keeping appointments."

(j) A resident shall receive assistance in attaining clean, seasonal clothing that is age and gender appropriate.

COMMENT: Clarification is needed as to what measures are considered "assistance in attaining". If this is interpreted to mean financial assistance this could have a substantial negative financial impact on the facility. In addition, this regulation impedes upon the residents right to wear what they want.

SUGGESTION: Remove this regulation

(x) A resident shall have the right to immediate payment by the personal care home to the resident's money stolen or mismanaged by the home's staff.

COMMENT: The PCH should not necessarily be responsible for repayment of moneys stolen by staff. This regulation does not take into account the judiciary system.

SUGGESTION: This regulation should be removed.

(z) A resident shall have the right to be free from excessive medication.

COMMENT: Clarification would be needed as what is what is considered excessive medication additionally, this issue that is more between a doctor and resident than the PCH and the resident. Clarification on who decides on "excessive" medication needs to be more clear. Such a regulation would also need to address the ramifications involved is removing a resident from medication would make them no longer appropriate for the PCH.

SUGGESTION: This regulation should be removed.

Original: 2294

14-475 (453)

PROPOSED RULEMAKING
DEPARTMENT OF PUBLIC WELFARE
[55 PA. CODE CHS. 2600 AND 2620]

PERSONAL CARE HOMES

COMMENTS AND OBSERVATIONS

LIZA'S HOUSE PCH

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NOVEMBER, 2002

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CONTENTS

EXECUTIVE SUMMARY

Discussion:

Thank you for the opportunity to provide input into this proposed rulemaking, 55 PA. CODE CHS. 2600 and 2620, development process. The quality of input would be improved with more time to digest the proposed regulation and reevaluate our initial comments and observations.

It is difficult to find sufficient quality time for a comprehensive study and evaluation of the PROPOSED RULEMAKING 2600. Providing quality care to our residents is and remains our first priority. However, remaining in business and turning sufficient profit to remain in business is essential for us to fulfill our first priority of quality care for our residents.

A "Process Dictated" drop dead time of November 4, 2002 is rapidly approaching for final comments on the PROPOSED RULEMAKING. The criticality of this time line requires a direct approach in addressing this critical issue. While a lot of hard and dedicated good work has been done, and much progress made, much remains to be done. The focus on this PROPOSED RULEMAKING has recently shifted from quality of product to meeting some arbitrarily determined time line. This shift in focus leads to bad rulemaking. There is not enough time to review and assess impact of changes, updates and modifications to the PROPOSED RULEMAKING since the March 7, 2002, draft regulation was put out for comment.

This PROPOSED RULEMAKING VERSION is a significant improvement over the March 7, 2002 version, but it still falls fall short of realistic and practical implementation by the Provider. As written, the PROPOSED RULEMAKING is:

- **cost prohibitive.**
  - **For the 30 resident average Personal Care Home, an investmet in systems development of $145,580.00 and an ongoing annual operating cost of $371,642.00 on a current income projection of $720,000.00.**
  - **The annual operating cost increase is 51.6% of current income.**
  - **The increased operating costs must be passed on the the resident and that equates to roughly $1,000.00 per month increase, an increase most personal care home residents or their families can not absorb.**
  - **This is an industry impact cost of $260,000,000.00 system development cost and an annual ongoing operating expense increase of $664,000,000.00.**
- **filled with red flags.**
- **would put most small and medium providers out of business.**
- **significantly raise the costs on the few surviving large 'institutional' facilities, significantly increasing their cost and pricing all but the most affluent of the senior community out of the personal care home option.**

- **not ready nor worthy of the department to forward for review and enactment.**

Options:

Three basic courses of action are available:

1. Extend the "Process Imposed" drop dead date to let the current ongoing process have a couple more passes to try and resolve more of the unacceptable provisions and prohibitive costs imposed.
2. Stop the PROPOSED RULEMAKING process and reassess 2620, the current regulation which has served the Personal Care Home sector quite well for many years.
3. Steamroll the PROPOSED RULEMAKING through and either **be shot down is flames** at the legislature hearings **or force many small and medium homes to close and put thousands of dependent elderly out of their homes.**

Recommendations:

Adopt course of action 2, stop the Proposed Rulemaking process and reassess 2620 for enhancements.

The second recommended option is course of action 1, with the concern is the quality of the product, with a parameter that the PROPOSED RULEMAKING be realistic, affordable, and responsible, not adherence to an artificial time line and irresponsible social engineering.

OVERVIEW

While reading the PROPOSED RULEMAKING, and thinking about the real world of the provider, I am reminded of a noteworthy passage. I do not know the author of these thoughts so I can give proper credit. I just wish they were mine rather than simply agreeing with them.

"The Man in the Arena"

It is not the critic who counts, nor the one who points out how the strong man stumbled or how the doer of deeds might have done better. The credit belongs to the man who is actually in the arena, whose face is marred with sweat and dust and blood; who strives valiantly; who errs and comes short again and again; who knows, the great enthusiasms, the great decisions, and spends himself in a worthy cause; who, if he wins, knows the triumph of high achievement; and who, if he fails, at least fails while daring greatly, so that his place shall never be with those cold and timid souls who know neither victory or defeat.

The Provider is 'The Man in the Arena." The PROPOSED RULEMAKING, DEPARTMENT OF PUBLIC WELFARE,[55 PA. CODE CHS. 2600 AND 2620],PERSONAL CARE HOMES, (2600) outcome should support 'The Man in the Arena' rather than make the job more difficult! **The provider is not only the man in the arena, (s)he is the number one advocate for the resident. We not only empathize with their needs, we actually satisfy their needs. We know that without residents, we are out of business.**

The following critical comments are based on more than 40 years experience as a senior manager and management consultant. I made my living for 30 years doing this kind of work, for large, medium and small enterprises. I am 1 of about 2,000 Certified Management Consultants in the country. I feel I have a solid background and knowledge in the management process, and Personal Care Homes are private businesses, not government agencies.

The summary assessment of the introductory paragraphs contained in the Internet posting of 2600 are very interesting and deserve objective assessment.

:

dBackground: focused on process timeline, not outcome, and **dominated by inputs from ADVOCATES, who have no responsibility or liability for home operations, incidents, costs or outcomes.**

Resident Rights: 2600.41, 2600.42, and 2600.43 are over kill. **Should be scrapped and retain current provisions of 2620.**

Administrative Training and Orientation: 2600.57 **lacks cost justification for the impact** of these requirements. What is the projected cost increase on small and medium sized homes that employ an independent administrator to oversee their faciliy?

Staff Training and Orientation: 2600.58, **lacks cost justification for the impact these mandated requirements.** Trainee and trainer time expenses, before the facility can even expose the new hire

to the residents, is prohibitive. The interactions between the new hire and the residents are the critical factor to determine if the new hire will remain and be successful in this field. **To be forced to absorb about 4 weeks of trainer time and new hire staff time wage costs then find out the new hire is not a satisfactory candidate is a very poor cost management decision.**

Safe Management Techniques: 2600.501. This is an interesting concept, but is this new concept and requirement appropriate for PCH? **This is a skill needed in handling MH/MR consumers**, that also have State funding. I do not know the frequency or density of such residents in PCH homes. This information should have been factored into the cost benefit analysis, data which is lacking. This process is a change of mind set type training, not a couple hours in the class room. To be successful in changing an individual's mind set and method of interaction with other individuals requires at least three weeks of intensive indoctrination and oversight, a training cost that would be difficult for small and medium size homes to absorb.

Development of the Support Plan: 2600.226. This is a management **time intensive undertaking** as envisioned. The time required to get everyone together, to then get every one to agree on the care plan, and then have them sign off of the document is prohibitive for small and medium care homes to absorb. Even in large homes, the time involved is probable cost prohibitive. While this is envisioned as a once a year plan, to include updates, in reality this will probable be required twice a year per resident and involve about 8 hours of administrator time per resident for the initial plan and 6 hours for each update, sign offs are tough.

Medication Administration:

- 2600.181-2600.188, **very few PCH residents can meet the standards of 2600.181(e) for self administration.**

- 2600.186(2) **implies the PCH making a diagnosis of drug side effects for altered physical of mental condition. We are not permitted to diagnose, this is an invitation to disaster and litigation.**

- 2600.186(3) **implies responsibility on the PCH, this is a professional decision we are not qualified to make. The responsibility for this decision is with the Pharmacy and or Physician, not the PCH.** Yet the resident has the right to take any medication (s)he wants, when (s)he wants, and in the quantity (s)he wants. Families have the right to bring in any outside PRESCRIPTION, OTC or CAM medication, put them it in the resident's room, and the resident can consume them at their option, yet the PCH remains liable for any adverse outcomes. How about a little authority to intervene and manage this risk?

Personal Care Home Providers: The claim that "the Department gave careful consideration to the effect the regulations will have on the costs of providing and receiving services" IS NOT TRUE. The overview of the cost benefit analysis would be a failing grade for any Business 101 high school class project. As a management consultant for over 30 years, if any of my staff had produced such an incomplete, inaccurate and misleading document, even in draft, I would have fired them. A magnitude cost impact projection for the average

size personal care home shows hundreds of thousands of dollars annually, per home. See cost impact section below.

FIXED	ANNUAL	INCOME
$ 145,850.00	**$ 371,642.00**	**$ 720,000.00**

PERCENT OF INCOME; **51.6%**

ANNUAL COST PER RESIDENT **$ 12,387.00**

MONTHLY COST PER RESIDENT **$ 1,032.00**

PROJECTED COST IMPACT ON 1,786 LICENSED PERSONAL CARE HOMES

$ 260,488,100.00 **$ 663,752,612.00**

General Public: **"There will be no costs to the general public as a result of this proposed rulemaking." IS A FALSE STATEMENT. It is the result of an ineffectual cost/benefit analysis, if indeed one was made. This proposed rulemaking will substantially increase the costs of doing business in the PCH. The slim, if any, profit margins of the PCH will not permit absorbing the costs and these costs must be passed on to the private sector, the general public that is currently paying for PCH services. The projected cost impact on an average size personal care home is hundreds of thousands of dollars annually, per home. See cost impact section below.**

FIXED	ANNUAL	INCOME
$ 145,850.00	**$ 371,642.00**	**$ 720,000.00**

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Paperwork Requirements: The statement that there is no reasonable alternative to the increased paperwork is not true. From many years of productivity control and improvement experience, **most well run departments were accomplished from the notebook in the hip pocket of the foreman, not the elaborate Total Quality Management Procedure Manuals** we developed and implemented. Once the total burden of these proposed paperwork systems is felt, the next logical step is to introduce computerization and electronic data collection technology, which will permit monitoring via remote location. These processes, which I have also developed and

installed, are definitely cost prohibitive for small and medium sized PCHs, but will give greater "oversight. and supervision" to the regulators. Is that the true objective? I have trouble finding any cost savings or tangible benefits to offset these procedure documentation and records keeping costs.

2600, does not yield the outcome desired as stated in 2600.1. 2600, as presented, runs a great risk of forcing many small and medium homes out of business. Costs will be forced up to the point that only the most affluent dependent adults can affordthe option of placement in the Personal Care Home environment.