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 you 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. Pleasant, Pa.
15666

#14-475 586

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 Elkin
R.R. 1 Box 340I Brown 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.

Original: 2294

IRRC

From: msbear [msbear@wpa.net]
Sent: Monday, November 04, 2002 3:09 PM
To: IRRC@irrc.state.pa.us
Subject: Chapter 2600

4 November 2002

Dear Independent Regulatory Review Commission,

The consumer advocates, the members of the Pennsylvania Health Law Project, formulated 99% of the proposed regulations in Chapter 2600.

P.H.L.P. has 51% of the seats on the Advisory Committee to the Department of Public Welfare concerning Personal Care Home Licensing.

Comments submitted to The Office of Licensing and Regulatory Management on Chapter 2600 by professionals of the personal care industry were discarded.

To have only one point of view regulating the Personal Care Homes of this state is unjust.

The P.H.L.P "White Papers" dated February 2002 are a smear to the Personal Care Home Profession, their repeated mention of "Unlicensed Personal Care Homes" is misleading. They are not Personal Care Homes.

I don't fully understand your commissions goals, but the number one criteria listed on your publication is the economic or fiscal impact of the regulations. The impact to the private citizen seeking Personal Care Services will be devastating.

IF 2600 replaces 2620 the Pennsylvania government and P.L.H.P. will be putting a great financial burden on the people they are supposed to protecting.

Thank you for you time in this matter.

Sincerely,

Mark Sayre
Sunnyland Retirement Home's Inc.
21 Years service in Personal Care Program..

Original: 2294

14-475
494

Facsimile Cover Sheet

To:	Teleta Nevius, Director
Company:	Office of Licensing & Regulatory Management
Phone:	
Fax:	717-705-6955
From:	Gwen Lehman on behalf of Ken Certa, MD
Company:	Pennsylvania Psychiatric Society
Phone:	800-422-2900
Fax:	717-558-7841
Date:	November 4, 2002
Pages including this cover page:	3

Comments:

Pennsylvania
Psychiatric Society

The Pennsylvania
District Branch of the
American Psychiatric Association

Nov. 4, 2002

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

Dear Ms. Nevius:

The Pennsylvania Psychiatric Society has reviewed the Proposed Rulemaking on Personal Care Homes (32 Pa.B. 4939), published in the October 5 issue of *Pennsylvania Bulletin*. We have several comments.

First, we applaud the effort to bring additional protection to the people who live in personal care homes. These residents comprise a vulnerable population, many of whom are consumers of mental health services. Any measure that will increase their safety and improve their care is welcome.

Nevertheless, we are aware that improvements will not come without costs. One of the fundamental problems of the personal care home system is the tenuous nature of its financial underpinnings. As we comment on the improvements contained in the proposed regulations, and as we suggest ways in which they could provide even greater safety, we are concerned that the measures may lead to cost increases that will limit further the availability of this housing resource. Unfunded mandates on services are of no help to consumers if they render the services unavailable. Pennsylvania must find a way to provide sufficient funds to meet the basic safety needs of this vulnerable group.

We are most concerned about several sections of the proposed regulations that only begin to assure that residents' behavioral health needs will be recognized and satisfied. In particular, the sections on the training of administrators and staff (**sections 2600.57 and 2600.58**) need additional work. A requirement for training in the recognition of signs and symptoms of mental illness, as well as specific measures to help the resident access appropriate services, should be included in the regulations.

In addition, staff in personal care homes must be made aware of standards and mechanisms for involuntary mental health commitment. Section **2600.141** should include an affirmative responsibility of the home staff to apply for involuntary commitment if the resident's behavior appears to meet criteria for serious mental illness. Residents with serious medical needs who are unable to recognize them because of their mental illness, or who are unable to access services on their own because of the effects of their illnesses, should not be left to languish. Personal care home staff should be required to apply for, or help residents apply for, the necessary interventions available through the courts or adult protective services. Vulnerable adults should not have to seek care on their own when others are charged with looking to their welfare, nor should the home staff be able to use a resident's refusal of services as license to ignore obvious needs.

Executive Director
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The requirements for secured units **(section 2600.229)** are of great concern to us, as well. The recent New York investigations into the abuse of secure units in personal care homes as an alternative to involuntary commitment is a warning to us in Pennsylvania. The regulations seem to assume that the secured units are for individuals with dementia; if this is so, it should be explicit. In addition, the regulations should better address the subject of how the rights of individuals in such settings are to be protected. The regulations seem to presume that the resident, or his "designee," has consented to placement in the secured unit. Instead of this presumption, the regulations should provide safeguards to residents through verification of both initial and continued consent. They should also contain a mechanism for withdrawal of consent and/or the naming of a different designee.

Section 2600.181-188, concerning the use of medications, is quite problematic. In particular, the section dealing with self-administration and assistance is fraught with internal inconsistencies. The regulations resemble those for hospital and nursing homes, but unlike those settings, in the personal care home there is no licensed person accountable for having the knowledge or responsibility to adhere to such standards. We recommend that the Department rethink these sections. There is too much disparity between the rules for residents who store their medications in their rooms and those who need assistance. For example, the only requirement for those not needing assistance is that the home maintain a record of the prescribed medication, not whether the resident is actually taking them, or getting the prescriptions refilled in a timely way, or whether the pill count is dropping by the appropriate amount weekly.

Those needing assistance, on the other hand, have the equivalent of a medication administration record, complete with requirements for contemporaneous notations of dose, date, time, and the person who "assisted" the "self-administration," as well as requirements for medication error tracking and recording of verbal "changes" (orders). We are hesitant to suggest that only licensed professionals should administer medications (which is the reality of the term "assist with self-administration") in these homes; the cost would sky-rocket, and we know that many individuals living in family situations receive such assistance routinely from family members. At the very least, however, any staff member having responsibility for medication assistance should have specific, additional training in medication identification, double-checking, side-effect management, and record-keeping.

We are sure that other stakeholders will recommend revisions to additional sections of the proposed regulations. The extensive record-keeping they require, for example, raises equally extensive confidentiality concerns. Defining reportable incidents, and the extent to which it is left to the judgment and initiative of the personal care home staff, will need further thought, as well.

We look forward to working with the department as it seeks appropriate regulations for this important part of the system of care for impaired individuals. We also hope to work to ensure that the regulations, once promulgated, are enforced, and that funds are available to make the mandated enhancements in resident health and safety.

Sincerely yours,

Kenneth M. Certa, MD
President

Govt/pch regs

Original: 2294

"The future of long term care"

PHCA
PENNSYLVANIA HEALTH CARE ASSOCIATION

CALM
Center for Assisted Living Management

November 4, 2002

Contact: Patricia A. McNamara
Phone: 717-221-7934/ E-mail: pmcnamara@phca.org

Teleta Nevius, Director
Office of Licensing and Regulatory Management
Department Public Welfare
316 Health Welfare Building
P.O. Box 2675
Harrisburg, PA 17101-2675

Re: Proposed Personal Care Home Regulation Comments -- *via e-mail and hand delivery*

Dear Ms. Nevius:

The Center for Assisted Living Management (CALM), affiliate of the Pennsylvania Health Care Association (PHCA), representing more than 100 personal care homes with more than 6500 beds, respectfully submits the attached comments on the draft personal care home (PCH) regulations.

We have attached general overview comments and observations and also line-by-line comments for only the areas in the proposed regulations where would like to see changes made.

It is our hope that we can continue to work together to fashion an updated set of regulations that will:

- Embody a philosophy of regulation that reflects the elements of personal choice and assumption of risk inherent in personal care homes today.
- Protect small and large operators from financial ruin so that access to care is preserved.
- Protect frail seniors as they "age in the *appropriate* place" and as their care needs grow.
- Establish the predicate for greater public funding for personal care homes residents in PA.
- Preserve the social, home-like model of personal care that meets the preferences of the consumer.
- Establish a "quality improvement" rather than a "punishment" model of oversight (for example, the state should consider creating an Office of Technical Assistance for providers that is funded in part by the fines they collect from enforcement).

We appreciate the opportunity to comment and look forward to working together to modify the proposed regulations further to meet all of our goals.

Sincerely,

Alan G. Rosenbloom
President

CC: Robert E. Nyce, Executive Director, IRRC
Senate Public Health and Welfare Committee
House Health & Human Services Committee

General Observations and Comments to the Proposed Personal Care Home Regulation 55 Pa. Code Chapter 2600 as published in the Pennsylvania Bulletin on October 5, 2002

Economic or fiscal impact of the regulation

Despite years of work by stakeholders and admittedly significant modifications by the Department of Public Welfare (DPW), the proposed regulations continue to pose problems for operators, especially smaller personal care homes. Indeed, several of the regional provider groups of personal care homes believe that they will be forced out of business by the proposed regulations as they stand.

The regulatory analysis form that accompanied the regulations to the Independent Regulatory Review Commission (IRRC) states that the total cost to each licensed personal care home related to certain sections of the regulations is estimated to be $680.00. This is a gross understatement of the overall increased costs to providers and ultimately consumers.

We have some providers estimating that it will mean two to three times their overall operating costs. On the average, our members have estimated that it will cost an additional $900 per month or more than $10,000 per year. DPW's estimated costs did not fully account for the development of more than 15 new policies and procedures and reporting requirements, new training requirements, or the new staff positions that will accompany the implementation of these, such as legal review, staff development trainers, additional administrative personnel to carry out the paperwork requirements, and additional direct care staff. Providers will be forced to pass on increased costs to consumers as a result. In the case of the more than 10,500 residents who receive $29/day for care in this setting on SSI and the State Supplement, this will mean displacement with few alternatives other than an unlicensed home, the streets, or possibly a nursing facility if functionally eligible.

The Department has repeatedly stated that their goals for this regulatory revision process are as follows:

- Update 20 year old regulation
- Enhance health and safety standards
- Preserve operation of existing homes
- Involvement of Personal Care Home Advisory Committee
- Assure continuous ongoing public meetings

We appreciate and concur with the stated goals of the Department and it is our hope that DPW will see that all of these goals are met through this process. We are especially concerned with the goal of preserving the operation of existing homes given the cost implications of the proposed regulations. To help preserve the operation of existing homes, we would propose the following:

- The Commonwealth should consider alternative solutions for smaller homes placed in jeopardy by the costs inherent in the proposed regulations. Is there a way to set less burdensome

standards for homes with, for example, 20 beds or under since these comprise 41% of the licensed homes (approximately 740 homes out of the 1786) while continuing to ensure the safety and welfare of the residents in these homes? The Commonwealth was able to do this with Domiciliary Care Homes years ago, and there may be a similar solution for this group. For instance, the Commonwealth may want to consider introducing "Assisted Living" as a licensing category and preserve smaller homes under a less prescriptive personal care home regulation. Alternatively, the Commonwealth might consider a small home waiver under whatever final set of regulations is developed.

- Additionally, we strongly recommend that the Department, together with stakeholder groups through the DPW Personal Care Home Advisory Committee (PCHAC) develop *sample* policy and procedures and staff training curriculum for new requirements. This would help assure standardization and provide some monetary relief to the homes who cannot afford to do this on their own.

- Grandfathering provisions must be in place for physical sites (buildings) doing business as a personal care home prior to the date of implementation of the regulations. We are not aware of any other facility regulation that has changed that does not make provisions for existing buildings.

- Further, we believe that DPW has a moral obligation to address the public funding issue for the more than 10,500 residents in personal care homes who receive SSI and the State Supplement *at the same time they are implementing new regulations*. DPW must recognize the real costs to providers which were $60 per day on the average in 1999[1] to care for residents in this setting. DPW must increase the State Supplement for SSI residents in PCHs to a total benefit of at least $60 per day in addition to their personal needs allowance. New government mandates cannot be implemented until this is accomplished or we fear that these 20% of the total personal care home residents will be displaced and find it nearly impossible to access the level of care they require.

Protection of the public health, safety and welfare and the clarity, feasibility and reasonableness of the regulation

There is little controversy that the current regulations need to be updated in some areas to keep up with the marketplace phenomena that has occurred within the personal care home community and protect the increasingly frailer residents. However, PHCA/CALM views the proposed regulations as a work in progress that needs significant refinement before it can be implemented.

We support a regulatory system that will focus on standards for service outcomes and resident satisfaction. The *process or how* you accomplish this is not as important as the resulting outcome. We feel that the proposed regulations are far too prescriptive in dictating *how* providers must accomplish compliance rather than focusing on the outcomes. Our detailed comments and suggested language changes outlined below seek to change this focus.

---

[1] *Costs of Providing Housing and Services in Personal Care Homes in Pennsylvania: A study conducted for the Department of Public Welfare's Personal Care Home Advisory Committee June 17, 1999* by PANPHA and Shippensburg University's Center for Applied Research and Policy Analysis.

We have to keep in mind that these settings are still not classified by the state as health care facilities but rather they continue to be residential in nature. As such, we should find a way to preserve these home-like settings which consumers prefer without imposing nursing-home like standards on them. We further need to help consumers understand up front that there is most likely a point at which their care needs cannot be met in these settings so that the expectation for indefinite "aging in place" is not perpetuated.

Does the regulation represent a policy decision of such a substantial nature that it requires legislative review?

There are significant considerations as we move forward with new regulations for personal care homes. These include the fiscal impact on providers and the public (consumers), the severe workforce shortages that we are experiencing in our profession, and future needs of our aging population which is the second oldest in the nation.

There is a national movement to more uniformly define "assisted living" in each state. Pennsylvania is one of the few states who have yet to do this, despite having assisted living legislation for nearly four years that has not been acted upon. Personal Care Homes are considered the closest entity to "assisted living" in our state and will be impacted by any assisted living legislation. With public and federal pressure to define assisted living, DPW must consider how this will impact the current regulatory reform process.

Further, PHCA/CALM believes there are provisions within the proposed regulations that speak to broader public policy issues. These are in the area of staff training which could have a significant impact on our workforce. The direct care staff training requirements pose a new set of standards for a pool of workers who frequently change jobs from home health to attendant care to nursing facilities to personal care homes. PHCA/CALM supports developing a standardized training and competency-based program that all direct caregivers in our Commonwealth could take that would apply across any setting. This may require legislative review and action. Ultimately this could enhance our workforce and save costs to providers and consumers so that staff could be trained and tested once instead of each time they switch care settings.

In this vein, we also support the creation of a medication administration technician training and testing program that would permit unlicensed personnel to administer medications under the supervision of licensed personnel. This would help providers to keep costs down for consumers and also be part of the solution to the nursing shortages we are experiencing. This too may take legislative review and action. Our organization stands ready to assist with training programs such as these.

Finally, there are questions as to DPW's legal ability to utilize tools such as "bans on admissions" or impose temporary management in the course of their enforcement. We strongly believe that DPW needs the authority to enforce the regulations in a timely and effective manner. There may be a need to review their statutory authority in the area of enforcement.

Conclusion

Our organization has dedicated enormous resources over the past 8 years in participating in the development of new regulations. We believe the framework has been established to move forward to develop a final set of regulations that make sense for everyone and have been told that the DPW Office of Licensing and Regulatory Management is open to continuing stakeholder discussions.

We would like the opportunity to continue working with the Department and other stakeholders to develop a new set of regulations that will assure protection, choice, access and quality to our residents in personal care homes and be operationally feasible to providers. We hope the process will not be rushed but rather conducted with careful consideration in a manner that will permit this care setting to thrive.

Specific Comments and Language Change Suggestions in the Proposed Regulations

Key:

Underlined text is PHCA/CALM suggested changes to the language.

Underlined italicized text is PHCA/CALM's comments, questions, or rationale.

~~Strikethroughs~~ are language that PHCA/CALM would like to see deleted.

PROPOSED RULEMAKING

DEPARTMENT OF
PUBLIC WELFARE

[55 PA. CODE CHS. 2600 AND 2620]

Personal Care Homes

GENERAL PROVISIONS

§ 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 the residents.

(ii) The term includes full and part time employees, temporary employees and volunteers who routinely perform direct care staff services.

We would like to see the following definition added (or something similar) once the barriers have been work out for a medication-technician program. Note that this is the language being used by the National Assisted Living Workgroup. Their work can be found at: http://www.aahsa.org/alw.htm

Medication Assistive Personnel (MAP)-- are caregivers who are not licensed health professionals but have successfully completed training and a competency examination, approved by the appropriate state licensing agency, that permits the person to administer medications to a resident.

Personal care resident or *resident*--A person, unrelated to the licensee, who resides in a personal care home and who may require and receive personal care services but does not require the level of care provided by a hospital or long-term care facility. In

references to the resident's involvement in decision-making, this term may also refer to the resident's power of attorney or legal representative or responsible party if the resident is incapable of understanding or making decisions on their own behalf.

Volunteer--A person who, of his own free will, and without monetary compensation, provides services for residents in the personal care home.

(i) Volunteers who routinely perform direct care services shall meet the minimum qualifications and training of staff persons.

(ii) Residents receiving personal care services who voluntarily perform tasks in the personal care home are not to be considered volunteers for the purpose of determining compliance with the staffing requirements of this chapter.

GENERAL REQUIREMENTS

§ 2600.11. Procedural requirements for licensure or approval of personal care homes.

(a) Except for §§ 20.31 and 20.32 (relating to annual inspection; and announced inspections), the requirements in Chapter 20 (relating to licensure or approval of facilities and agencies) apply to personal care homes.

(b) Personal care homes shall be inspected as often as required by section 211(l) of the Public Welfare Code (62 P. S. § 211(l)), and more often as necessary. After initial approval, homes need not be visited or inspected annually except that the Department will schedule inspections in accordance with a plan that provides for the coverage of at least 75% of the licensed personal care homes every 2 years and all homes shall be inspected at least once every 3 years.

We appreciate the Department's intent here to focus on poor performing facilities more frequently than those facilities who routinely remain in full compliance.

§ 2600.16. Reportable incidents.

(11) An incident requiring the services of an emergency management agency, fire department or law enforcement agency. *Please clarify whether this includes use of ambulance services.*

(18) A final termination notice from a utility.

§ 2600.17. Confidentiality of records.

Resident records shall be confidential, and, except in emergencies, may not be open to anyone other than the authorized home designee, resident, the resident's designee, if any, agents of the Department and the long-term care ombudsman unless the resident, or a designee, consents, or a court orders disclosure.

§ 2600.19. Waivers.

(g) A structural waiver will not be granted to a new facility, new construction or renovations begun after _____ (*Editor's Note*: The blank refers to the effective date of adoption of this proposed rulemaking.) Upon request, the Department will review building plans to assure compliance with this chapter.

We would hope that the Department will take into consideration those homes with building plans that have been submitted and/or approved prior to the effective date of the final regulation that may already be underway but not completed.

§ 2600.20. Resident funds.

(12) Upon discharge or transfer of the resident, the administrator shall ~~immediately~~ return the resident's funds being managed or being stored by the home to the resident in accordance with the terms outlined in the resident contract, not to exceed 30 days. *(Rationale: The home should be given a reasonable amount of time to determine whether the resident has outstanding charges and also nursing facility requirements in PA allow for a 60 day refund period.)*

§ 2600.24. Tasks of daily living.

A home shall provide residents with assistance with tasks of daily living as indicated in their support plan and assessment, which may include ~~including~~ one or more of the following: ...

§ 2600.25. Personal hygiene.

A personal care home shall provide residents with assistance with personal hygiene as indicated in the support plan and assessment which may include ~~including~~ one or more of the following:

§ 2600.26. Resident-home contract: information on resident rights.

(ii) The actual amount of ~~allowable~~ public funding or cost as outlined in the resident contract ~~resident charges~~ for each service or item. The actual amount of the periodic--for example, monthly--charge for food, shelter, services and additional charges, and how, when and by whom payment is to be made. *The word "allowable" implies public funding in our interpretation and while this may not be the intent we prefer the language above to clarify this.*

(3) The resident, or a designee, or the home, has the right to rescind the contract for up to 72 hours after the initial dated signature of the contract. Rescission of the contract shall be in writing addressed to the home, or the resident or a designee. *The home sometimes discovers within three days that the resident's assessment was not accurate and in fact the resident cannot be cared for by that particular home and therefore should be permitted to rescind the contract as well, giving the resident sufficient time to find alternative placement but not the full 30 days they would otherwise have. This is for the welfare of the resident as well.*

§ 2600.27. Quality management. *Alternative provisions for small homes should be made under this section. We would suggest that the DPW PCH AC work to create a sample plan and one that might be simplified for smaller homes.*

§ 2600.29. Refunds.

(a) If, after the personal care home gives notice of discharge or transfer in accordance with § 2600.26 **and 2600.228** (relating to requirements for resident/home contract; information on resident rights, and notification of termination), and the resident moves out of the home before the 30 days are over, the home shall give the resident a refund equal to the previously paid charges for rent and personal care services for the remainder of the 30-day time period. The refund shall be issued within 30 days of discharge. The resident's personal needs allowance shall be refunded within 1 week of discharge or transfer.

(b) After a resident gives notice of the intent to leave in accordance with § 2600.26 and 2600.228 and if the resident moves out of the home before expiration of the required 30 days, the resident owes the home the charges for rent and personal care services for the entire length of the 30-day time period for which payment has not been made.

(d) If the personal care home does not require a written notice prior to a resident's departure, the administrator shall refund the remainder of previously paid charges to the resident within ~~7~~ 30 days of the date the resident moved from the home. In the event of a death of a resident, the administrator shall refund the remainder of previously paid charges to the estate of the resident within 30 days of the room being vacated. ~~when the room is vacated and within 30 days of death.~~ The home shall keep documentation of the refund in the resident's file.

(e) If a resident is identified as needing a higher level of care and is discharged to another facility, the personal care home shall provide a refund within 30 ~~7~~ days from the date of discharge when the room is vacated or within 30 ~~7~~ days from notification by the facility. *Rationale: Again, nursing facilities are given 60 days to refund monies, and facilities, particularly those under corporate structure, may have possible delay in releasing funds within 7 days.*

RESIDENT RIGHTS

§ 2600.41. Notification of rights and complaint procedures.

(e) A resident and, if applicable, the resident's family and advocate, if any, have the right to lodge a written complaint with the home for an alleged violation of specific or civil rights without retaliation, or the fear or threats of retaliation.

(f) The personal care home shall ensure investigation and resolution of written complaints regarding an alleged violation of a resident's rights. The procedures shall include the timeframes, steps, and the person or persons responsible for determining the outcome of the complaint and appeal procedures.

§ 2600.42. Specific rights.

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

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

(l) A resident shall have the right to purchase, receive and use personal property, unless the personal property presents a danger to self or others.

(u) A resident shall have the right to remain in the personal care home, as long as it is operating with a license, except in the circumstances of:

Please add:

(4) Violation of house rules and/or violation of others residents rights.

(w) A resident or designee shall have the right to appeal in writing discharge, reductions, changes or denials of services originally contracted. The personal care home shall have written resident appeal policies and procedures. The resident shall receive an answer to the appeal within 14-calendar days after submission.

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

(y) A resident shall have the right to manage personal financial affairs.

(z) A resident shall have the right to be free from excessive medication which constitutes a chemical restraint (2600.202).

STAFFING

§ 2600.53. Staff titles and qualifications for administrators.

(a) The administrator shall have one of the following qualifications:

(1) A valid license as a registered nurse from the Commonwealth.

(2) An associate's degree, 60 credit hours or greater, from an accredited college or university or commensurate life experience.

(d) The administrator and/or legal entity shall be responsible for the administration and management of the personal care home, including the safety and protection of the residents, implementation of policies and procedures and compliance with this chapter.

§ 2600.54. Staff titles and qualifications for direct care staff.

Direct care staff shall have the following qualifications:

(2) Have a high school diploma or GED, or commensurate life experience.

Please add:

(4) Sixteen or 17 year olds may be employed as a direct care staff person at a personal care home, but may not perform tasks related to medication administration, and the incontinence care or bathing of persons of the opposite sex.

§ 2600.55. Exceptions for staff qualifications.

(a) The staff qualification requirements for administrator and direct care staff do not apply to persons hired or promoted to the specified positions prior to _____ (*Editor's Note*: The blank refers to the effective date of adoption of this proposal.) as long as the home maintains a current license and the individual maintains their continuing education. *Rationale: Almost all licensed professionals (nursing home administrators, doctors, attorneys, etc.) are able to retain their credentials as long as they maintain continuing education requirements no matter how long of a break in service they have. Nurses in our state may maintain their license without continuing education requirements and without practicing. Keep a level playing field here.*

(b) A staff person who transfers to another licensed home, ~~with no more than a 1-year break in service,~~ may work in the same capacity as long as the staff person ~~meets the qualifications outlined in subsection (a)~~. maintains their continuing education.

§ 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 an appropriate facility or a local assessment agency or agent under § 2600.225(e) (relating to initial assessment and the annual assessment).

(k) When regularly scheduled direct care staff persons are absent, the administrator shall arrange for coverage by substitute personnel who meet the direct care staff qualifications and training requirements. *This poses a concern regarding temporary staff and the cost associated with training them according to yet another set of standards that differ from home health or CNAs. There should be a uniform training standard in PA for direct care workers so that they can work more universally across the continuum of care settings.*

(m) An administrator may be counted in the staffing hours ~~ratios~~ if the administrator is scheduled to provide direct care services.

§ 2600.57. Administrator training and orientation.

As a trainer of the 40-hour program since 1991, PHCA CALM has evaluated the list of training subjects required here and is of the opinion that to cover this with any justice, you would need to increase the hours to 80 or more. We originally recommended 120 hours and would support increased hours. Our suggestion is to reduce the inservice requirement and increase the classroom hours.

(d) The 80 *(change this to 60 hours)* hours of competency-based internship in a licensed personal care home under the supervision of a Department-trained administrator shall include the following:

(e) An administrator shall have at least ~~24~~ 48 hours of ~~annual~~ training relating to the job duties within a two-year period, which may include the following:

...

(g) A licensed nursing home administrator who is employed as a personal care home administrator prior to _____ (*Editor's Note*: The blank refers to the effective date of adoption of this proposal.) is exempt from the training and educational requirements of this chapter if the administrator continues to meet the requirements of the State Board of Nursing Home Administrators. A licensed nursing home administrator hired as a personal care home administrator after _____ (*Editor's Note*: The blank refers to the effective date of adoption of this proposal.) shall pass the ~~40-hour~~ personal care home administrators competency-based training test *Do you mean have them take the exam or the class or both? Why just 40 hours and not the full course of 60 or more hours as we have recommended above? This would mean that 2 different standardized courses would have to be developed. We would suggest that there be a standardized competency based test that they have to pass.* A licensed nursing home administrator who fails to pass the test shall attend the required 40-hour personal care home administrators training, and retake the competency test, until a passing grade is achieved.

§ 2600.58. Staff training and orientation.

(a) Prior to working with residents unsupervised, all staff including temporary staff, part-time staff and volunteers shall have an orientation within 30 days that includes the following: *It is not possible to train them without having them work with residents.*

(c) Training of direct care staff hired after _____ (*Editor's Note*: The blank refers to the effective date of adoption of this proposal.) shall include a demonstration of job duties, *(Note: In discussion with the Department of Public Welfare's Personal Care Home Advisory Committee task groups, this demonstration was intended to be a check list of tasks that a supervisor would have the trainee perform in a satisfactory manor. This was not intended to be a written exam. We would just like this to be clarifies here)* 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 (1) Resident care.

~~(11) Needs of residents with special emphasis on the residents being served in the personal care home.~~ Special emphasis on the needs of the residents being served in the PCH

(e) Direct care home staff shall have at least ~~24~~ 12 hours of annual in-house training relating to their job duties. Staff orientation shall be included in the ~~24~~ 12 hours of training for the first year of employment. On the job training for direct care staff may count for ~~12~~ 6 out of the ~~24~~ 12 training hours required annually. *(Rationale: The DPW PCH Advisory Committee task groups had recommended this be changed to 12 hours and DPW has verbally agreed but was unable to make the change prior to publication. Note also that nursing assistants in nursing facilities are only required to have 12 hours of continuing education a year).*

(f) Training topics for the required annual training for direct care staff may ~~shall~~ include aspects of the following:

(1) Current training in first aid, certification in obstructed airway techniques and certification in cardio-pulmonary resuscitation that is appropriate for the residents served, and shall be completed by an individual certified as a trainer by a hospital or other recognized health care organization. Registered nurses, licensed practical nurses, certified registered nurse practitioners, emergency medical technicians, paramedics, physician's assistants or licensed physicians are exempt from the requirement for annual first aid training.

(2) Medication self-administration training.

(3) Understanding, locating and implementing ~~preadmission screening tools, initial assessments, annual~~ assessments and support plans.

(4) Care for persons with dementia and cognitive impairments if applicable.

(5) Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration as it relates to the resident populations.

(6) Personal care service needs of the resident.

(7) If the population is served in the home, safe management technique training, which shall include positive interventions such as: *(Note that this may be excessive for some homes It would be helpful for the Department to develop some standardized training in this area as this is new for some providers).*

§ 2600.59. Staff training plan.

The administrator shall ensure that a comprehensive staff-training plan is developed and conducted annually for the development and improvement of the skills of the home's ~~direct care~~ staff for the resident population being served. The staff training plan shall include the personal care home's policies and procedures for developing and conducting the staff training plan, indicating who is responsible ~~and the time frames for completion of the following components~~. The plan shall be reviewed/updated annually with staff input.

Note: In discussion with the Department of Public Welfare's Personal Care Home Advisory Committee task group on staffing, the following was agreed to be deleted along with all of 2600.60.

~~(1) An annual assessment of staff training needs shall include questionnaires completed by all staff with data compiled, or a narrative summarizing group discussion of needs.~~

~~(2) An overall plan for addressing the needs identified in paragraph (1). This plan shall be based on the assessment of staff training needs, and shall indicate training content, trainers and proposed dates of training.~~

~~(3) A mechanism to collect written feedback on completed training.~~

~~(4) An annual evaluation of the staff training plan, including the extent to which implementing the plan met the identified training needs.~~

~~§ 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.~~

~~(1) The plan shall be based upon an employee's previous education, experience, current job functions and job performance.~~

~~(2) The employee shall complete the minimum training hours as listed in § 2600.58(d) (relating to staff training and orientation) with the subject selections being based upon the needs identified in the training plan.~~

~~(3) Annual documentation of the required training in the individual staff training plan shall be maintained for all staff.~~

PHYSICAL SITE

§ 2600.81. Physical accommodations and equipment.

Upon new construction and significant renovation 6 months after _____ (Editor's Note: The blank refers to the effective date of adoption of this proposal.) The home shall provide or arrange for physical site accommodations and equipment necessary to meet the health and safety needs of a resident with a disability and to allow safe movement within and exiting the home. *Rationale: We understand that it has been common practice to grandfather existing buildings prior to a reasonable date after implementation of new regulations so that any existing buildings or building plans in the works will not be unfairly disadvantaged. This was done most recently with the Drug & Alcohol regulations. We ask for similar consideration here, especially in light of the new Labor & Industry Building code regulations that go into effect January 1, 2003.*

§ 2600.83. Temperature.

(a) The indoor temperature in resident living areas shall be at least 70°F when residents are present in the home. *(concern for garage area in smaller homes and whether the inspector would require the garage to be 70 degrees)*

§ 2600.85. Sanitation.

(a) Sanitary conditions shall be maintained in the home.

Note that (b) through (f) should be under (a) and therefore should be numbered in roman numerals.

b) There may be no evidence of infestation of insects, rodents or other animals *(do you mean dogs and cats?)* in the home.

(c) Trash shall be removed from the premises at least once a week.

(d) Trash in kitchens and bathrooms shall be kept in ~~covered~~ trash receptacles that prevent the penetration of insects and rodents. *Covered containers do not prevent infestation.*

(e) Trash outside the home shall be kept in closed receptacles. ~~that prevents the penetration of insects and rodents.~~

(f) A home that is not connected to a public sewer system shall have a written sanitation approval for its sewage system by the sewage enforcement official of the municipality in which the home is located.

§ 2600.90. Communication system.

(a) The home shall have a working, noncoin operated, telephone with an outside line that is accessible in emergencies for all residents and staff in the home and is accessible to persons with disabilities.

2600.93. Handrails and railings.

(a) Each ramp, interior stairway and outside steps exceeding two steps shall have a well-secured handrail.

(b) Each porch that has over a 30-inch drop shall have a well-secured railing. for new construction or renovations.

§ 2600.94. Landings and stairs.

(a) Interior and exterior doors that open directly into a stairway and are used for exit doors, resident areas, and fire exits shall have a landing, which is a minimum of 3 feet by 3 feet. For new construction or renovations.

(b) Interior stairs, exterior steps, walkways and ramps shall have nonskid surfaces.

§ 2600.96. First aid supplies.

(a) The home shall have at a minimum, in each building, a first aid manual, nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, tape, scissors, breathing shield, eye coverings and ~~syrup of ipecac~~. These items shall be stored together in a first aid kit.

§ 2600.98. Indoor activity space.

(a) The home shall have indoor activity space for activities such as reading, recreation and group activities.

(b) The home shall have at least one furnished living room or lounge for the use of residents, their families and visitors. The combined living room or lounge areas shall be sufficient to accommodate all residents at one time. ~~These rooms shall contain a sufficient number of tables, chairs and lighting to accommodate the residents, their families and visitors.~~ *This is excessive. There has not been a problem with this in the current regulations that we know of.*

§ 2600.99. Recreation space.

The home shall provide regular access to outdoor and indoor recreation space and recreational items~~, including books, magazines, puzzles, games, cards, gliders, paper, markers and the like~~. *This list will change with new generations. Don't specify.*

§ 2600.101. Resident bedrooms.

(c Upon new construction and significant renovation after _____ (Editor's Note: The blank refers to the effective date of adoption of this proposal.) each bedroom for a resident with a physical immobility shall have 100 square feet per resident, or allow for easy passage between beds and other furniture, and for comfortable use of a resident's assistive devices, including wheelchairs, walkers, special furniture or oxygen equipment. This requirement does not apply if there is a medical order from the attending physician that states the resident can maneuver without the necessity of the additional space.

(3) Pillows and bedding that are ~~is~~ clean and in good repair.

((l) Cots and portable beds are prohibited for residents.

(n) Upon new construction and significant renovation after _____ (Editor's Note: The blank refers to the effective date of adoption of this proposal.) ~~A~~ bedroom may not be used as a means of egress from or used as a passageway to another part of the home unless in an emergency situation.

(o) A resident may share a room with a resident of the opposite sex if they choose but are not required to. ~~not be required to share a bedroom with a person of the opposite sex.~~

§ 2600.102. Bathrooms.

(a) There shall be at least one functioning flush toilet for every six or less residents. ~~users, including residents, family and personnel~~.

(b) There shall be at least one sink and wall mirror for every six or less users, residents. ~~users, including residents, family and personnel~~.

(c) There shall be at least one bathtub or shower for every 15 or less users, residents. ~~users, including residents, family and personnel~~.

(g) Individual toiletry items including toothpaste, toothbrush, shampoo, deodorant, comb and hairbrush shall be made available for SSI residents.

(h) Toilet paper shall be provided for every toilet.

(i) A dispenser with soap shall be provided in all of the bathrooms. Bar soap is not permitted unless there is a separate bar in a clearly labeled container for each resident sharing a bathroom

(j) Toiletries and linens shall be accessible. ~~in the possession of the resident in the resident's living space.~~

§ 2600.103. Kitchen areas.

(a) A home shall have an operable kitchen area with a refrigerator, sink, stove, oven, cooking equipment and ~~cabinets~~ storage.

(d) Food shall be stored off the floor or the lowest shelf shall be sealed to the floor. *Most health departments say 6 inches or more above floor.*

(e) Food shall be labeled, dated, rotated and inventoried on a regular basis ~~weekly~~.

(l) With the exception of service animals, Animals are not permitted in the kitchen or other food service areas when meals are being prepared, served or consumed,

§ 2600.104. Dining room.

(a) A dining room area shall be equipped with tables and chairs and able to accommodate the ~~maximum~~ number of residents scheduled for meals at any one seating time.

(c) Condiments shall be available in the dining area. ~~at the dining table~~.

(d) Special provisions shall be made and adaptive equipment shall be provided, when necessary, to assist residents in eating ~~at the table~~ in order to meet the needs of the residents.

§ 2600.105. Laundry.

(a) Laundry service for bed linens, towels and personal clothing shall be provided by the home, at no additional charge, to residents who are recipients of or eligible applicants for Supplemental Security Income (SSI) benefits. This service shall also be made available to all residents who are unable to perform these tasks independently according to the resident contract. Laundry service does not include dry cleaning.

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

§ 2600.107. Internal and external disasters.

(a) The home shall have written emergency procedures that are ~~shall be developed and~~ approved by qualified fire, safety and local emergency management offices.

(b) The written emergency procedures shall be reviewed and updated annually by the administrator, and approved by qualified fire, safety and local emergency management offices.

(c) Disaster plans shall include at a minimum:

(1) Contact names.

(2) Contact phone numbers of emergency management agencies and local resources for the housing and emergency care of residents affected.

(3) Alternate means of supply of utilities shall be identified and secured. *Excessive cost for small providers if they need to purchase a generator.*

(4) The home shall maintain at least a 3-day supply of nonperishable food and drinking water or plan for obtaining a supply of drinking water for all residents and

personnel. *(drinking water may be a problem to store 3-day supply)* ***We need some reasonableness here. 1 gallon per resident per day is the standard.***

(5) The home shall maintain at least a 3-day supply of all resident medications or have identified an alternate plan for obtaining meds. *(e.g., delivery systems are sometimes weekly only)*

FIRE SAFETY

(b) Doors used for egress routes from rooms and from the building may not be equipped with key-locking devices, electronic card operated systems or other devices which prevent immediate egress of residents from the building.§ 2600.122. Exits.

Unless otherwise regulated by the Department of Labor and Industry for new construction and significant renovation after _____ (Editor's Note: The blank refers to the effective date of adoption of this proposal.) all buildings shall have at least two independent and accessible exits from every floor, each arranged to reduce the possibility that both will be blocked in an emergency situation.

§ 2600.123. Emergency evacuation.

(a) In homes housing five or more immobile residents, the fire alarm system shall be directly connected to the local fire department or 24-hour monitoring service that has been approved by the local fire department where upon new construction and significant renovation after _____ (Editor's Note: The blank refers to the effective date of adoption of this proposal.) (b) Evacuation routes shall be well lighted and clear of obstructions at all times.

§ 2600.130. Smoke detectors and fire alarms.

(d) If the home serves four or more residents or if the home has three or more stories including the basement and attic, there shall be at least one smoke detector on each floor interconnected and audible throughout the home or an automatic fire alarm system that is audible throughout the home.

(e) Upon new construction and significant renovation after _____ (Editor's Note: The blank refers to the effective date of adoption of this proposal) if one or more residents or staff persons are not able to hear the smoke detector or fire alarm system, all smoke detectors and fire alarms shall be equipped so that each person with a hearing impairment will be alerted in the event of a fire.

(f) All smoke detectors and fire alarms shall be tested for operability ~~at least~~ once annually ~~monthly.~~ A written record of the ~~monthly~~ annual testing shall be kept. *Residents will be up in arms about the noise when testing smoke detectors on a monthly basis. Many large homes have a large number of smoke alarms and this could be very time consuming as well as disruptive to the home's harmony. We also understand that wired smoke detectors may require an electrician to test. This could be very costly on a monthly basis.*

(i) Upon new construction and significant renovation after _____ (Editor's Note: The blank refers to the effective date of adoption of this proposal.) in homes housing five or more immobile residents, the fire alarm system shall be directly connected to the local fire department or 24-hour monitoring service approved by the local fire department.

§ 2600.132. Fire drills.

(d) Residents shall be able to evacuate the entire building into a public thoroughfare, or to a ~~fire-safe~~ area designated in writing within the past year by a fire safety expert, within 2 1/2 minutes or within the period of time specified in writing within the past year by a fire safety expert. The fire safety expert may not be an employee of the home. *We continue to have concerns about the 2 ½ minute requirement even with the alternative to get a fire safety expert to sign off on something higher. Due to liability reasons, we are not sure fire safety experts would agree to sign off on a more reasonable evacuation time. The risk factor for falls and fractures in evacuating frail and physically disabled residents in a very short amount of time is our concern.*

RESIDENT HEALTH

§ 2600.141. Resident health exam and medical care.

(a) A resident shall have a health examination that is documented on standardized forms provided or approved by the Department within 60 days prior to admission or within 30 days after admission. The resident health examination shall be completed annually thereafter. The exam shall include the following:

§ 2600.143. Emergency medical plan.

(1) The resident's name, ~~age~~ and birth date. *Birth date should be sufficient so that age does not need to be changed every year.*

(11) Personal information and related instructions from the resident regarding advanced directives, do not resuscitate orders or organ donation if the resident has executed the documents. *We would like clarification on this. Our concern is that residents and families will be expecting the home to honor advance directives. Will DPW permit homes to honor them or will current policy continue?*

NUTRITION

§ 2600.161. Nutritional adequacy.

(c) Daily nutrition ~~Each meal~~ shall contain at least one item from the dairy, protein, fruits and vegetables, and grain food groups, unless otherwise prescribed in writing by a licensed physician or certified nurse practitioner for a specific resident.

(g) Drinking water shall be available to the residents at all times. Other beverages shall be available ~~and offered~~ to the resident each day and the residents shall be

informed where they can obtain these beverages. ~~at least every 2 hours.~~ *The outcome here is to have water and beverages available to the resident with some assurance that the resident is aware they are available. Leave it to the home to determine how this will be accomplished. Many homes now have water, juice, soda and other beverages available throughout the day in the community areas. This can be accomplished without the need for additional staff to make rounds every two hours to offer them.*

§ 2600.162. Meal preparation.

(c) There may not be more than ~~14~~ 16 hours between the evening meal and the first meal of the next day, unless a resident's physician has prescribed otherwise, and there may not be more than ~~4~~ 6 hours between breakfast and lunch, and between lunch and supper.

(f) Meals may shall include a variety of hot and cold food to meet the preferences of the residents. *Depending on the season, the home with resident input may choose not to offer both hot and cold at some meals.*

§ 2600.163. Personal hygiene for food service workers.

(d) Staff, volunteers or residents who have a discharging or infected wound, sore, lesion on hands, arms on ~~or~~ any exposed portion of their body may not work in the kitchen areas in any capacity.

§ 2600.164. Withholding or forcing of food prohibited.

(c) If a resident refuses to accept any nutrition by mouth ~~eat~~ consecutively during a 24-hour period, the resident's primary care physician and the resident's designee or a family member shall be immediately notified.

2600.171. Transportation.

(1) ~~Staff to resident ratios specified in § 2600.56 (relating to staffing) apply.~~ Staffing should be based on needs of the residents.

(5) At least one staff member transporting residents has completed the initial new hire direct care staff training or been grandfathered in.

MEDICATIONS

§ 2600.181. Self-administration.

(e) A resident is capable of self-administering medications if the resident can use the medication as prescribed in the manner prescribed. The resident shall be able to

recognize and distinguish the medication ~~and know the condition or illness for which the medication is prescribed, the correct dosage and when the medication is to be taken~~ Examples include being capable of placing medication in the resident's own mouth and swallowing completely, applying topical medications and not disturbing the application site, properly placing drops in eyes, correctly inhaling inhalants and properly snorting nasal therapies. *We recommend that this be defined as being the physician's determination as to whether the resident is capable of self-administering medications.*

(f) The appropriate state agency shall develop a medication assistive personnel (MAP) training program that will permit trained staff to assist with administration of medications. *(Rationale: With the severe nursing shortage and high cost of care to consumers when you are required to provide professionally licensed services, it makes good sense to train unlicensed staff to assist where needed. This should be a "Train the trainer" model).*

(g) Medication assistive personnel (MAP) may administer medications after successfully completing a state approved and appropriate training course that includes a written and performance-based competency examination. To qualify for training as a MAP, the individual must be a high school graduate and have English language proficiency.

§ 2600.182. Storage and disposal of medications and medical supplies.

(a) Prescription, OTC and ~~CAMs~~ shall be kept in their original labeled containers and may not be removed more than 2 hours in advance of the scheduled administration. Assistance with injections and sterile liquids shall be provided immediately upon removal of the medication from its container. Many homes *do not have the room to store CAMs and CAMs are not always labeled correctly when received by the home.*

(b) Prescription, OTC, ~~CAM~~ and syringes shall be kept in an area or container that is locked.

(c) Prescription, OTC and ~~CAM~~ stored in a refrigerator shall be kept in a separate locked container. *What if refrigerator is in the med room that is locked? Permitted?*

(d) Prescription, OTC and ~~CAM~~ shall be stored separately. *Clarify that you mean each resident's meds are stored apart from each other? (e.g., does a divider in med drawer work?)*

(f) Prescription, OTC and CAM, discontinued and expired medications, and prescription medications for residents who are no longer served at home shall be destroyed of in a safe manner according to the Department of Environmental Protection and all Federal and State regulations. When a resident permanently leaves the home, the resident the designated person, if any, or the person or entity taking responsibility for the new placement on the day of departure from the home. shall be offered their meds upon discharge. ~~medications shall be given to the resident,~~

(h) Prescription, OTC, ~~CAM~~ and syringes shall be stored in accordance with Federal and State regulations.

§ 2600.183. Labeling of medications.

(b) OTC, ~~CAM and sample medications~~ shall be labeled with the original label.

(c) If the OTC and CAM belong to the resident, they shall be identified with the resident's name.

(d) Sample medications shall be identified by the physician with the dosage, time and resident's name. the particular resident's use and accompanied by a physician's order. *Note: It's not always possible for provider to get this from the physician. Let home determine whether they will store sample meds whether they take them and how many and frequency or in resident contract.*

§ 2600.184. Accountability of medication and controlled substances.

(3~~) Limited access to medication storage areas~~. Medication storage for controlled substances shall be locked with limited access *(i.e., not everyone has a key).*

§ 2600.185. Use of medications.

(a) Prescription, OTC, CAM and sample medications shall be clearly marked for whom the medication was prescribed or approved.*repetative*

(b) If the home helps with self-administration, then the only prescription, OTC and CAM medications that are allowed to be given are those prescribed, approved or ordered by a licensed physician, certified registered nurse practitioner, licensed dentist or physician's assistant within its scope of practice. *May be a hardship to get order for OTC and residents get this on their own sometimes without the knowledge of the provider (e.g., nasal spray).*

(c) Verbal changes in medication may only be made by the prescriber and shall be documented in writing in the resident's record and the medication record as soon as the home is notified of the change. *(make part of training for med assistant)*

§ 2600.186. Medication records.

(b) If the home helps the resident with self-administration, a medication record shall be kept to include the medications ordered by those prescribed, approved or ordered by a licensed physician, certified registered nurse practitioner, licensed dentist or physician's assistant within its scope of practice. ~~following for each resident's prescription, OTC and CAM:~~

(1) The prescribed dosage.

(2) Possible side effects as provided by pharmacy.

(3) Contraindicated medications as provided by the pharmacy.

(4) Specific administration instructions.

(5) The name of the prescribing physician.

(6) Drug allergies identified on med eval

(7) Dosage, date, time and the name of the person who helped with the ~~self-~~administration of the medication. *This is not self-administration if we are doing all this. Contradicts definition of self-administration.*

(c) The information in subsection (b)(7) shall be recorded at the same time each dosage of medication is ~~self-~~administered. *This is not self-administration if we are doing all this. Contradicts definition of self-administration.*

(d) If a resident refuses to take a medication, the refusal shall be documented in the resident's record and reported to the physician ~~by the end of the shift.~~ promptly. Subsequent refusals to take a prescribed medication shall be reported as required by the physician. *Faxes acceptable?*

SAFE MANAGEMENT TECHNIQUES

§ 2600.201. Safe management techniques.

(a) The home shall use positive interventions to modify or eliminate a behavior that endangers residents, staff or others. Positive interventions include improving communications, reinforcing appropriate behavior, redirection, conflict resolution, violence prevention, verbal praise, deescalation techniques and alternatives, techniques or methods to identify and defuse potential emergency situations. *How will DPW measure this? Homes may not understand what their responsibilities are under this requirement. This is a new training piece that may be costly.*

(b) ~~A home shall incorporate a quality improvement program designed to continuously review, assess, and analyze the home's ongoing steps to positively intervene when a resident demonstrates a behavior that endangers residents, staff or others.~~ There shall be documentation of the follow-up action that was taken to prevent future incidences.

§ 2600.202. Prohibition on the use of seclusion and restraints.

(2) The use of aversive conditioning, defined as the application of startling, painful or noxious stimuli. *What does this mean? Not all providers understand this terminology. Give examples.*

SERVICES

§ 2600.222. Community social services.

The administrator may ~~shall~~ encourage and assist residents to use social services in the community where available and appropriate which may benefit the resident, including a county mental health and mental retardation program, a drug and alcohol program, a senior citizens center, an area agency on aging or a home health care agency.

§ 2600.223. Description of services. *Repetitive (required in resident contract. What is it that you are asking for here? Is this a marketing brochure?)*

(a) The home shall have a written description of services provided or not provided shall be stated in the resident contract. ~~and activities that the home provides to include the following:~~

~~(1) The scope and general description of the services provided by the home.~~

~~(2) The criteria for admission and discharge.~~

~~(3) Specific services provided by the home.~~

§ 2600.225. Initial assessment and the annual assessment.

(b) The resident's initial assessment and annual assessment shall include the following areas if appropriate for resident:

(1) Background information.
(2) Medical assessment.
(3) Social assessment.
(4) Mobility assessment.
(5) ADL assessment.
(6) IADL assessment.
(7) Medication assessment. *Define.*
(8) Psychological assessment. *Define: Is this a MM or GDS and is it required for everyone?*

(d) In addition to the initial assessment at admission, the resident shall have additional assessments as follows:

(1) Annually within 30 days before or 30 days after the resident's anniversary date of admission.

(2) If the condition of the resident ~~materially~~ substantially changes prior to the annual assessment, the review shall be completed and updated on the current version.

(3) At the request of the State agency upon cause to believe that an update is required.

(4) At the time of a hospital discharge. if a substantial change has occurred. *(Does this include ER or overnight hospital?)*

(h) If a resident is determined to be immobile as part of the initial intake or annual assessment, specific requirements relating to the care, health and safety of an immobile resident shall be met immediately. The resident shall be ~~continually~~ assessed for mobility annually or upon a substantial change as part of the resident's support plan.

§ 2600.226. Development of the support plan.

(a) A support plan shall be developed and implemented for each resident within 15-calendar days of admission to the home. This plan shall also be revised within 30 days upon completion of the annual assessment or upon changes in the level of functioning of the resident as indicated on the assessment. It shall address all of the needs of the resident's current assessment including the resident's personal care needs.

(b) The resident or the resident's family or advocate, or both, shall be informed of the right to have the following people assist in the development of the resident's support plan: *(may not be able to coordinate this in 15 days)*

(1) Case manager from the social service agency when the resident has a case manager.

(2) Other social service entities *(ambiguous, give examples).*

(3) The home staff.

(4) Family or advocates.

(5) Doctors.

(6) Other interested persons designated by the resident.

~~(c) Documentation of reasonable efforts made to involve the resident's family, with the consent of the resident, shall be kept. If the resident's family declines, this fact shall be documented in the record.~~ *Have inspectors look at outcome too much documentation.*

~~(d) Persons who participated in the development of the support plan shall sign and date the support plan.~~ *Can't do this on computer; we're not a nursing home.* Administrator or home designee shall signoff on the support pan.

~~(e) If a resident or family member chooses not to sign the support plan, proper documentation of the effort to obtain their signature must be shown.~~

§ 2600.228. Notification of termination.

(b) If the home initiates a discharge or transfer of a resident, or if the legal entity chooses to close the home, the home shall provide a 30-day advance written notice to the resident, the resident's legal representative, and the referral agent citing the reasons for the discharge or transfer. This shall be stipulated in the resident-home contract signed prior to admission to the home. A 30-day advance written notice may not be given if a delay in discharge or transfer would jeopardize the health or safety of the resident or others in the home, ~~as certified by a physician.~~ This shall occur when the resident needs psychiatric or long-term care or is abused in the home, or the Department initiates a closure of the home. *The home should be able to determine this without a physician certification.*

(h) The only grounds for discharge or transfer of a resident from a home are for the following conditions:

(3) If a resident's functional level has ~~advanced or~~ declined so that the resident's needs cannot be met in the facility even with supplemental services provided by outside providers as outlined in the resident's contract. In this situation, a plan for other placement shall be made as soon as possible by the administrator in conjunction with the resident or designated person, if any, or both. If assistance with relocation is needed, the administrator shall contact appropriate local agencies, such as the area agency on aging, county mental health/mental retardation program or drug and alcohol program, for assistance. The administrator shall also contact the appropriate personal care home regional field licensing office.

(5) If the resident has failed to pay or cooperate with efforts to obtain public funding within 30 days, if home accepts residents with public funding.

(6) If closure of the home is initiated by the Department.
(7) Violation of home rules.
(8) Repeated violation or disruption of the home's harmony.

SECURED UNIT REQUIREMENTS

§ 2600.231. Doors, locks and alarms.

Doors locked by using an electronic or magnetic system to prevent egress are considered mechanical device restraints and are permitted in licensed homes for specialized secured units so long as the following safety standards are met:

(1) If the building meets current Labor and Industry occupancy certification for a small or large personal care home, the secured unit shall be located at grade level of home with an outside enclosed area such as a porch or patio located on same grade level adjacent to the secured unit. *We suggest grandfathering here for current providers.*

(4) Doors that open to the outdoor enclosed areas may not be operated by an electronic or magnetic locking system, or similar device.

(5) Residents shall have free and easy access to the enclosed areas year round, except after dusk and during inclement weather *(what do you mean by inclement weather – excessive heat cold, humidity, rain, national weather service – needs further clarification).*

(9) Fire alarm systems shall be interconnected to the local fire department, where available, or a 24-hour monitoring/security service approved by the local fire department. *Cost for small providers is a concern.*

(10) The home shall provide for even illumination and appropriate levels of light to maximize vision. *How will DPW determine or measure it? Look at the desired outcome here.*

(11) The home shall take proactive safety measures to minimize hazards and risk of falls. ~~through the provision of sturdy furniture, ramps and removal of clutter.~~ *How will DPW determine or measure it? Look at the desired outcome here.*

§ 2600.232. Environmental standards.

Environmental standards include the following:

(1) The home shall provide adequate (define) exercise space, both indoor and outdoor.

(2) The home shall ensure that no more than two residents are housed in a bedroom regardless of its size to help the resident live as comfortably as possible in a secured unit.

(3) Space shall be provided for privacy and for common activities.

(4) The home shall provide a full description of the environmental cues and way-finding *(define)* assistance to be utilized for the resident population.

§ 2600.233. Admission standards.

Admission standards include the following:

(2) A licensed physician, or a geriatric assessment team *?? Define team* shall complete these assessments for the resident requiring the secured unit.

(3) A complete medical and cognitive assessment is not required for the spouse or relative of the resident requiring the secured unit, if the spouse or relative does not have a diagnosis requiring the secured unit but expresses a desire to live with the resident.

(4) Each resident record shall have documentation that the resident or the resident's legal representative has consented to the resident's admission or transfer to the secured unit.

(5) The home shall maintain a written agreement containing a full disclosure of services as outlined in the resident contract, admission and discharge criteria, change in condition policies, services, special programming and cost and fees pertaining to the resident.

§ 2600.234. Care standards.

Care standards include the following:

(2) Within 15 days ~~72 hours~~ of the admission ~~or within 72 hours prior to the resident's admission~~ to the secured unit, a support plan shall be developed, implemented and documented in the resident record and shall identify the resident's physical, medical, social, cognitive and safety needs, who will address these needs and the responsible person. *(be consistent with other requirement for support plans)*

(4) The resident or the resident's legal representative, or both, shall be involved in the development and review of the support plan if interested.

§ 2600.235. Discharge standards.

Discharge standards which shall provide that if the home initiates a discharge or transfer of a resident, or the legal entity chooses to close the home, the administrator shall give a 60-day advance written notice to the resident, unless the resident meets the discharge criteria outlined (2600.228) the resident's legal representative and the referral agent citing the reasons for the discharge or transfer. This requirement shall be stipulated in the resident-home contract signed prior to admission to the secured unit.

§ 2600.236. Administrator training.

Administrator training includes the following:

(1) In addition to the training requirements found in § 2600.57 (relating to administrator training and orientation), the administrator of the home with a secured unit shall complete orientation related to dementia, secured unit management and staff training.

(2) Ongoing education shall be competency-tested training including the following content areas specific to the stage of dementia and addressing issues particular to the resident:

(i) Psychosocial issues.

(ii) Specific cultural issues.

(iii) Psychological changes.

(iv) Functional consequences of other age-related diseases.

(v) Interpersonal skills in communications and team building.

(vi) Care-giving strategies.

(vii) Sexuality issues.

(viii) Nutrition issues.

(ix) Communication issues with residents and family and therapeutic activities, techniques and strategies.

(x) Medication use, effects and side effects.

(xi) Abuse prevention and resident rights consistent with the Older Adult Protective Services Act (35 P. S. §§ 10225.101--10225.5102).

The above requirements needs a thorough review as to the length, cost, who will train, standardized course, etc.

§ 2600.237. Staff training on dementia.

In addition to the training requirements in § 2600.58 (relating to staff training and orientation), all staff of a secured unit shall receive and successfully pass competency-based training related to dementia, to include the following:

(1) The normal aging-cognitive, psychological and functional abilities of older persons.

(2) The definition and diagnosis of dementia, description of reversible and irreversible causes, and an explanation of differences between dementia, delirium and depression.

(3) The definition of dementia and related disorders, progression, stages and individual variability.

(4) Communication techniques.

(5) The description of behavioral symptoms of dementia and how to manage resident behaviors.

(6) The role of personality, culture and environmental factors in behavioral symptoms and dementia care.

(7) The home's philosophy of dementia care, including mission statement, goals, policies and procedures.

(8) Working with family members.

(9) Resources for residents with dementia and their families.

(10) Team building and stress reduction for the staff.

(11) The Older Adult Protective Services Act (35 P. S. §§ 10225.701--10225.707).

The above requirements needs a thorough review as to the length, cost, who will train, standardized course, etc.

§ 2600.239. Programming standards.

Programming standards include the following:

(1) Activity programming in the secured unit, which shall maximize independence while focusing on strengths and abilities. *How do they measure this?*

(2) General activity programming, which shall be offered with a frequency that meets the individual needs of the resident.

(3) Resident participation in general activity programming, which shall:

(i) Have a purpose that the resident can appreciate and endorses.

(ii) Be done voluntarily.

(iii) Respect the resident's age and ~~social status.~~ *and cognitive limitations.*

(iv) Should promote the ~~Take advantage of the~~ resident's retained abilities.

§ 2600.240. Notification to Department.

Notification to the Department is required as follows:

(3) The following documents shall be included in the written notification:

(i) The name, address and legal entity of the home.

(ii) The name of the administrator of the home.

(iii) The total resident population of the home.

(iv) The total resident population of the secured unit.

(v) A building description and general information.

(vi) A unit description. *(can this be a floor plan?)*

(vii) The type of locking system.

(viii) Emergency egress.

(ix) A sample of a 2-week staffing schedule.

(x) Verification of completion of additional training requirements.

(xi) The operational description of the secured unit locking system of all doors.

(xix) A sample consent form from the resident, or the resident's legal representative agreeing to the resident's placement in the secured unit. *which can be included in the resident contract.*

(xx) A sample of the written agreement containing full disclosure of services, admission and discharge criteria, change in condition policies, services, special programming and cost and fees.

(xxi) A description of environmental cues being utilized.

(xxii) A general floor plan of the entire home.

(xxiii) A specific floor plan of the secured unit, outside enclosed area and exercise space. *repetitive*

RESIDENT RECORDS

§ 2600.251. Resident records.

(a) A separate record shall be kept for each resident.

(b) The entries in a resident's record shall be permanent legible, dated and signed by the person making the entry. *Does this imply that progress notes are being required?*

§ 2600.252. Content of records.

(b) Each resident's record shall include emergency information such as:

(1) The name, address, telephone number and relationship of a designated person to be contacted in case of an emergency.

(2) The name, address and telephone number of the resident's physician or source of health care and health insurance information, if any.

(3) The current and previous 2 years' med evals from physician's examination reports, including copies of the medical evaluation forms, where applicable.

(11) If the resident dies in the home, a record of the death of the resident. A photocopy of the official death certificate shall be retained in the resident's file.

§ 2600.253. Record retention and disposal.

(3) The home shall maintain a log of resident records destroyed on or after _____ (*Editor's Note*: The blank refers to the effective date of adoption of the proposal.). This log shall include the resident's name, record number *(not all homes use record numbers – say "where applicable")*, birth date, admission date and discharge date.

§ 2600.254. Record access and security.

(b) Each home shall have and utilize a policy and procedures addressing record accessibility, security, storage, authorized use and release, and who is responsible for the records. *For all newly required policies and procedures we would like to see DPW together with stakeholder groups through the PCH Advisory Committee develop sample policies and procedures.*

(c) Resident identifying information shall be stored in locked containers or a secured, enclosed area used solely for record storage and be accessible ~~at all times~~ during business hours to the administrator or a designee.

ENFORCEMENT

§ 2600.261. Classification of violations.

(a) The Department will classify each violation of this chapter pertaining to homes into one of three categories as described in paragraphs (1)--(3). A violation identified may be classified as Class I, Class II or Class III, depending upon the severity, duration and the adverse effect on the health and safety of residents.

(1) *Class I.* Class I violations have a substantial probability of resulting in death or serious mental or physical harm to a resident.

(2) *Class II.* Class II violations have a substantial adverse effect upon the health, safety or well being of a resident.

(3) *Class III.* Class III violations are minor violations, which have an adverse effect upon the health, safety or well being of a resident.

(b) The Department's criteria for determining the classification of violations are available from the appropriate personal care home regional field licensing office.

Where are paper violations/errors classed?

§ 2600.262. Penalties.

(j) If the home wishes to contest the amount of the penalty or the fact of the violation, the home shall forward the assessed penalty, not to exceed $500, to the Secretary of Public Welfare (Secretary) for placement in an escrow account with the State Treasurer. A letter stating the wish to appeal the citation or penalty shall be submitted with the assessed penalty. This process constitutes an appeal.

(1) If, through an administrative hearing or judicial review of the proposed penalty, it is determined that no violation occurred or that the amount of the penalty shall be reduced, the Secretary will, within 30 days, remit the appropriate amount to the licensee together with interest accumulated on these funds in the escrow deposit, and the department will expunge all records regarding this on paper and on the I-net if reported there

(5) Money collected by the Department under this section will be placed in a special restricted receipt account and will be used first to defray the expenses incurred by residents relocated under this chapter or Chapter 20. The Department each year will use money remaining in this account to assist with paying for enforcement of this chapter relating to licensing. Fines collected will not be subject to 42 Pa.C.S. § 3733 (relating to deposits into account). *Conflict of interest? Concern that self-funding equals quotas. We would suggest that the fees collected go to fund an "Office of Technical Assistance" for quality improvement in poor-performing homes.*

§ 2600.263. Revocation or nonrenewal of licenses.

(c) Upon the revocation of a license in the instances described in subsections (a) and (b), or if the personal care home continues to operate without applying for a license as described in § 2600.262(h) (relating to penalties), residents shall be relocated. *Immediately? Within what time frame?*

PEOPLE BEFORE PROFITS

Original: 2294

PANPHA

1100 Bent Creek Boulevard
Mechanicsburg, PA 17050

November 4, 2002

Teleta Nevius
Director
Office of Licensing & Regulatory Management
Department of Public Welfare
P.O. Box 2675
Harrisburg, PA 17105-2675

Dear Ms. Nevius:

PANPHA, an association of more than 350 non-profit senior services providers, has participated in many public input sessions on the human services licensing project, which included an attempt to license all adult residential facilities with a uniform set of regulations, then shifted its focus to personal care home regulations. PANPHA does not believe that the proposed changes to the current personal care home regulations are in the public interest. **PANPHA has serious concerns about the public policy directions, financial costs, and the reasonableness of implementation of certain provisions of the proposed regulations. The impact, especially on small homes and on residents at all income levels, will be significant and negative.** (Please note that PANPHA's comments follow the text as published in the October 5, 2002 *Pennsylvania Bulletin* as found on the *Pennsylvania Bulletin's* website. In reviewing the proposed regulations, PANPHA held 7 regional meetings with our members to get their feedback.)

The proposed regulations would impose significant new costs on homes and residents and, in most cases, these costs would not improve the health, safety or welfare of the residents. They would instead verify paper compliance with planning documents. To pay for these requirements, homes must either increase costs to the resident, reduce care and services, or allow the costs to impact the viability of the provider. PANPHA members already provide significant subsidies so that they can continue to provide the care and services residents need.

These proposed regulations would not address the severe insufficiency of the public payment source for low-income Pennsylvanians who need the care provided by a personal care home.

The proposed regulations do not change the definition of who is served in personal care homes or the services that are provided. They would, however, make significant changes to many aspects of personal care homes that do not need to be changed. Unfortunately, they do not change the important area of enforcement which all agree should be improved.

Finally, the proposed regulations do not recognize that requirements imposed on all of the personal care homes in the Commonwealth -- but not enforced -- will not improve the health and safety of residents anywhere. In the absence of effective enforcement, additional requirements will continue to be ignored by the homes that have no intention of complying. **The Commonwealth will be well-served if the current personal care home regulations were effectively enforced.**

PANPHA's Major Concerns on The Proposed Regulations

1. Given the many, many discussions that have occurred in the past few years about creating assisted living and allowing people to "age in place," **it is important to note at the outset that the proposed regulations deal with what exists now in the 2620 regulations and Act 185 of 1988 and the population that is currently served in personal care homes.** The definition of personal care home is in statute and has not been changed in the proposed regulations. It continues to be *A premise in which food, shelter and personal assistance or supervision are provided for a period exceeding 24 hours, for four or more adults who are not relatives of the operator, who do not require the services in or of a licensed long-term care facility, but who do require assistance or supervision in matters such as dressing, bathing, diet, financial management, evacuation of a home in the event of an emergency or medication prescribed for self-administration.* The state apparently intends to continue to limit who may reside in a personal care home to the population described in Act 185 and the 2620 regulations without addressing "assisted living" or "aging in place" or any of the other concepts and philosophies discussed over the years. The proposed regulations address personal care homes and the same population who have resided in personal care homes for the past 10 years.
2. While PANPHA and other groups have discussed with DPW the need to address the issue of aging in place, Act 185 and regulatory definitions of personal care home and personal care resident have not been changed to allow it. However, many of the proposed requirements assume a much more vulnerable population. If the state intends for personal care homes to serve a nursing home eligible population, it should change the definitions to allow nursing home eligible people to reside in personal care homes. If not, the state need not impose rules that, in some cases, are even more onerous than those with which nursing homes comply.
3. Given the U.S. Supreme Court's *Olmstead* decision, **it seems bizarre that the Commonwealth would be moving to close small, community-based providers by requiring them to be more like institutions than homes.** It is our understanding that DPW views personal care homes as community-based services. Enclosed is a PANPHA *Government Affairs* article about the *Olmstead* decision.
4. It should also be noted that the statute requires a medical examination by a physician, an initial standardized screening instrument, and a standard written admission agreement to include the disclosure to each resident the actual rent and other charges for services provided by the PCH. **The many additional paperwork requirements envisioned** – including assessments, support plans, individualized staff training plans, etc., etc. **are not required by statute.** The requirements for many of these plans go well beyond the intent of the

regulations, which is to assure that PCHs provide safe, humane, comfortable and supportive residential settings 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.

5. **PANPHA is disappointed that the proposed regulations do not change the enforcement requirements to assist DPW in its licensure activities to improve the compliance of homes that consistently provide poor care, violate residents rights, and should not be in business.** It is essential that the issue of enforcement be addressed, rather than simply putting additional requirements on the homes that already comply with the existing regulations. More requirements that are not enforced are the least effective, most intrusive way to regulate: They will just limit the resources of the homes that want to provide good service and comply with the regulations yet they will not change in any meaningful way the activities of homes which have no interest in providing good care or being in compliance with the regulations. **Because the statute is very detailed in what the department must do to enforce licensing requirements, it may be the case that the Department cannot change – or perceives that it cannot add to the enforcement provisions in statute and that these must be changed by the General Assembly rather than through regulation.** PANPHA supports the recommendations of DPW's Personal Care Home Advisory Committee on improving DPW's ability to enforce the regulations.
6. Finally, **there must be a true estimate of the costs involved**. The costs for personal care homes and the residents of these homes are enormous. The proposed requirements would surely cause access issues for both current personal care home residents and those who would need but not be able to get into a personal care home. Since most people do not move to a care facility unless they have exhausted their family and other informal resources, something will need to be provided for them, and in many cases, it will need to be provided by the state. This may translate into additional costs for nursing facilities; home and community based waiver slots; or investigations for neglect due to the inability of these people to find or provide their own care.

THE FOLLOWING ARE PANPHA'S DETAILED COMMENTS ON THE PROPOSED PERSONAL CARE HOME REGULATIONS.

First, we continue to recommend a review for consistency of language. One specific area of concern for inconsistent language is in the apparently interchangeable use of the terms "designated person," with "the resident's family and advocate." We recommend using the term "designated person." In addition, check "resident's agreement" and "contract" wording for consistency throughout. In addition, many sections need to be clarified and many concepts are duplicated in several sections of the requirements, which is confusing.

Areas that PANPHA Cannot Support in this Regulation

1. The staff training provisions are very costly and many would not contribute to good quality of care. In addition, although the population served in personal

care homes is, by definition both in statute and regulation, people who do not need care in a hospital or nursing home, it is questionable why staff would need more training in a personal care home than is required for nursing home staff. Section 2600.58 - Staff Training.)

2. Providers must have the ability to discharge a resident who is disruptive, offensive or in other ways disturbs other residents and staff even if it is not a threat to anyone's health or safety. A home should be allowed to have home rules, which are disclosed to the resident prior to admission, and to evict residents who have shown that they will not follow these rules. (Section 2600.42(u) - Specific Rights, and Section 228 (h) - Notification of Termination.) In addition, these requirements duplicate one another in intent but are not the same in content, making them very confusing.
3. We were extremely disappointed to see in the proposed regulation a definition of self-administration that DPW never discussed with stakeholders. This definition should be deleted. The physician, rather than the state, is best able to decide who is capable of self-administration. There are additional difficulties with the definition that will be discussed in the detailed portion of PANPHA's comments. (Section 2600.181- Self Administration)
4. There needs to be a public policy discussion on a medications technician program for long-term care programs. PANPHA is aware of unlicensed personnel administering medication, with appropriate training, in programs serving people with mental retardation and suggests using this program as a model. PANPHA has three public policy positions on this topic. They are as follows:

    - " The state should allow the establishment of a medications technician program to educate unlicensed personnel in the administration of medications in the long-term care continuum."

    - "Medication administration is one of the nursing tasks that can be appropriately delegated. Certain functions, however, such as administration of intravenous and intra-muscular injections, and assessment of the patient should not be delegated."

    - "If delegation is allowed for administration of, or assistance with, certain medications, a good pharmacology course that would be standardized and recognized by the state is necessary. The course should be taught by a variety of approved providers, such as community colleges, pharmacies, long-term care nursing facilities, home health agencies, or personal care facilities. Continuing education should be required of persons who administer or assist with medications."

5. There is a need to be consistent in clarifying that residents are mobile if they can exit to a fire-safe area, rather than being required to exit to the outside of the personal care home. (Section 2600.4 Definitions of "Mobile Resident" and "Immobile Resident" for example.)

6. There are several new residents rights proposed that are especially unreasonable, conflicting, and infeasible. See sections 2600.42 (u), (w), (x),, (y), and (z). More specific discussion will be provided under each specific section. These are simply unrealistic.
7. Support plans for all residents (including those, apparently, who just live at the personal care home in case they need services later or to live with their spouse) will either drive up the cost of providing care or reduce the care available for residents. Any need for support plans is adequately addressed in the section on secured units. The residents of these units are more vulnerable than those envisioned in the current regulations because the unit is secured, and these people will be required to receive support plans under the proposed regulations. While it may be argued that support plans are a good business practice in a large home or for staff who do not know the residents well, support plans will do more to detract from care than to help in homes where the residents and staff know each other well. In addition, discussion of having the support plans as part of the resident record conflicts with the uses for each document. If a support plan is to be of any use, staff must have access to it. There is information (including social security numbers) in the resident record, however, that must be kept private. The whole discussion of assessment and support plans needs much more thought if it is to be included in regulation. The impact and the potential for unintended negative consequences of these two proposed requirements would be significant.
8. The current regulations require that meals be provided, but do not prescriptively say that they must come from a kitchen in the PCH and what appliances the kitchen must have. The proposed regulations would require a kitchen in the home. Some homes now are able to have the meals provided through a kitchen nearby, which is perfectly adequate to meet the needs of the residents. Under the proposed regulations, these homes would be required to build a kitchen.
9. The number of reportable incidents is increased significantly by the proposed regulation and the description of these incidents fails to take into account whether they are of an unusual nature or more routine transport due to illnesses. In addition, the reporting is increased from one notice to three. The Older Adult Protective Services Act and Regulations provides guidance on reporting of abuse, so the discussion of several of the incidents is duplicative.

DETAILED COMMENTS

Text with strikethroughs indicates current text of the draft which we suggest deleting. Text in capital letters is text we suggest adding.

SUBCHAPTER A. GENERAL ADMINISTRATIVE REQUIREMENTS

GENERAL REQUIREMENTS

Section 2600.3 – Inspections. Recognizing that DPW licensing staff has the authority to enter and inspect a home whenever it is necessary, we commend the Department for changing the requirement for annual inspections and hope that this will allow the Department to focus its resources on the homes that require the most supervision in

order to better assure the health, safety and welfare of the residents of these homes. The proposal clearly reflects the intent of the legislature given the language of Act 185 saying that, "after initial approval, personal care homes need not be visited or inspected annually, provided that the department shall schedule inspections in accordance with a plan that provides for the coverage of at least seventy-five percent of the licensed personal care homes every two years and all homes shall be inspected at least once every three years."

Section 2600.4 – Recommended Changes to Definitions. Several additional definitions are needed, including Assessment, Community, Eating, (to differentiate assistance with eating from food preparation and serving), and Designated Person. Medication errors should be defined in the definitions section rather than the medications section, and if "Resident with Special Needs" continues to be used in the final regulations, this term must be defined. All residents have special needs.

Suggested definitions include:
Assessment – A thorough review and analysis of a consumer's functional status. The term includes a personal history, assessment of physical and emotional health, ability to carry out activities of daily living, informal supports, environmental factors and cognitive functioning, including immobility assessment. Registered nurses from PANPHA facilities stress that assessment is done by RNs only, so perhaps a different word should be used to describe this document, such as "information collection".

Community – A population cluster which offers commercial, social and cultural activities closest to the home.

Eating – the act of eating food, which does not include preparing or serving the food or cleaning up after the meal, except that assisting the resident with personal hygiene needs following a meal may be considered assistance with eating.

Several of the definitions should be revised:

Administrator is defined in the current regulations, but not in the proposed.

Ancillary staff – This is a helpful addition. Perhaps some examples would be useful.

Agent – Contains additional people "other state agency" who are allowed to enter, visit, inspect a home. Additional duties are also covered: conduct an investigation. If other agencies are authorized under their statutes and regulations to enter, visit, inspect and conduct investigations, let them be authorized through those statutes and remove this open-ended reference to persons authorized by other state agencies. In addition, the proposal would fail to discuss the Department's authority to enter, visit and inspect homes that should be licensed but are not. This definition should read:
Agent--A person authorized by the Department ~~or other State agency~~ to enter, visit inspect ~~or conduct an investigation of~~ a personal care home OR A HOME THAT MAY REQUIRE A LICENSE UNDER THIS CHAPTER.

The definition of complaint is not in current regulations. If used, it should read:
Complaint--A written ~~or verbal~~ criticism, dispute, or objection presented by or on behalf of a resident regarding the care, operations or management policies of a personal care home. If the processes envisioned in the rest of this proposal are required for all complaints verbal and written, the effect of the documentation and response would be to do little else than document verbal complaints about problems that usually do not affect health and safety, but may more likely be difficulty in getting along together in a community. Written Grievances may be a better term for instances that would rise to a level that should be documented.

Community - If the home is assisting the resident to remain connected to the community, a definition of community is necessary. The definition in the current regulations is adequate.

Designated Person – The current definition is fine. A person, chosen by the resident and documented in the resident's record, to be notified in case of emergency, termination of service, home closure or other situations as indicated by the resident or as required by this chapter. A resident is not required to have a designated person.

Designee - The term Designee in the proposed regulations is confusing and is not used consistently. Used to define the administrator's designee.

Direct Care Staff – This definition is in statute, therefore delete (ii):
~~(ii) The term includes full and part time employees, temporary employees and volunteers~~.
The definition of Direct care staff in Act 185 is "a person who directly assists residents with activities of daily living; provides services; or is otherwise responsible for the health, safety and welfare of the resident." It would be helpful if the regulations clarified what provides services and is otherwise responsible for the health, safety and welfare of the residents" means.

IADL – If this definition remains, it should be changed to:
IADL--Instrumental activities of daily living--The term includes the following:
(i) Doing PERSONAL laundry.
(ii) Shopping.
(iii) ~~Using~~ SECURING transportation.
(iv) Managing money.
(v) Using a telephone.
In addition, the current regulation discusses several other tasks of daily living, which the Department should consider adding.

Immobile Resident – Definition should be changed to clarify that the person cannot get to a point of safety. A resident who can get to the fire tower without a problem but cannot get down the steps to get out of the building should be considered mobile.
Immobile resident--

(i) An individual who is unable to move from one location to another, or has difficulty in understanding and carrying out instructions without the continual and full assistance of other persons, or is incapable of independently operating a device, such as a wheelchair, prosthesis, walker or cane to ~~exit a building~~ TO MOVE TO A FIRE SAFE AREA.

(ii) The term does not mean that an immobile resident is incapable of self-administering medications.

Medication Errors - If medication errors will be defined, the definition belongs in this section rather than in 2600.187.

Mobile Person – Please take the opportunity to clarify that a person must be able to exit to a point of safety. We recommend that the definition be changed to:

Mobile resident--

(i) A resident who is physically and mentally capable of ~~vacating the personal care home~~ MOVING TO A FIRE SAFE AREA on the resident's own power or with limited assistance in the case of an emergency, including the capability to ascend or descend stairs if present on the exit path. Limited physical assistance means assistance in getting to one's feet, into a wheelchair, walker or prosthetic device. Verbal assistance means giving instructions to assist the resident in ~~vacating the personal care home~~ MOVING TO A FIRE SAFE AREA.

(ii) The term includes a person who is able to effectively operate a device required for moving from one place to another, and able to understand and carry out instructions for MOVING TO A FIRE SAFE AREA ~~vacating the personal care home~~.

Personal Care Home or Home – This definition does not change the population served in personal care homes. The definition is the same as under the current regulations and so, there is no basis for the additional documentation envisioned in the proposed regulations.

Personal Care Resident - PANPHA does not support the requirement for assessments and support plans for residents who are not in the secured units described in section beginning at 2600.231 of the internet www.pabulletin.com version of the proposed regulations. If this requirement is retained for in the final regulation for residents who are not in a secured unit, change the definition of personal care resident to clarify that only those residents who need and receive personal care services must receive assessments and support plans and that staffing ratios or minimum staffing hours are based on those residents who receive personal care services. We recommend changing the definition to: "A person, unrelated to the licensee who resides in a PCH and who ~~may~~ requireS and receiveS personal care services ...."

SP-Support Plan – At a minimum, clarify that support plans are prepared only for those residents who receive personal care services. PANPHA recommends that support plans only be required for residents of secured units, so the definition should read: "A written document for each resident OF A SECURED UNIT describing HOW the resident's care,

service, or treatment needs ~~and when the care, service or treatment will be provided, and by whom~~ WILL BE MET."

Restraint – There is a completely different definition of restraints in 2600.202. The definitions in 2600.4 are the ones that should be used. The definitions in 2600.202 have not been discussed with stakeholders. Having more than one definition is very confusing.

Section 2600.5 - A portion of the current regulations should be added back in to the proposed regulation in section (a): AN INSPECTION WILL BE CONDUCTED DURING NORMAL BUSINESS HOURS EXCEPT WHEN THERE IS REASONABLE CAUSE TO BELIEVE THAT INSPECTIONS AT OTHER TIMES ARE NECESSAR TO DETECT VIOLATIONS OF APPLICABLE STATUTES AND REGULATIONS. PERSONAL EFFECTS OF RESIDENTS WILL NOT BE SEARCHED WITHOUT THE RESIDENT'S CONSENT. The Department has broad authority to enter and inspect whenever necessary. It is more useful for everyone if a routine inspection can be conducted during normal business hours when appropriate staff is available to assist the inspector and provide access to necessary documents.

Change the access requirements (b)(1) to " Agents of the Department ~~or other State Agencies~~.

Section 2600.11 – Procedural Requirements for Licensure or Approval of Personal Care Homes
(b) – PANPHA supports the Department's proposal to inspect some homes less often than annually. Homes with good records of compliance should receive fewer visits and allow the Department to better focus its resources on homes with poor compliance histories.

Section 2600.14 – Fire Safety Approval
Recommend changing to "Except in the cities of Scranton, Pittsburgh and Philadelphia, a personal care home shall have written fire safety approval ~~prior to issuance of a certificate of compliance~~...."

Section 2600.15 - Abuse Reporting.
Since abuse reporting is covered by statute and regulation, just provide the references as you did in 2600.15(a), without the additional paraphrasing in 2600.15(b). In addition, the word "immediately" should be removed from 2600.15(a) in deference to the actions and timeframes specified by the abuse reporting act and regulations.

The requirements of the Older Adult Protective Services Act (OAPSA) and regulations should be reviewed in conjunction with the list of reportable incidents in Section 2600.16 because some of the reporting is duplicative and some of the requirements may be different in each section. The personal care home regulation was promulgated prior to the abuse reporting regulation under OAPSA, so some of the list in current regulations are now covered by the OAPSA requirements.

Section 2600.16 – Reportable Incidents. Please review these requirements in conjunction with the mandatory abuse reporting requirements to make sure the time frames for reporting are consistent.

The use of the word "reportable" as opposed to the current word, "unusual" leaves out the discretion of reporting actions that would be expected given a resident's disease process or frailty. PANPHA is concerned that facilities will have to contact the licensing office whenever someone is transported to the hospital for chest pains, a hip fracture or other routine medical transfers.

Please clarify that hip fracture is not considered a reportable incident. Revise (a) (3) to read as follows: "A serious physical bodily injury, trauma, or medication error requiring ~~treatment at a~~ hospitalIZATION ~~or medical facility~~, not to include HIP FRACTURE or minor injuries such as sprains or cuts." If left as is, DPW may be receiving notice of every trip to the emergency room for any reason.

There are many, many additions to the list of reportable incidents in contrast to the current requirements. Some of these are a good idea. Some of them are either listing one specific type of abuse ((6) misuse of funds), which should already be covered by OAPSA. PANPHA suggests deleting:
(a) (4), violation of the resident's rights;
(a) (6) – misuse of a residents funds THAT ARE MANAGED BY THE HOME by the personal care home staff or legal entity;
(a)(9), A physical assault by or against a resident;
(a)(11) – An incident requiring the services of an emergency management agency, fire department or law enforcement agency (Does DPW want incident reports for the required fire drills? Or when the home receives assistance in emergency planning? Perhaps a definition of incident is required to limit this reporting to something manageable.)
(a)(13) complaint of resident abuse (covered by OAPSA)
(a)(15) no staff (this is neglect, presumably and there would be no staff to report it.).

Additional comments on this section:
(a)(12) should be changed to "A condition that results in an unscheduled closure of the personal care home AND ~~or~~ the relocation of the residents for more than one day of operation.

Section (a)(18) should be changed to "A termination notice from a WATER, HEAT, OR ELECTRIC utility." to differentiate from cable television or internet provider service. This item could be problematic for providers who switch telephone companies or respond to the ability to purchase electricity from various sources.

2600.16(b) requires development of written procedures on prevention, reporting, notification, investigation and management of reportable incidents. Please recognize that it takes time and human resources to develop and write down a procedure.

2600.16(c)(d) and (e) describe reporting and notification requirements for reportable incidents. Given that homes already comply with the reporting requirements under OAPSA for abuse, neglect and misappropriation of funds, it is not necessary for three reports to be issued for incidents not covered by OAPSA. Providers should use the PB22 for OAPSA reporting and DPW should develop a separate schedule and protocol for other incidents. PANPHA suggests that for incidents not covered by OAPSA, the personal care home notify the department within 5 working days in a manner designated by the Department (phone call or fax report). If a written report is required, PANPHA recommends that date, time, description of the incident, action taken, witnesses, whether the designated person or family and physician have been notified are sufficient information.

Current regulations allow 5 working days for reporting of unusual incidents while the proposed would require an immediate report, a preliminary written notification within 5 days, and a final report following the conclusion of the investigation. PCH staff should be working to resolve the incident immediately rather than immediately calling DPW to report it. Also, presumably most incidents other than those already covered by OAPSA will not require an investigation, so there is no need of a final report. A requirement for more reporting than necessary is time consuming and counterproductive. Reporting requires investment of human resources that either must increase costs or reduce care to the residents. This section and 2600.15 need to be reworked and reorganized to be less onerous and confusing and hopefully, the cost of the compliance burden involved will also be reduced.

Section 2600.19 – Waivers. Providers should be expected to comply with the regulations unless there is a reasonable justification for an exception. Providers should be informed about the process for applying for a waiver, including time frames, documentation required and the duration of the waiver, and affected residents should be informed of a waiver application. Some suggested changes:

§ 2600.19. Waivers.

(a) IT IS THE POLICY OF THE DEPARTMENT THAT LICENSEES COMPLY WITH APPLICABLE DEPARTMENTAL REGULATIONS. THE DEPARTMENT MAY, WITHIN ITS DISCRETION AND FOR GOOD REASON GRANT WAIVERS TO SPECIFIC REQUIREMENTS CONTAINED IN THIS CHAPTER.

(b) A licensed personal care home may submit a written request for a waiver of a specific requirement contained in this chapter. The waiver request shall be on a form prescribed by the Department. The Department may grant a waiver of a specific section of this chapter ONLY if the following conditions are

met:

(1) ~~There is no jeopardy to the residents of the home.~~ (**Discussion**: There is no 100% safety guarantee on anything and "equivalent level of health, safety and well-being protection covers the idea of not reducing the resident's well-being.)

(2) IF GRANTED A WAIVER, THE HOME WOULD CONTINUE TO PROVIDE The~~re is an alternative for providing~~ an equivalent level of health,

safety and well-being protection of the residents of the home THAT WOULD BE PROVIDED IF THE WAIVER WAS NOT GRANTED.

(3) ~~Residents will benefit from the waiver of the requirement.~~ (**Discussion**: Residents may benefit from a waiver being granted, but the threshold should be that their health, safety and welfare is equally protected with or without the waiver, not that they must benefit.)

(c) ~~The scope, definitions, applicability or residents' rights under this chapter may not be waived.~~ (**Discussion**: Waivers are intended to provide flexibility for circumstances not anticipated when the regulations are promulgated. To limit when waivers may be used considerably reduces the ability of the Department to respond to innovations, individual circumstances and preferences.)

(c) Thirty days prior to the submission of the completed written waiver request to the Department, the personal care home shall provide a copy of the completed written waiver request to the AFFECTED resident(s) of the home to allow the AFFECTED resident(s) the opportunity to submit comments to the Department. The personal care home shall also provide the residents with the name, address and phone number of the personal care home field licensing field office to submit their comments. (**Discussion**: This is a little unwieldy, but it seems reasonable that residents should be informed. There are privacy concerns if a waiver has been submitted to meet an individual resident's request or need, however, so that all of the residents don't need to know about and comment on this accommodation if they will not be affected by it. ~~The home shall interview affected residents as appropriate.~~

(d) A personal care home seeking a waiver shall submit a written request for a waiver to the appropriate personal care home licensing field office. A waiver granted by the Department will be in writing, also be part of the home's permanent record and shall be maintained on file in the home's records.

(e) The personal care home shall notify the AFFECTED residents of the approval or denial of the waiver request. ~~A copy of the waiver request shall be posted in a conspicuous public place within the home.~~

(f) Waivers are subject to a periodic review by the Department to determine whether acceptable conditions exist for renewal of the waiver. The Department reserves the right to revoke the waiver if the conditions required by the waiver are not met.

~~(g) A structural waiver will not be granted to a new facility, new construction or SIGNIFICANT renovations begun after _____ (Editor's Note: The blank refers to the effective date of adoption of this proposed rulemaking.) Upon request, the Department will review building plans to assure compliance with the this chapter.~~ (**Discussion**: This is another limitation to the flexibility that must be available to respond to innovations in care, some of which may affect the building requirements or to needs and preferences of various groups. If this paragraph is retained, "renovations" should be defined. It would make sense to use the Americans with Disabilities Act (ADA) renovation spending thresholds.)

Section 2600.20 – Resident Funds

In general, there is considerable duplication of requirements in this section. Please clarify what the Department wants and state it clearly. Calling this assistance

"maintaining a resident's funds" sounds more like the home is responsible to make sure a resident has funds than that the home is accepting the responsibility to assist the resident in tracking and managing the funds.

§ 2600.20. Resident funds.

(a) If the personal care home assumes the responsibility of ASSISTING A RESIDENT WITH FINANCIAL MANAGEMENT ~~maintaining a resident's financial resources~~, the following records shall be maintained for each resident:

~~(1) A separate record of financial resources, including the dates, amounts of deposits, amounts of withdrawals and the current balance.~~ (**Discussion**: this duplicates (a)(2) and (a) (5). Record should be separate from what?)

(2) Deposits and expenditures shall be documented with written receipts. Disbursement of funds to the resident shall be documented and the resident shall acknowledge the receipt of funds in writing. Accounts shall clearly reflect deposits, receipt of funds, disbursal of funds and the current balance.

~~(3) A record of gifts or other funds received by or deposited with the home on behalf of the resident.~~ (**Discussion**: This duplicates the documentation of deposits described in (a)(2).)

(b) If the personal care home assumes the responsibility of ~~maintaining~~ a resident~~'s financial resources~~ WITH FINANCIAL MANAGEMENT, the following requirements shall be met:

~~(1) There shall be documentation of counseling sessions, concerning the use of funds and property, if requested by the resident.~~ (**Discussion**: There is a cost associated with this service that is not documented in DPW's assessment of costs.)

~~(2) The home may not prohibit the resident's right to manage his own finances.~~ (**Discussion**: This resident right is not mentioned in the resident's right section. It also may conflict with (a) (3) in some circumstances.)

(3) Resident funds and property shall only be used for the resident's benefit.

(4) The resident shall be given funds requested within 24 hours if FUNDS ARE available~~, and immediately if the request is for $10 or less~~. This service shall be offered on a daily basis. (**Discussion**: there are costs associated with providing staff who are allowed to disburse funds 24 hours a day 7 days a week. The proposed requirement that the service providing access to funds be offered on a daily basis in not now required and may add costs to those homes who are now willing to provide assistance with financial management.)

~~(5) The home shall obtain a written receipt from the resident for cash disbursements.~~ (**Discussion**: Duplicates (a)(2).)

(6) There may be no commingling of the resident's personal needs allowance with the home's or staff person's funds or the home's operating accounts.

(7) If a home is holding funds in excess of $200 for more than 2-consecutive months, the administrator shall notify the resident and offer assistance in establishing an interest-bearing account in the resident's name at a local Federally-insured financial institution. This does not include security deposits.

(8) The owners of the home, its administrators and employees are prohibited from being assigned power of attorney or guardianship of a resident.

(9) The home shall give the resident an annual written account of

financial transactions made on the resident's behalf. The home shall provide the resident the opportunity to review his own financial record upon request during normal working hours. A copy shall be placed in the resident's record.

(10) WITHIN 30 WORKING DAYS OF ~~Upon~~ the death of a resident, the administrator shall surrender to the resident's estate funds and valuables of that resident which were entrusted to the administrator or left in the home. In addition, an itemized written account of the resident's funds and valuables, which were entrusted to the administrator, shall be surrendered, and a signed receipt shall be obtained and retained by the administrator.

(11) Within 30 days of either the termination of service by the home or the resident's decision to leave the home, the resident shall receive an itemized written account of THE RESIDENT'S funds, including notification of funds still owed the home by the resident or a refund owed the resident by the home.

(12) Upon discharge or transfer of the resident, the administrator shall ~~immediately~~ return the resident's funds being managed or being stored by the home to the resident. (**Discussion**: Immediately is not practical. In addition, the resident may have a balance with the home which needs to be paid, so all of the funds being managed or stored by the home may not be due.)

Section 2600.21 Offsite Services

Suggest changing to read If services or activities are provided by the home at a location other than the premises, the home shall TAKE REASONABLE STEPS TO ensure that the residents' support plans are followed and that the health and safety needs are met for all of the residents. (**Discussion**: Note that PANPHA believes support plans are necessary only for residents of special care units. The change to the wording is suggested because it is impossible to ensure that plans will be followed in all circumstances. Sometimes situations demand some flexibility.)

Section 2600.23 – Personnel Management

Currently personal care homes are required to maintain documentation to verify the work schedule (using payroll records or time sheets.) The work schedule that would be required by the proposed regulations would not be as accurate a document to verify staff hours as payroll or time sheets. All of the other requirements in this section add a lot of overhead in time and costs and do not necessarily improve health and safety of the residents. Job descriptions, titles, and qualifications seem especially onerous for small homes where the operator may "do it all." Delete this entire section and use language from the current 2620.64(e)(2).

Section 2600.24 Tasks of Daily Living

Change to read:

A home shall provide residents with assistance with tasks of daily living ~~as indicated in their support plan and assessment~~ AS NEEDED, ~~including one or more of the following~~ SUCH AS: ...

Section 2600.25 Personal Hygiene

Change to read:

A personal care home shall provide residents with assistance with personal hygiene as NEEDED ~~indicated in the support plan and assessment including one or more of the following~~ SUCH AS: ...

Section 2600.26(a) – Resident/Home Contract; Information on Resident Rights. In 2600.26(a) (1)(ii), what does allowable mean? Does this requirement describe a list of typical ancillary charges or every possible item or service that may be provided by the home to the resident. Change this to read, "~~The actual amount~~ A standard list of ~~allowable~~ resident charges for ~~each~~ typical serviceS AND ~~or~~ itemS.
2600.26(a)(1)(iii) should read, "An explanation of the annual screening, medical evaluation, and support plan IF APPLICABLE, requirements and THE procedures which shall be followed if...."
2600.26(a)(1)(iv) Delete this requirement. It duplicates information already required in (a)(1)(ii).
(vii) terminology "assistance with financial management" is not consistent with 2600.20 Resident Funds terminology for the same service. "Assistance with financial management" is preferred.
(viii) What does "requirements related to home services" mean?
(xi) and (xii) duplicate (ii). Delete them.
(xiii) First, separate resident rights from grievance procedures. These are two separate concepts. Check terminology for consistency so that either "grievance" or "complaint" is used, but not both.
2600.26(2) – Currently this prohibition on the amount of funds a home may seek from the resident's Senior Citizens Rebate and Assistance Act applies to residents who use SSI. The proposed regulation would extend this prohibition to all residents. Under the proposal, no charge may be made to the resident for assistance in filling out the paperwork for the rebate even though the assistance would cost staff time and salary.
2600.26(3) – The home should also have right to rescind contract within 72 hours.
Add (b) (i) to allow Continuing Care Retirement Communities (CCRCs) with a Certificate of Authority from the Insurance Department to permit addenda to the contract to cover items required by the personal care home contract that are not dealt with in the initial CCRC agreement: "Providers with a Certificate of Authority from the Insurance Department as a Continuing Care Provider may use addenda to the original contract to cover items required by regulation in the personal care home contract."
(d) should be changed to a requirement that the home may not close for holidays unless it has disclosed any anticipated closure for holidays or other occasions and the arrangements that will be made to assure that the resident receives necessary services. Please note that neglect is already covered under OAPSA, if the home would close without providing care for a resident. Also know that it may be impossible to obtain some services (public transportation on Christmas) on some days, whether or not these are in any plan. Delete the reference to a support plan.

Section 2600.27 Quality Management Delete this entire section. Regulations are to protect the resident's health and safety, not prescriptively recommend business practices. If this requirement to establish and implement quality assessment and management plans is retained, DPW must recognize that this will either add to the cost of providing care or will reduce the amount of time available to provide care and

services. If retained, the requirement should be fulfilled if a larger entity such as a CCRC has a quality management plan that includes the PCH.

Section 2600.28 Supplemental Security Income (SSI) Residents
The restrictions on the ability of a PCH to charge a resident from Rent Rebate funds should be moved from 2600.26(d) to the SSI Residents section to clarify that it applies only to SSI residents.

Section 2600.29 – Refunds. Providers should not be required to make refunds for rooms that still have the resident's furniture and belongings. (d) should be changed to read: If the personal care home does not require a written notice prior to a resident's departure, the administrator shall refund the remainder of previously paid charges to the resident within 7 days of the date the resident moved from the home. In the event of a death of a resident, the administrator shall refund the remainder of previously paid charges to the estate of the resident when the room is vacated ~~and within 30 days of death~~. The home shall keep documentation of the refund in the resident's file.
(e) should read: If a resident is identified as needing a higher level of care and is discharged to another facility, the personal care home shall provide a refund within 7 days from the date of discharge when the room is vacated ~~or within 7 days from notification by the facility~~. (**Discussion**: If the proposed language is retained, clarify what is meant by facility. Hospital would be a more descriptive word if that's what is meant. For both (d) and (e), the issue is whether the home should have to refund money to the resident or the estate of a resident when the resident is still using the room at the PCH to store belongings and the home is not able to move a new resident in.)

RESIDENT RIGHTS

Section 2600.41(a) – Notification of Rights and Complaint Procedures. This section should read (a) Upon admission each resident and, if applicable, the resident's DESIGNATED PERSON OR POWER OF ATTORNEY ~~family and advocate~~, if any, shall be informed of the resident rights and the ~~right~~ ability of residents and designated persons to lodge complaints without retaliation ~~or the fear~~ or threats of retaliation of the home or its staff of the home against the reporter. Retaliation includes discharge or transfer from the home. This phrase, "family and advocate" is repeated in (b), (c), (d), (e), (g), (h), and (i). Each time it is used, it should be changed as suggested above. In addition, sections (h) and (i) should be combined. A person may have unfounded fear of retaliation that the home cannot control. It can only control actual retaliation or threats of retaliation.

Organizationally, it would be less confusing to separate grievance procedures from resident rights. It doesn't make sense to have descriptions of procedures in A list of resident rights. Operationally, it makes sense for a home to have a procedure to help resolve resident complaints so that the resident doesn't need to contact the ombudsman or another outside source of assistance, but just because this discussion is about good management practice on the home's part not resident rights.

(b) It is important to strive for communication in a language or mode of communication of the resident, however, DPW must recognize that this requirement may be expensive. If the home must hire a signer for deaf people, the rate is approximately $1500 per day. Interpreters for various spoken languages and translators for written languages can also be very costly.

(c) Recognize that providing written copies of the resident rights and the complaint procedures requires copying and distribution, which adds to paperwork and costs.

(d) This section would require every resident or her designated person to sign a statement that they received a copy of their resident rights and the complaint procedures. These documents are already required to be posted, so a resident and his or her designated person always has access to them and anyone who goes into the facility can check to see whether they are posted. Recognize that the requirement for signatures documenting that residents received a listing of their rights and a copy of the complaint procedures would add staff time to discuss, explain and ask for these signatures. This requirement should be deleted. (e) should be changed to read "A resident and, if applicable, the resident's designated person, MAY ~~have the right to~~ lodge a WRITTEN complaint with the home for an alleged violation of specific or civil rights without retaliation ~~or the fear~~ or threats of retaliation." (f) is already discussed in reportable incidents and should be deleted from this section. It is a good idea for a home to have a grievance or complaint process for residents and if the home has such a process, it's a good idea to tell the residents about it, but this recommendation goes well beyond disclosure of the grievance or complaint process and is more prescriptive than necessary. Same applies to (g).

Section 2600.42 (a) Specific Rights – This section should refer to the Pennsylvania Human Relations Act in order to list what is protected under Pennsylvania and federal law. As is, it adds protection for sexual orientation, which is not protected under state or federal law, yet does not describe the state protections from discrimination for those who use or train guide or support animals. Refer to the Pennsylvania Human Relations Act and federal statutes to list all applicable classes. The Pennsylvania Human Relations Act contains the following guidance: The practice or policy of discrimination against individuals or groups by reason of their race, color, familial status, religious creed, ancestry, age, sex, national origin, handicap or disability, use of guide or support animals because of the blindness, deafness or physical handicap of the user or because the user is a handler or trainer of support or guide animals is a matter of concern of the Commonwealth. Such discrimination foments domestic strife and unrest, threatens the rights and privileges of the inhabitants of the Commonwealth, and undermines the foundations of a free democratic state. The denial of equal employment, housing and public accommodation opportunities because of such discrimination, and the consequent failure to utilize the productive capacities of individuals to their fullest extent, deprives large segments of the population of the Commonwealth of earnings necessary to maintain decent standards of living, necessitates their resort to public relief and intensifies group conflicts, thereby resulting in grave injury to the public health and welfare, compels many individuals to live in dwellings which are substandard, unhealthful and overcrowded, resulting in racial segregation in public schools and other

community facilities, juvenile delinquency and other evils, thereby threatening the peace, health, safety and general welfare of the Commonwealth and its inhabitants.

.42(e) – Recognize that some homes under the current requirements may have a pay phone in reasonable privacy for a resident's use, while the proposed would require private access to a telephone. This may impose a requirement to put in a new phone system for some homes, which would be costly.

.42(f) – Resident right to send and receive mail currently describes U.S. mail and states that it is at the resident's expense. If the home must provide computers to assist resident with a right to send and receive e-mail, that will be expensive. If the home must pay for postage for the resident to send and receive U.S. mail it is an added expense as well. If available, residents should be able to send and receive e-mail, but who provides the access needs to be discussed further and should not appear in the resident's rights section.

.42(g) – Although a large personal care home will likely be open 365 days a year, smaller homes may choose to find alternate care for residents so that the operator can have a vacation or respite. If adequate arrangements have been made to the resident's satisfaction, it is not necessary that the home stay open 365 days a year. This issue is handled adequately through disclosure in the contract and the requirement that residents not be neglected in .42(b) above.

.42(j) – PANPHA members are concerned about what "assistance" means and how they are to balance resident preferences that are contrary to this new resident right. Does assistance mean take residents clothes shopping, provide catalogues, pay for clothing?

.42(l) Appears to duplicate .42(s). Keep (s) and delete (l).

.42(n) This section should read, "A resident shall have the right to request and receive assistance~~, from the personal care home,~~ in relocating to another facility." Again, "assistance" should be defined. Does it mean providing the needed security deposit for the resident to move, help with appointments to tour other homes, providing a moving truck? Current regulations have a right to request and receive assistance in relocating, but does not specify that the home must provide this assistance. Recognize that staff time and costs will be associated with this new service.

.42(r) - Change to: "A resident, AND, AT THE RESIDENT'S REQUEST, the resident's family, advocates, if any, community service organizations and legal representatives shall have access to the personal care home during visitation hours or by appointment." These are resident rights, not family and agency rights, so recommended language is added to protect the resident from unwanted visits.

.42(t) Change to: "A resident shall have the right to voice complaints and recommend changes in policies and services of the personal care home without ~~fear of~~ reprisal, intimidation or retaliation." (**Discussion**: This is the appropriate place for listing right

to voice complaints. Remove discussion from .41, where it is mixed as a right, documentation of receipt of procedures, and description of procedures.)

.42(u) This section discusses a new resident right to remain in the home even if the provider has good cause to terminate their residency. This section should be deleted or at the very least should include the circumstance of inappropriate, obnoxious or annoying resident behaviors out of compliance with house rules. If kept, and we can't stress enough how important it is to providers that they retain the ability to discharge a resident who disturbs the other residents or has other unacceptable behavior, the phrase "IF THE RESIDENT BREAKS THE HOME RULES OR LEASE AGREEMENT" should be inserted in the list of reasons for discharge. In HUD housing leases, there is a phrase discussing the "right to peaceful enjoyment of the premises" that may be useful to describe home rule violations that disrupt the resident's neighbors. The other residents and the provider also should have rights. This is not appropriate to be a resident right. There should be disclosure of contract provisions and home rules and residents should be able to be discharged within the parameters described.

.42(v) This is a proposed new resident right. Check "resident's agreement" and "contract" wording for consistency.

.42(w) – Changes to services can happen frequently. This idea of appealing every change to services as a resident right is infeasible. Again, please note that this new right would create additional costs. If kept and PANPHA recommends that it be deleted entirely, it should read: "A resident shall have the right to appeal IN WRITING discharge~~, reductions, changes~~ or denials of services originally contracted~~. The personal care home shall have written resident appeal policies and procedures. The resident shall receive an answer to the appeal within 14 calendar days after submission~~." Recognize that creating policies and procedures takes staff time and therefore increases costs or reduces services available to residents; in addition, responding to appeals also takes staff resources that either add costs or reduce services available.

.42(x) - Delete this. It is unreasonable for the home to bear responsibility for funds a resident believes are stolen, whether or not the funds are actually stolen, a crime is proven, and whether or not the home had any responsibility for a theft. There are criminal laws that apply if funds are stolen. Use these. Immediate payment assumes guilt before it is proven. PANPHA members relate that investigating thefts that are unfounded already takes a good deal of time and staff resources. A resident right like this will increase this time and cost. If staff must all be bonded, this will produce an additional cost.

.42(y) – Concern that it may not be in a person's interest to exercise this proposed new right if they are not competent to manage their financial affairs.

.42(z) – Delete this proposed new right. Who will determine what is excessive medication? Will DPW be setting up a table for non-physicians to look up what is excessive by age, weight, condition? The physician should determine the resident's medications, not the state.

SUBCHAPTER B. HEALTH AND SAFETY REQUIREMENTS

STAFFING

Section 2600.53 – Staff titles and qualifications for administrators. Act 185 of 1988 provides only that administrators be 21 years of age, of good moral character, and have training in certain listed topics. It does not appear that the legislative intent was to prevent people from becoming administrators unless they have a college degree, nursing home administrator license or are a nurse. This requirement would prohibit many good administrators from continuing to operate personal care homes and prevent new administrators with appropriate life experience from entering the profession, limiting consumer's options and increasing the costs of hiring an administrator or becoming an administrator. Having a good moral character is listed in the statute. Is there any way DPW could better define this requirement to prevent people who are known to have operated noncompliant homes from opening a new home? What does good moral character mean?

Section 2600.54 (2) – Staff Titles and Qualifications for Direct Care Staff
Many excellent caregivers do not have a high school diploma. Please either delete this requirement or recognize life experience and competency.

Section 2600.55 – Exceptions for Staff Qualifications.
.55(a) - PANPHA supports the grandfathering of current staff who continue to work in the field from having to comply with the qualification requirements. This will assist in keeping good people in the field who do not currently have the newly proposed qualifications and will minimize disruption. Nursing Home Administrators (NHAs) who maintain a current license should not be required to obtain the personal care home (PCH) administrator training if they work in the field of long-term care and maintain their continuing education requirements even if they do not currently work in a personal care home. An addition exception that should be added is an Assisted Living Administrator license through the National Association of Board of Examiners of Long Term Care Administrators (NAB).

.55(c) - Although it is a good idea for direct care staff to be over 18 years of age for the most part, the exceptions made in the proposed regulation make sense. Additional flexibility may be needed for circumstances where the help is needed and the 16-17 year old is competent and able to provide care and is closely supervised. Add that PERSONS UNDER 18 YEARS OF AGE MAY NOT BE THE SOLE DIRECT CARE STAFF ON DUTY IN THE HOME. In addition, change "tasks related to medication administration" to "tasks related to ASSISTANCE WITH medication administration".

Section 2600.56 –Staffing Ratios
The minimum staffing levels should continue to be 1.0 for mobile residents and 2.0 for immobile residents. PANPHA does not endorse support plans for residents except those in secured units.

(a) should be changed to read, "A personal care home shall employ a sufficient number of trained staff to PROVIDE ~~ensure the daily provision of~~ the DAILY aggregate total of personal care service
hours required by the ~~support plans for all~~ residents in the facility. At minimum, each mobile resident shall receive an average of 1 hour of personal care services per day, and each immobile resident ~~or resident with special needs~~ shall receive an average of 2 hours of personal care services per day. (**Discussion**: either define resident with special needs or rely on definition of immobility which includes mental immobility and immobility due to living in a secured unit.)

(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 daily aggregate total of personal care services hours to meet 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).

It appears that one of the concerns DPW seeks to address with the staffing ratios is ensuring a safe evacuation in case of emergency rather than simply meeting residents' personal care needs. If this is the case, staffing levels could be reduced for buildings with alarm and construction features, availability of sprinklers, proximity to fire department additional staff nearby, etc. that would provide additional safety for residents. PANPHA has a public policy position on life safety for immobile residents in personal care homes, it is as follows:

> "For homes choosing to provide care for immobile residents, standards and regulations governing safety can be assured through staffing, programming, or building design. Sprinklers should be provided in personal care homes that choose to provide specialized programs and care for immobile residents; and staffing and programming should be sufficient to address safety needs of temporarily immobile residents. Temporarily immobile residents are defined as those unable to evacuate the building for a limited time period (of six months or less). It is the responsibility of the provider to advise residents of the risks involved in the situation. Evacuate the building is defined as exiting to a point of safety, including a fire tower."

It would be useful to add to this section language to indicate that LICENSED PRACTITIONERS CAN ACT WITHIN THEIR SCOPE OF PRACTICE IN LICENSED PERSONAL CARE HOMES.

.56(c) –It would be a new requirement to require the administrator's designee to have the qualifications outlined in 2600.54. In addition, the requirement that the administrator shall be present in the PCH at least 20 hour per week would be new. Consider that these requirements may be very costly for some homes.

.56(i) – Change this to read, (i) Additional staffing may be required by the Department, and will be based on safety, the Department's assessment of the amount of care needed by the residents ~~as reflected in their support plans~~, WHICH CAN BE BASED ON RESIDENT SUPPORT PLANS, IF APPLICABLE, and the design, construction, staffing or operation of the home.

.56(m) – Change to "An administrator may be counted in the MINIMUM staffing HOURS ~~ratios~~ if the administrator is scheduled to provide direct care services."

Please note that in current regulations at 2620.74(k), it is stated that staff shall provide care without abuse, exploitation or discrimination. Perhaps this concept is picked up by the resident rights and the OAPSA requirements, but it may be good to add it back in to this section.

Sections 2600.57- .58
Training and Orientation
General comments on training and orientation:
While PANPHA recognizes the importance of education and training, we also doubt that, in the absence of oversight and enforcement activities, it will improve conditions for residents in marginal homes. Additionally, several of the training categories in the administrator's initial training hours are not included in the Personal Care Home statute, including:

- Cardio-pulmonary resuscitation (CPR) certification,
- Obstructed airway techniques certification,
- Care for persons with dementia and cognitive impairments,
- Mental retardation,
- Development of orientation and training guidelines for the staff,
- Writing and completing pre-admission screening tools, initial intake assessments, annual assessments, and support plans.

Given the specificity of the statute regarding training topics for the administrator, it is unclear whether the Department has the authority to add to the list of topics. In larger homes, staff other than the administrator would be doing assessments, developing training guidelines for staff, providing direct care, acting in the event of emergencies. Administrative personnel in large homes should be allowed to meet the administrator staffing training requirements as a group rather than requiring one person to meet each of the training requirements.

Volunteers should be covered in a separate section. Including agency staff in initial and ongoing training would be cost prohibitive and much less beneficial than training for permanent staff. "Temporary staff" should be deleted from the orientation and training provisions. Their agencies should provide training for temporary staff.

Section 2600.57 – Administrator Training and Orientation.
.57(a) – It is not realistic to require that administrators complete the training prior to employment, change this to "Prior to initial employment AS ADMINISTRATOR 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~~. (Comment: The phrase "approved by the Department" does not preclude the Department from administering a course and would clarify that others knowledgeable about the regulations could provide the orientation.)

Change (b) to read: Prior to licensure of a personal care home, the legal entity shall appoint an administrator who has successfully completed and 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 PERSONAL CARE ~~Department-trained~~ administrator OR NHA WHO MEETS THE DEPARTMENT'S QUALIFICATIONS TO BE A PERSONAL CARE ADMINISTRATOR. (**Discussion**: Recognize that the additional hours of training and an internship will add to the costs of providing care.)

(c) The 60 hours of Department-approved competency-based training shall include the following:

(1) Fire prevention and emergency planning.

(2) First aid training, medications, medical terminology and personal hygiene, which shall include:

(i) Medication procedures.

(ii) Cardio-pulmonary resuscitation (CPR) ~~certification~~. (**Discussion**: It is not necessary that the administrator be CPR certified unless certification is needed to assure adequate coverage.)

(iii) Obstructed airway techniques ~~certification~~. (**Discussion**: It is not necessary that the administrator be certified unless certification is needed to assure adequate coverage. According to a Central Pennsylvania American Red Cross office, obstructed airway techniques are included in CPR training.)

(3) Local, State and Federal laws and regulations pertaining to the operation of a home.

(4) Nutrition, food handling and sanitation.

(5) Recreation.

(6) Mental illness and gerontology, which shall include:

(i) Resident rights.

(ii) Care for persons with dementia and cognitive impairments.

(iii) Care for persons with mental retardation.

(7) Community resources and social services.

(8) Staff supervision, budgeting, financial recordkeeping and training, which includes the following:

(i) Writing, completing and implementing pre-admission screening tools, initial assessments, annual assessments and support plans. (**Discussion**: Note that the term "assessment" implies a medical assessment to RNs who assert that assessment is within their scope of practice and a unique RN skill. If it is not anticipated that RNs will complete the initial and annual assessments, choice of a different word like evaluation is recommended. If it is anticipated that RNs will do assessments, this will be an even more costly requirement than if unlicensed people will be allowed to complete assessments.)

(ii) Resident-home contracts.

(iii) Development of orientation and training guidelines for staff.

(d) The 80 hours of competency-based internship in a licensed personal care home under the supervision of a PERSONAL CARE HOME ~~Department-trained~~ administrator shall include EXPERIENCE IN THE TOPICS LISTED IN 2600.57(c). ~~the following:~~ (**Discussion**: Clarify whether the internship is to be under supervision of a personal care administrator or is this an administrator who has completed a special, if not yet defined, training course envisioned by the Department? Also, it is not necessary to re-list the topics discussed in Section c above.)

~~(1) Staff supervision, budgeting, financial record keeping and training, which shall includes the following:~~

~~(i) Writing, completing and implementing preadmission screening tools, initial assessments, annual assessments and support plans.~~

~~(ii) Resident-home contracts.~~

~~(iii) Staff management.~~

~~(iv) Marketing.~~

~~(2) Community resources and social services.~~

~~(3) Nutrition, food handling and sanitation, which includes the following:~~

~~(i) Housekeeping.~~

~~(ii) Dietary needs.~~

~~(iii) Laundry.~~

~~(iv) Maintenance.~~

~~(v) Safety.~~

~~(4) Medications, medical terminology and personal hygiene.~~

~~(5) Mental illness and gerontology, which includes the following:~~

~~(i) Resident rights.~~

~~(ii) Care for persons with dementia and cognitive impairments.~~

~~(iii) Care for persons with mental retardation.~~

~~(6) Local, State and Federal laws and regulations pertaining to the operation of a home.~~

(e) An administrator shall have at least 24 hours of annual training relating to the job duties~~,~~. TRAINING IN EXCESS OF 24 HOURS IN ONE YEAR MAY BE CARRIED OVER INTO THE NEXT TWO YEARS. TRAINING TOPICS ~~which~~ MAY includes the following:

(1) Current training in first aid, certification in obstructed airway techniques and certification in cardio-pulmonary resuscitation that is appropriate for the population served. Training in first aid, obstructed airway techniques and cardiopulmonary resuscitation shall be provided by an individual certified as a trainer by a hospital or other recognized health care organization. ~~Registered nurses, licensed practical nurses, certified registered nurse practitioners, emergency medical technicians, paramedics, physician's assistants or licensed physicians are exempt from the requirement for annual first aid training.~~ (Discussion: PANPHA agrees with an exemption for these professionals from training in first aid and CPR, but disagrees with the idea that these same topics must be part of training each year. Let this be a list of topics from which administrators can choose for annual training. Please note that American Red Cross

provides certification valid for more than a year, so there is no need to have annual training on first aid and CPR.)

(2) Personal care service needs of the resident.

(3) Fire prevention and emergency planning.

(4) Medications, medical terminology and personal hygiene, which includes the following:

(i) Medication procedures.

(ii) Medication self-administration.

(iii) Infection control and general principles of cleanliness and hygiene, and areas associated with immobility such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration. (**Discussion**: Except for incontinence, people with these conditions will not usually be in a personal care home due to the prohibition on serving residents who need the services in or of a nursing home.)

(5) Staff supervision, budgeting, financial recordkeeping and training, which includes the following:

(i) Writing, completing and implementing preadmission screening tools, initial assessments, annual assessments and support plans.

(ii) Resident-home contracts.

(iii) Development of orientation and training guidelines for staff.

(6) Local, State and Federal laws and regulations pertaining to the operation of a home.

(7) Nutrition, food handling and sanitation.

(8) Recreation.

(9) Mental illness and gerontology, which includes the following:

(i) Resident rights.

(ii) Care for persons with dementia and cognitive impairments.

(iii) Care for persons with mental retardation.

~~(iv) Safe management technique training, which includes positive interventions such as:~~

~~(A) Improving communications.~~

~~(B) Reinforcing appropriate behaviors.~~

~~(C) Redirection.~~

~~(D) Conflict resolution.~~

~~(E) Violence prevention.~~

~~(F) Verbal praise.~~

~~(G) Deescalation techniques.~~

~~(H) Alternatives and techniques to identify depression.~~

~~(I) Methods to identify and diffuse potential emergency safety situations.~~

(J) Managing medical emergencies.

(10) Community resources and social services.

(11) Staff supervision, budgeting, financial recordkeeping and training, which includes the following:

(i) Writing and completing preadmission screening tools, initial intake assessments, annual assessments and support plans.

(ii) Resident-home contracts.

(iii) Development of orientation and training guidelines for staff.

(**Discussion**: Recognize that 24 hours annual training for the administrator is equivalent to what is required of Nursing Home Administrators (NHA) to provide for the health and safety of a much more medically complex, vulnerable population than is allowed to reside in a personal care home. This is a significant increase over the currently-required 6 hours annual training and will add to the costs of providing care or reduce services available. Credits should be allowed to be carried over into the future if a person wants to take advantage of educational opportunities that will provide more than the required hours one year, these credits can also be applied in the next two years. The list is fine if is a list of suggested topics that should be considered. If a person is limited to these topics and required to take these same topics each year, the list is overly prescriptive and will not provide sufficient flexibility. PANPHA suggests that the attendance by the individuals on the management team at sessions appropriate to their job duties be allowed to meet the continuing education requirements for the administrator so that the person responsible for finances attends those sessions and the person who helps residents access community resources attends education on community resources and social services. If one staff person is responsible for all aspects, such as an administrator in a small home may be, one person would need to attend all sessions in the suggested topic areas.

~~(f) An administrator who has successfully completed the training in subsections (a)-(e) shall provide written verification of successful completion to the appropriate personal care home regional field licensing office designated by the Department.~~
(**Discussion**: Why have the administrator send to field office and also maintain at the home as required in (h), where licensing staff can verify it when they do a site visit. Use one or the other.)

(g) A licensed nursing home administrator who is employed as a personal care home administrator OR SUPERVISES A PERSONAL CARE HOME ADMINISTRATOR prior to _____ (Editor's Note: The blank refers to the effective date of adoption of this proposal.) is exempt from the training and educational requirements of this chapter if the administrator continues to meet the requirements of the State Board of Nursing Home Administrators. A licensed nursing home administrator hired as a personal care home administrator after _____ (Editor's Note: The blank refers to the effective date of adoption of this proposal.) shall pass the ~~40-hour~~ personal care home administrators competency-based training test. A licensed nursing home administrator who fails to pass the test shall attend the required 60-~~40~~-hour personal care home administrators training OR A SHORTENED (40-HOUR) PERSONAL CARE HOME ADMINISTRATORS TRAINING COURSE FOR NHAS, and retake the competency test, until a passing grade is achieved.

Add a new section to exempt NAB-licensed assisted living administrators from the 60 hours and the continuing education requirements as long as they maintain their NAB license.

(h) A record of training including the person trained, date, source, content, length of each course and copies of any certificates received, shall be kept by the personal care home.

2600.58 Staff Training and Orientation

This section should be changed so that temporary staff and volunteers are not included with the full-time staff. It should read, "Prior to INDEPENDENT DIRECT CONTACT ~~working~~ with residents, ~~all~~ staff ~~including temporary staff, part-time staff, and volunteers~~ shall have an orientation to the following..."

A separate section should discuss volunteers, stating that VOLUNTEERS SHOULD BE OFFERED THE OPPORTUNITY TO HAVE ORIENTATION APPROPRIATE TO THEIR ROLES AND FUNCTIONS IN THE HOME. PANPHA members do not think that it is appropriate for volunteers to receive comprehensive annual training in the same areas as direct care staff unless they are providing personal care services. There is no objection to *offering* the orientation topics to volunteers, with the exception of personnel policies and procedures, which is not an appropriate topic for volunteers. Finally, note that instead of the current requirement that the orientation be completed within 30 days, the proposed requirement would be "prior to working with residents". The change in timing means that homes will provide the training to new hires who may leave or be dismissed almost immediately. While it is agreed that this is important training, a brief adjustment period of one or two weeks may allow the home and staff to sort through whether the new hire is staying with the home. It should be noted that having the orientation so early in the staff person's tenure means additional costs because people will receive the orientation before they and the home decide whether they will be staying.

Add section (a)(1)(viii) FIRE PREVENTION.

Delete Sections (a) (4) Personnel policies and procedures and (a) (5) General operation of the personal care home. This may be good practice, but how does it protect the health, safety and residents of the home?

Delete 2600.58(b). Ancillary staff need training specific to their job function but an orientation on their job duties is not necessary, as noted in 2600.58(d), which duplicates and adds to (b).

Section 2600.58 – (c) Training of direct care staff hired after _____ (Editor's Note: 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:~~
(**Discussion**: This implies a written test, which would be a very poor way to prove competency for a skill. Staff should prove competency in areas relevant to their job duties. If the list of topics is retained it needs to be clarified and reviewed for duplication. It should be clarified that direct care staff need to have training in only those topics that apply to their job functions. Please note that the current requirement for training is within 6 months of hire and that not having an adjustment period to see whether the new staff person will work out adds costs.)
~~(1) Resident care.~~

~~(2) ADL's.~~
(**Discussion**: 1 and 2 duplicate 5, Personal care services.)
(3) Medication procedures, medical terminology and personal hygiene.
(4) Care of residents with mental illness and cognitive impairments.
(5) Personal care services.
~~(6) Implementation of the initial assessment, annual assessment and support plan.~~
(**Discussion**: direct care staff will not be using the assessments; they may be implementing support plans, if applicable.)
(7) Nutrition, food handling and sanitation.
(8) Recreation. (**Discussion**: is it necessary to receive training in recreation prior to working with residents or can this topic be delayed?)
(9) Gerontology.
(10) Staff supervision, if applicable.
(11) Needs of residents with special emphasis on the residents being served in the personal care home.
~~(12) Safety management and prevention.~~
(**Discussion**: This has already been discussed in orientation. Do you mean prevention of hazards? The way it is written it is unclear what prevention applies to.)
~~(13) Use of medications, purposes and side effects of medications, and use of universal precautions.~~
(**Discussion**: This is already covered in (3).)
(14) Policies and procedures of the home, including the following:
(i) Reportable incidents.
(ii) Implementation of support plans, IF APPLICABLE.
(d) ~~Ancillary staff shall have a general orientation to their specific job functions as it relates to their position prior to working in that capacity.~~ Ancillary staff shall receive training specific to their job function. (**Discussion**: It is not necessary for ancillary staff to receive both a general orientation to their job functions and specific training in their job functions.)
(e) Direct care home staff shall have at least 12 ~~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 ALL ~~12 out of the 24~~ training hours required annually. (**Discussion**: This proposed requirement would impose a significant reoccurring cost on residents and homes. Will DPW support the value of this education by providing additional financial support or educational resources or will the residents, owners, and charitable funds be required to pay for this?)

(f) Training topics for the required annual training for direct care staff shall include the following:
(**Discussion**: Use the list from above, as edited for the annual training guidelines. To ensure that at least one person on site has had first aid and CPR training, make it a requirement *and enforce it* to have at least one person on site have current certification in CPR and obstructed airway techniques and training in first aid. To require all staff to be annually trained in first aid and certified in CPR, obstructed airway techniques is excessive, unnecessary to meet safety concerns, and expensive. Nursing homes don't even require this and neither does the Red Cross. Local Red Cross provides the training

for $35 per person for a 6 to 7- hour class. Please recognize that the home would need to pay both those in training and those working in the home during this time frame.)

~~(1) Current training in first aid, certification in obstructed airway techniques and certification in cardio-pulmonary resuscitation that is appropriate for the residents served, and shall be completed by an individual certified as a trainer by a hospital or other recognized health care organization. Registered nurses, licensed practical nurses, certified registered nurse practitioners, emergency medical technicians, paramedics, physician's assistants or licensed physicians are exempt from the requirement for annual first aid training.~~

~~(2) Medication self-administration training.~~

~~(3) Understanding, locating and implementing preadmission screening tools, initial assessments, annual assessments and support plans.~~

~~(4) Care for persons with dementia and cognitive impairments.~~

~~(5) Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.~~

~~(6) Personal care service needs of the resident.~~

~~(7) Safe management technique training, which shall include positive interventions such as:~~

~~(i) Improving communications.~~

~~(ii) Reinforcing appropriate behaviors.~~

~~(iii) Redirection.~~

~~(iv) Conflict resolution.~~

~~(v) Violence prevention.~~

~~(vi) Verbal praise.~~

~~(vii) Deescalation techniques.~~

~~(viii) Alternatives and techniques to identify depression.~~

~~(ix) Methods to identify and diffuse potential emergency safety situation.~~

~~(x) Managing medical emergencies.~~

~~(8) Care for persons with mental illness or mental retardation, or both, if the population is served in the home.~~

~~(g) Full-time, part-time and temporary staff persons and volunteers shall be trained annually on:~~ (**Discussion**: These topics should be able to be counted in required annual training hours and not be required in addition.)

(1) Fire safety. Training in fire safety shall be completed by a fire safety expert or, ~~in personal care homes serving 20 or fewer residents,~~ by a staff person trained by a fire safety expert. Videotapes/DVD's prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.

(2) Disaster plans and recognition and response to crises and emergency situations.

(3) Resident rights.

(4) The Older Adult Protective Services Act (35 P. S. §§ 10225.101—10225.5102).

(5) Falls and accident prevention.

~~(6) New personnel policies and procedures of the home.~~

(**Discussion**: What does this have to do with resident health, safety and welfare?)

(7) New population groups that are being served at the home that were not previously served, if applicable.

(h) If a staff person has completed any of the required training identified in this section prior to the staff person's date of hire, the requirement for training in this section does not apply if the staff person provides written verification of completion of the training. (**Discussion**: Thanks for recognizing that many staff begin work at a home with prior experience in the field of long-term care.)

(i) If volunteers are used in the home as staff persons to provide direct personal care services, they shall meet the same requirements as staff provided for in this chapter.

(j) A record of training including the person trained, date, source, content, length of each course and copies of any certificates received, shall be kept on file at the home.

Add a new section to exempt nurse aides deemed competent from the proposed personal care home staff training requirements as long as they continue to meet the requirements to be a nurse aide.

Section 2600.59 – Staff Training Plan. This requirement is excessive. Delete it. DPW should enforce the required training provisions to assure that staff receive appropriate training.

Section 2600.60 - Individual Staff Training Plan. This requirement is excessive, overly prescriptive and expensive. Delete it.

PHYSICAL SITE

Note that there were some PCHs in operation before the effective date of the current regulation that were grandfathered in and probably do not meet these requirements. There may be significant costs incurred for these homes to come into compliance.

Section 2600.81 – Physical Accommodations and Equipment. This section doesn't contain the basic protections that are in the Americans with Disabilities Act. The concept of *reasonable* accommodation is missing entirely as are the limitations of undue burden and fundamental alteration.

Section 2600.83 - Change 2600.83 (a) to read: "The indoor temperature IN ROOMS USED BY RESIDENTS shall be at least 70...."

Section 2600.85 – Sanitation. Delete (b) through (f) and replace with: (b) THE HOME SHALL FOLLOW THE GUIDELINES PROVIDED BY STATE AND LOCAL HEALTH AUTHORITIES. Note that trash removal services are not available weekly in some areas and that there is cost involved in purchasing covered trash receptacles in kitchens, bathrooms and outside areas and, in keeping them covered. This means a staff person needs to lift the lid and if this is done with the person's hands, the person must wash each time they use the trash container.

2600.85 (f) is under the authority of the municipality rather than DPW, so should be deleted.

Section 2600.89(b) – Water. Lowering the water temperature requirements to 120 degrees makes it easier to comply with both requirements when a personal care home and a nursing facility share a building and a water heating system. However, the lower temperature may require the home to either install valves to prevent heat or boosters to increase the heat. Valves are approximately $100 each and would need to be installed in all of the faucets and showers available to the residents. A high temperature is required to sanitize laundry and dishes, so boosters would be required if the home chooses to lower the temperature at the hot water heater or boiler. Simply lowering the temperature at the hot water heater or boiler may cause there to be an inadequate supply of hot water at times, which may adversely affect the welfare of the residents. Specifying a range such as "between 110 and 130 degrees" may provide the needed flexibility for homes to have hot water for sanitizing and cool enough water to assure resident health and safety.

Section 2600.89(c) – Water. While this paragraph describes the current recommendations of the Department of Environmental Protection (DEP) with regard to water testing, we suggest referencing DEP recommendations, rather than incorporating them in the regulations in case they are subsequently updated.

Section 2600.89(d) – To add flexibility for providing safe drinking water, change this section to read, "If the water is deemed unsafe for drinking, the home shall conduct remediation activity in accordance with the recommendations of the Department of Environmental Protection OR MAKE PROVISIONS FOR A SAFE SUPPLY OF DRINKING WATER.

Section 2600.90 – Delete section (b). It is unnecessary in many homes (remember 41% of the homes in the Commonwealth have 20 or fewer licensed beds) and either cost prohibitive (intercoms, beepers) or too noisy (bells), depending on the method chosen. It is also not very homelike.

Section 2600.91 – Emergency Telephone Numbers. This section should be changed to read, "(A) AN EMERGENCY telephone numbers THAT IS CONNECTED TO A 24-HOUR STAFFED LOCATION (WHICH CAN BE 911) ~~for the nearest hospital, police department, fire department, ambulance, poison control, and personal care home hotline number~~ shall be posted on or by each telephone with an outside line. (B) TELEPHONE NUMBERS FOR THE NEAREST HOSPITAL, POLICE DEPARTMENT, FIRE DEPARTMENT, AMBULANCE, POISON CONTROL, AND PERSONAL CARE HOME HOTLINE NUMBER SHALL BE POSTED BY EACH STAFF TELEPHONE. (C) TELEPHONE NUMBERS FOR THE NEAREST HOSPITAL, POLICE DEPARTMENT, FIRE DEPARTMENT, AMBULANCE, POISON CONTROL, AND PERSONAL CARE HOME HOTLINE NUMBER SHALL BE POSTED IN A CONSPICUOUS PLACE IN THE PERSONAL CARE HOME."

Section 2600.96 – First Aid Supplies. Revise to read, "(a) The home shall have at a minimum, in each building, a first aid manual, nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, tape, scissors, breathing shield, eye coverings, and ~~syrup of ipecac~~ THE TELEPHONE NUMBER OF THE POISON

CONTROL CENTER that are stored together." Syrup of ipecac is not always the appropriate remedy for ingestion of poison; it may be better to include the number for the poison control center than to include syrup of ipecac in the kit. Recognize that, although the additional items proposed to be required are inexpensive, they do add some costs. Additions include first aid manual, nonporous disposable gloves, thermometer, breathing shield, eye coverings and syrup of ipecac.

Section 2600.101 (c) – Resident Bedrooms. This paragraph should take into account the additional square footage needs of someone who uses special equipment such as a wheelchair, but should not include all immobile people, since additional bedroom space is not generally necessary or helpful for persons with dementia who do not need special assistive devices. The following language is recommended. "Each bedroom USED BY AN IMMOBILE RESIDENT WITH SPECIAL NEEDS FOR EQUIPMENT SUCH AS WHEELCHAIRS, SPECIAL FURNITURE OR SPECIAL EQUIPMENT shall have ~~100 square feet for immobile residents~~ ADEQUATE SPACE to accommodate the special needs of ~~a~~ THE IMMOBILE resident ~~such as wheelchairs, special furniture, or special equipment~~ unless there is an order from the attending physician that states they can maneuver without the necessity of the additional space."

Section 2600.98 – Indoor Activity Space.
.98(b) - The current requirement is that residents shall have the use of recreational or living areas which, in combination, shall be large enough to accommodate all residents at once. The proposed requirement specifies that this room should be a living room or lounge (whereas now many personal care homes use the dining room as a space that will accommodate all residents at once. If homes are required to build new lounges to accommodate all residents at once, this will be a very expensive requirement to achieve no additional protection for the health, safety and welfare of the residents.

.98(c) – Delete this section. It is not about indoor activity space. See 2600.221 for duplicated requirement on activity program.

.98(d) - Delete this section. It is not about indoor activity space. See 2600.221 for duplicated requirement on activity program.

.98(e) - Delete this section. It is not about indoor activity space. See 2600.221 for duplicated requirement on activity program.

Section 2600.99 – Recreation Space. This section describe supplies and furniture as well as space. What is meant by outdoor recreation space? Would a porch be in compliance? If a home doesn't have a yard or a porch, how will it provide this? How will DPW enforce this? Will trips to a nearby park suffice? It will be very expensive to relocate the home to provide for outdoor recreation space. If by gliders, DPW means swings, this expense should be put in the calculation of expenses. Delete the reference to gliders.

Section 2600.100 – Exterior Conditions. On 2600.100(b), it may not be appropriate or feasible to remove snow from the outdoor recreation area. Delete this section, unobstructed egress is already dealt with in another section of the proposal.

Section 2600.101 – Resident Bedrooms.
We support the flexibility offered by the regulations in setting the requirements for resident bedrooms. There are some people and programs where more congregate space is preferred to larger bedrooms, for example, and others where people will choose a larger bedroom and less community space. This gives providers and consumers more options to choose from than would a more prescriptive requirement for the room configurations.

Section 2600.101 (c) – Change this to read: "Each bedroom for a resident with a physical immobility MAY REQUIRE ~~shall have 100~~ ADDITIONAL square feet ~~per resident, or~~ TO allow for easy passage between beds and other furniture, and for comfortable use of a resident's assistive devices, including wheelchairs, walkers, special furniture or oxygen equipment. IF ~~This requirement does not apply if~~ there is a medical order from the attending physician that states the resident canNOT maneuver without the necessity of the additional space.

Section 2600.101 (k) - Resident Bedrooms.
Since many residents provide their own beds, the regulations should allow them some choice of this furnishing. We are not sure how, in regulation, to deal the choices of some residents to sleep on a recliner or futon. We suggest changing (k) as follows. "Each resident shall have the following in the bedroom: (1) a bed. (I) IF THE BED IS PROVIDED BY THE HOME, IT SHALL HAVE a solid foundation and fire retardant mattress ~~that is plastic covered~~ that is in good repair, clean, and supports the resident. (II) THE RESIDENT MAY CHOOSE TO PROVIDE HIS OR HER OWN BED THAT MAY OR MAY NOT MEET THESE REQUIREMENTS. (Note that the need for a fire retardant mattress is significantly reduced in homes where residents are not allowed to smoke in their rooms. Since the proposed regulations would not allow residents to smoke in their bedrooms, the fire retardant mattresses are an added expense that would not add much to ensure residents' safety.)

Section 2600.101(l)(4) – Note that under current regulations a closet or dresser may be shared with one other resident. This will be an added expense for homes in which dressers are shared.

Section 2600.101 – Resident Bedrooms. We were pleased to see that the mirror is no longer required to be in a resident's bedroom, where it can sometimes be upsetting to the resident, but in the bathroom.

Section 2600.102 – Bathrooms. Change (a) through (c) to read as follows:

(a) There shall be at least one functioning flush toilet for every six or less ~~users, including residents, family and personnel~~ residents and other household members.
(b) There shall be at least one sink and wall mirror for every six or less ~~users, including residents, family and personnel~~ residents and other household members.
(c) There shall be at least one bathtub or shower for every 15 or less ~~users, including residents, family and personnel~~ residents and other household members. (**Discussion**:

This is not feasible. It is too hard to calculate how many family members a resident has who visit frequently and this will change as residents change. The number of licensed beds, household composition, and general staffing numbers will remain fairly constant.)

.102(g) – Current requirements are that private pay residents can purchase these supplies and that SSI residents receive these supplies as part of the monthly charge. The proposed requirement does not make it clear who pays for the supplies. Clarify that private pay residents can continue to be charged for these items.

.102(f) – Change to clarify that an individual BATH towel, and washcloth shall be provided to each resident. Delete the requirement to provide soap to each resident and allow the home to either provide a soap dispenser or soap bar, if requirements in (j) are met for the soap bars. Paper towels are allowed under the current requirements. Would individual hand towels be required for each resident under the new proposal? Please clarify.

.102(i) – Change to read: "A dispenser with soap shall be provided in all of the bathrooms. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident WHO USES BAR SOAP."

.102(j) – Change to read: "Toiletries ~~and linens~~ AND THE RESIDENT'S TOWEL shall be in the possession of the resident in the resident's living space OR AVAILABLE IN A COMMON AREA CONVENIENT TO THE RESIDENT." Residents may not have the storage space in their living space for these items and may not want these items in their living space, especially if the bathroom is down the hall. Homes may not want to provide unlimited access to these items, so it should be clarified that the residents need not have access to the entire stock of these items, but a reasonable supply to meet their needs.

Section 2600.102(g) – Bathrooms. Please clarify that individual toiletry items including toothpaste, toothbrush, shampoo, deodorant, comb and hairbrush, can be provided for additional charge for private pay residents.

Section 2600.103(a) – Kitchen Areas. Delete section .103(a) ~~A home shall have an operable kitchen area with a refrigerator, sink, stove, oven, cooking equipment, and cabinets for storage~~ and replace with "THE HOME SHALL HAVE THE ABILITY TO PROVIDE MEALS AND SNACKS." Some homes have meals prepared off site and delivered to a serving kitchen.

Section 2600.103(e) – Weekly inventory is excessive. Delete this section and put the current requirement in. Current regulations prohibit food beyond the expiration date from being served to residents, which is the desired outcome of .103(e). The proposed regulation would require food to be labeled, dated, rotated and inventoried weekly, but never says that it should not be served if past the expiration date. This is an ineffective and intrusive proposed requirement.

Section 2600.103(f) – Should the freezer temperature be 0 degrees Celsius?

Section 2600.103(i) – Having holding temperatures specified for food is really prescriptive and may not meet the preferences of the residents. Delete it or reword to require that food is served according to food service guidelines, if applicable.

Section 2600.103(j) – Recognize that homes are not currently required to use a mechanical dishwasher. This may add costs in smaller homes.

Section 2600.103(k) – This is already covered elsewhere. Delete it.

Section 2600.103(l) – Kitchen Areas. Delete this because personal care homes are a residential environment that may include pets, not a sterile environment that cannot.

Section 2600.104 – Dining Room. This should read: "Dishes, glassware, and utensils shall be provided for eating, drinking, preparing, and serving food. These utensils shall be clean, and free of chips or cracks. There shall be no regular use of ~~plastic~~ STYROFOAM /paper plates, PLASTIC utensils, and STYROFOAM/PAPER cups for meals." Many residents prefer plastic tableware, especially mugs and glasses, because they are lighter and easier to use.

Section 2600.104(e) If .103(l) is not deleted, state assistive animals as an exception to .103(l).

Section 2600.105(a) – Laundry. Change to say: (a) Laundry service for bed linens, towels and personal clothing shall be provided by the home, at no additional charge, to residents who are recipients of or eligible applicants for Supplemental Security Income (SSI) benefits. This service shall also be OFFERRED ~~made available~~ to all residents who are unable to perform these tasks independently. Laundry service does not include dry cleaning.

.105(g) – Change to read: "To reduce the risks of fire hazards, the home shall ~~ensure all~~ REMOVE lint ~~is removed~~ from ~~all clothes~~ DRYERS EACH CYCLE."

Section 2600.106 - Swimming Pools – Delete this entire section on swimming pools to defer to state requirements already in place for swimming pools.

Section 2600.107 – Internal and External Disasters.
Are local emergency management offices and fire safety offices going to be willing to develop and approve initially, then update and approve annually, written emergency procedures for 1700 personal care homes? Has this been discussed with them? What will happen to a home that cannot comply with this requirement because it cannot get cooperation from all of the fire, safety and local emergency management offices? The recommendations of these offices frequently conflict. What is the home to do then? This is not at all practical.

.107(c) (4) – How much is three day's worth of drinking water? If it is 8 glasses a day per resident, that is a lot of water to keep on hand. There will be a cost to purchasing and maintaining this extra supply of water and food.

.107(c) (5) - How will the home be able to obtain a 3-day supply of medications that are not to be used? This is not a feasible requirement and there is a cost associated with it.

Require that homes have written emergency procedures and delete the rest of this section.

Section 2600.109 – Firearms and Weapons.
Clarify what is meant by "located in a place other than the residents' room or in a common living area." It is used in .109(1) and .109(2). Note that this is very prescriptive and some homes may incur costs to comply, even if they currently have a way to ensure safety for any firearms stored at the home.

FIRE SAFETY

Section 2600.121 through .133 - Fire Safety. Generally, the proposed regulation makes an important clarification that people can exit to a point of safety, or as the proposed regulation regulations state, "the fire-safe area." To follow this concept through it would be helpful to add the following:

Section 2600.121 – Unobstructed Egress.

(a) "Stairways, hallways, doorways, passageways and egress routes from rooms TO A FIRESAFE AREA and from the building shall be unlocked ..."

(b) "Doors used for egress routes from rooms TO A FIRE SAFE AREA and from the building ... devices which prevent immediate egress of residents from the building IN THE EVENT OF AN EMERGENCY ..."

Section 2600.122 – Exits. Please clarify that you mean accessible to the residents rather than full Americans with Disabilities Act accessibility requirements for new construction/significant rehabilitation unless there is a period to come into compliance or "grandfathering" for older buildings. Exits should be accessible to the residents. Recognize also that this is not a state requirement for small homes and may impose additional costs.

Section 2600.123 – Emergency Evacuation. This duplicates 2600.130 (i). Delete it.
.123(b) is covered in .100 and in .121. A review for consistency and to avoid duplication is needed.
.123(c) should exclude exit doors for secured units. Doors for secured units should have locking mechanisms that release in the event of emergency.
.123(d) – Has DPW discussed this requirement with fire, safety or local emergency management offices who will be required to work with 1700 administrators to prepare these emergency evacuation plans? What will happen to a home that cannot get the local official to assist them?

Section 2600.124 – Notification of Local Fire Officials. This should read: " The home shall notify local fire officials in writing of the address of the home, location of the bedrooms, and the ~~assistance needed to evacuate in an emergency~~ EGRESS PLANS." At any given time various residents may temporarily need assistance with evacuating the home, so it would take considerable time to prepare and update the list to respond to daily changes in resident's conditions.

There are several new requirements proposed that would add costs, including the annual furnace inspection and annual fireplace inspection. One significant cost factor is discussed in 2600.130(f) to install smoke detectors for persons with hearing impairments. Alternate ways of alerting hearing impaired residents should be considered.

Section 2600.130(j) – Smoke Detectors and Fire Alarms. The current requirement is for homes with 10 or more immobile residents. Although it seems reasonable that such homes should be directly connected to the fire department or a monitoring service, recognize that, in homes housing 5-9 immobile people, the proposal would impose new costs.

2600.131 (e) – Fire Extinguishers.
Change this to say ..."Fire extinguishers shall be kept locked if access to the extinguisher by a resident ~~could cause a~~ IS A LIKELY safety risk to the residents...."

Section 2600.132– Fire Drills.

.132(a) -The requirement that fire drills be unannounced is not part of current regulations. Do not require unannounced fire drills during sleeping hours. These drills should be announced in advance.

.132(b) - Change (b) to read There shall be a documented annual ~~fire safety inspection and~~ fire drill conducted ~~by~~ WITH a fire safety expert.

.132(d) - 2.5 minutes is not enough time to evacuate a personal care home; this time frame should be extended to at least 5 minutes. The paragraph should read, "Residents shall be able to evacuate the entire building into a public thoroughfare, or to a fire-safe area designated in writing ~~within the past year~~ by a fire safety expert, within ~~2 ½~~ FIVE minutes or within the period of time specified in writing within the past year by a fire safety expert. ~~The fires safety expert shall not be an employee of the home.~~"

.132(e) – This should read: "A fire drill shall be held during sleeping hours at least ~~every 6 months~~ ANNUALLY." This is the resident's home and fire drills during sleeping hours are very intrusive to residents.

.132(h) – There may be more than one meeting place, so change to reflect that residents can "...evacuate to ONE OR MORE ~~a~~ designated meeting placeS..."

RESIDENT HEALTH

Section 2600.141 Resident Health Exam and Medical Care.
.141(a)(7) should read "Medication regimen~~, contraindicated medications and medication side effects.~~" Side effects and contraindications are not appropriate for the medical exam.

.141(a)(8) Delete this. Are people who need body positioning and movement stimulation appropriately residing in a personal care home?

.141(a)(9) - Clarify or delete this. Does this mean Do Not Resuscitate orders?

.141(a)(10) –Delete. There is already training for staff on personal hygiene, and proposed training for staff on universal precautions. It does not seem appropriate on a medical examination to describe precautions for communicable diseases. If the resident has active TB, most (if not all) personal care homes do not have the physical plant requirements to safely care for such a resident.

.141(a)(11) – Change to read, "~~Annually updated~~ Mobility Assessment, UPDATE ANNUALLY or at the Department's request."

Section 2600.142 – Physical and Behavioral Health.
Change to (a) Each home shall ~~address in the resident's support plan~~ DISCUSS WITH THE RESIDENT AND RESIDENT'S DESIGNATED PERSON, IF ANY, AND DOCUMENT the dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if deemed necessary by the ~~health exam~~ PHYSICIAN. This requirement does not mandate a home to pay for the cost of these medical and behavioral care services.

Change (b) to use the word "educate" or "inform" instead of "train".

Section 2600.143 – Emergency Medical Plan.
Change (a) to delete the first sentence, which implies that having an emergency medical plan can ensure immediate and direct access to emergency medical care and treatment. It cannot. A plan ensures nothing and many factors beyond the home's control affect the availability of emergency care. It is not feasible for the home to make a plan that guarantees availability of emergency care. The paragraph should read, "~~The home shall have a written emergency medical plan that ensures immediate and direct access to emergency medical care and treatment.~~ If a resident becomes ill or injured and is unable to secure necessary care, the administrator or a designee shall secure necessary assistance or care. Arrangements shall be made in advance between the administrator or a designee and the resident regarding the physician or dentist and designated person or community agency to be contacted, in case of illness or injury, and those persons shall be contacted."

.143(c) - Recognize that having an emergency medical plan is a new requirement, and another proposed document that the administrator will have to develop. Note also that in some cases, there may be more than one alternative for emergency care and a

resident's condition or preferences will need to be considered, as well as whether the hospital will accept patients.

.143(d)(9) – Add, "if applicable" to recognize that a resident does not need to have a power of attorney.

.143(d)(10) – Add, "if applicable" in case a person doesn't have a designated contact person.

.143(d)(12) – Delete this entire paragraph. Why would the home develop a plan to call the resident's family or designated person? They should simply contact the designated person. A plan is not necessary. The second sentence requires the support plan (which direct staff must have access to this to benefit the resident) to be part of the resident record (which is confidential) and accessible to staff in an emergency.

Section 2600.144 - Use of Tobacco and Tobacco Related Products.
.144(b)(1) Fire retardant furniture and outside ventilation are new and potentially expensive items listed in this proposed new requirement.

.144 (b)(2) – In this section, clarify that the requirement "Ensure the protection of the rights of nonsmoking residents." Does not introduce new rights for non-smokers, but that civil rights and resident rights specific to personal care home residents as specified in regulation apply. If this is the case, there is no need for the requirement. Delete it.

.144(d) – Require the home to have and disclose to residents during the application and admission process, a policy about smoking in transportation provided by the home.

.144(e) - Require the home to have and disclose to residents during the application and admission process, a policy about smoking in resident bedrooms. Statewide prohibition on smoking in resident bedroom is intrusive and impractical. This is the resident's home.

.144(f) – Clarify what is meant. Written fire safety procedures are not required or described elsewhere in the proposed regulations. Does this mean designated smoking areas will be listed or whether fire safety procedures for the smoking areas will be discussed?

.144(g) – "Written fire safety procedures shall be followed." The draft had a narrower scope to this requirement, where it addressed homes in which smoking was allowed. In the proposed, it is unclear to what this requirement applies. Whether or not the written fire safety procedures correctly anticipate any given situation and provide appropriate procedures to be followed under the circumstances?

Section 2600.145 – Supervised Care. An additional sentence should be added. "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. THE AREA AGENCY ON AGING IS THE APPROPRIATE ASSESSMENT AGENCY FOR PUBLICLY

FUNDED ELDERLY INDIVIDUALS AND IS RESPONSIBLE TO ASSIST THESE INDIVIDUALS IN FINDING APPROPRIATE PLACEMENT."

NUTRITION

Section 2600.161 – Nutritional Adequacy. Change (b) to read "At least three nutritionally well-balanced meals shall be ~~provided~~ OFFERRED to the resident. Each meal shall include an alternative food and drink item from which the resident may choose.

.161(d) Change this one to a daily rather than per meal requirement. A daily requirement of would provide adequate nutrition without being so restrictive that resident preferences may not be able to be addressed.

.161(e) Requiring that dietary alternatives be available for residents with special health needs, religious beliefs regarding dietary restrictions or vegetarian preferences goes too far. Delete this section and have the homes disclose what is available from the kitchen and what is not during the application and admission process.

.161(g) - Change to read, "Drinking water shall be available to the residents at all times. ~~Other beverages shall be available and offered to the resident at least every 2 hours."~~ There are several conditions for which offering fluids so frequently would be inappropriate and would endanger the health and safety of the resident (congestive heart failure, diabetes). Additionally, residents will not want to be awakened every two hours to be offered beverages. Finally, it would be expensive to have a staff person offer beverages every two hours. It is sufficient for the resident's needs to have water available.

Section 2600.162 – Meal Preparation.

.162(h) is already discussed in 2600.104(d). Delete this duplication.

Section 2600.163 – Personal Hygiene for Food Service Workers. Refer homes to local Health Inspector requirements.

Section 2600.171(a) – Transportation. Although DPW may not have the authority to regulate transportation services other than those provided by the home, don't advertise it. Change (a) to read: "The following requirements apply whenever staff persons, or volunteers of the home provide transportation for the resident. ~~These requirements do not apply if transportation is provided by a source other than the home.~~"

Delete .171(a)(1) to require that staffing be available to meet anticipated resident needs during transportation rather than referring to staffing ratios.

.171(a)(6) Recognize that this additional first aid kit adds to costs. Remove requirement for syrup of ipecac in the first aid kit. It is not always the recommended treatment.

.171(b)(1)-(5) list these as items under (a) unless the home is expected to maintain this information whether or not the transportation is provided by a source other than the home. If the home must collect this information for all transportation vendors used by residents, this requirement is infeasible.

.171(C) – Change to read, The home shall assist a resident with the coordination of transportation to and from medical appointments, if requested by resident~~, or if indicated in the resident's support plan~~.

Section 2600.181 – Self Administration. Delete .181(c). The physician should determine whether the resident is able to self-administer medications and this information will be available in the medical exam.

Delete .181(e). This definition of self-administration has not been discussed by stakeholders and is too narrow. Delete it. Specific concerns with the definition include: If the resident is blind or has difficulty seeing the medication, but is perfectly competent otherwise, they will not be able to self-administer. Many people – including most people in their own homes - know very, very generally what medication is for what condition, but would not be able to describe the condition or illness very well. What is meant by "applying topical medications and not disturbing the application site"? Nasal therapies are not necessarily snorted. Many people live in a personal care home to receive assistance with self-administration of medications. Too narrow a definition of self-administration would mean that homes would have to hire nurses on all shifts, which is very expensive for the resident and the home, or these people will need to live in a nursing home, which may be very expensive for the state. This definition is a significant area of concern to PANPHA members and must be deleted.

Section 2600.182(d) Storage and Disposal of Medications and Medical Supplies. Please either delete or clarify this requirement. What must prescription, OTC and CAM medications be stored separately from? If by category of medication, this requirement doesn't make sense.

.182(e) - Change to "Prescription, OTC and CAM THAT ARE STORED BY THE HOME shall be stored under proper conditions of sanitation, temperature, moisture and light ~~comply~~ IN COMPLIANCE with the manufacturer's instructions."

Section 2600.185 - Use of Medications. Change (f) to read, "Prescription, OTC and CAM, discontinued and expired medications, and prescription medications for residents who are no longer served at home shall be destroyed of in a safe manner according to the Department of Environmental Protection and all Federal and State regulations. When a resident permanently leaves the home, the resident's medications shall be given to the resident, the designated person, if any, or the person or entity taking responsibility for the new placement ~~on the day of departure from the home~~. (Discussion: many times it is unknown whether the person will be returning to the PCH.)

Section 2600.184 – Accountability of medication and controlled substances.

Recognize that this additional development of policy and procedures will take the administrator's time and will therefore either increase costs or decrease services to residents.

Section 2600.185 – Use of Medications In .185(b), please clarify that if the home chooses not to assist with alternative medications, it does not need a physicians order and does not need to store supplies related to the alternative medications.

Section 2600.186 – Medication Records. Delete .186(b)(2) and .186(b)(3). Possible side effects and contraindicated medications are not appropriate to put in a Medication Administration Record. Staff should call the pharmacy or check a reference like the Physician's Desk Reference if there are questions. Make sure that the regulation allows what is available through the blister packs from pharmacies to meet the documentation requirement. Recognize that this new requirement for documentation, while a good idea, will add significant costs in staff time.

Section 2600.187 – Medication Errors. (a) The definition should be moved to the definitions section. Retain the first and last sentences of this paragraph. Change last sentence to "A medication error shall be reported to the physician ~~immediately~~ WITHIN A REASONABLE PERIOD OF TIME." Some errors cannot be expected to adversely affect the health and safety of the resident and the physician need not be disturbed for these on weekends and holidays. Some medication errors are a cause for immediate concern. Perhaps the staff person assisting with medications should report all errors to the administrator immediately so that the administrator can sort out what should be reported right away and what can wait.

Section 2600.188 – Adverse Reaction.
Change to read, "If a resident has a suspected adverse reaction to a medication, the home shall immediately ~~consult~~ REPORT TO a physician. The resident's ~~family~~ DESIGNATED PERSON shall be notified, if applicable...."

Section 2600.201 – Safe Management Techniques. Several PANPHA reviewers have voiced concerns about the discussion of safe management techniques in this section and in the proposed training requirements, fearing that DPW thinks PCHs are treatment facilities. Also, note that (b), a quality improvement program to continuously review, assess, and analyze the homes ongoing steps to positively intervene ..." is yet another plan and program (this one to run continuously) that will add to expenses or reduce services available to residents. Delete Section 2600.201.

Section 2600.202 - Prohibition on the Use of Seclusion and Restraints.
This section is unnecessary, confusing, and should be deleted. It duplicates the resident right prohibiting the use of restraints. OAPSA prohibits abuse, so all of the listed procedures would be prohibited under that statute and regulation. In addition, it introduces new definitions of restraints that do not coincide with the definitions in the definitions section, so it's very confusing as well.

Section 2600.223 – Description of Services The information listed in 2600.223(a) is already in the resident contract. (b) would require yet another set of written procedures, these on delivery and management of services from admission to discharge. What is meant by this? Delete .223 entirely. If this section is not deleted, recognize that it will add costs without providing additional benefit to residents.

Section 2600.225 – Initial Intake Assessment and the Annual Assessment. The current requirement is that if a resident is referred by a State mental hospital, a State mental retardation center, a county mental health/mental retardation program, a drug and alcohol program or an area agency on aging, the referral agent must provide a written assessment of the person's needs. The proposed requirement that PCHs provide assessments would be a significant new requirement, imposing new costs in staff training and time to fill out assessment forms. If it is within the RN's scope of practice and denied to other professions, this form should be called something other than an assessment. Providers were concerned about competency of staff to provide psychological assessment and recommend that this be part of the referral agency's assessment or the medical evaluation. We support requiring the intake assessment to be completed within 30 days of admission or within 30 days prior to admission, rather than in the first 72 hours.

Section 2600.225(g) - It would be useful to explore the concept of permanently vs. temporarily immobile.

Section 2600.226 – Development of the Support Plan. It is very important that DPW please clarify that support plans must be done only for those residents of the home who need and receive personal care services. To the extent that the support plans envisioned in the proposed regulation regulations formalize the concepts described in the current 2620.24 (1) and (2) describing, within the written agreement, the listing of personal care services to be provided to the resident, we can support a support plan. Support plans that would go beyond this description should be required only for residents of secured units.

Section 2600.226(a) – 30 days following the completion of the initial assessment is an appropriate amount of time to complete the support plan. It may take several weeks to coordinate with outside agencies who may provide services as well as to contact all of the people a resident wants involved in the planning process.

Section 2600.226(b) – Development of the Support Plan. This should read: "The resident or the resident's DESIGNATED PERSON ~~family and/or advocate~~ shall be ~~informed of the right~~ OFFERED THE OPPORTUNITY to have the following people assist in the development of the resident's support plan: case manager from the social service agency when the resident has a case manager, other social services entities, the home staff, family/advocates, doctors, and other interested persons designated by the resident. HOME STAFF WILL DEVELOP THE PLAN WITH INPUT, IF APPLICABLE, FROM THOSE LISTED ABOVE. (Discussion: This is a lot of overhead for a four-bed home; it could involve a considerable investment of staff time and resources for larger homes.

Delete Sections (c), (d), and (e). It is already a significant increase in paperwork and administrative overhead to complete support plans, it would be ridiculous to be required to get all of the signatures from family and advocates. The Department has the authority to require documentation it needs to assure health, safety and welfare of the residents. Let it request documentation of efforts to involve family if it feels the home is not offering this opportunity.)

If .226(c) is not deleted, a description of "reasonable efforts" is needed. This should read, "Documentation of reasonable efforts made to involve the resident's family, with the consent of the resident, ~~shall be kept~~ MAY BE REQUESTED BY THE DEPARTMENT. If the resident's family declines, this fact shall be documented in the record. REASONABLE EFFORTS CAN INCLUDE TWO DOCUMENTED ATTEMPTS TO CONTACT THE REQUESTED PERSON(S), BY TELEPHONE, MAIL OR E-MAIL, TO ENCOURAGE PARTICIPATION.

Section 2600.228(a) – Notification of Termination. Delete .228(a). It is already listed elsewhere in the proposed regulation. If this paragraph is retained, delete "from the home" to avoid confusion.

.228(b) – Change this to read: "If the home initiates a discharge or transfer of a resident, or if the legal entity chooses to close the home, the home shall provide a 30-day advance written notice to the resident, the resident's ~~legal representative, and the referral agent~~ DESIGNATED PERSON, IF ANY, citing the reasons for the discharge or transfer. ~~This shall be stipulated in the resident home contract signed prior to admission to the home.~~ A 30-day advance written notice may not be given if a delay in discharge or transfer would jeopardize the health or safety of the resident or others in the home.~~, as certified by a physician. This shall occur when the resident needs psychiatric or long-term care or is abused in the home, or the Department initiates a closure of the home.~~

Delete .228(d). This duplicates .228(b).

Section 2600.228(e) – Notification of Termination. Delete this section. It has been adequately discussed in .228(b). Discharge policies should be discussed with the resident at admission. If this section is retained, and PANPHA strongly recommends against keeping it, it should be changed to read: "~~The only g~~Grounds for discharge or transfer from a home ~~are for~~ MAY INCLUDE the following conditions:...."
Also change (4) to read "If MEETING the resident's needs would require a fundamental alteration in facility program or building site OR WOULD BE AN UNDUE BURDEN TO THE PCH." Add (7) IF RESIDENT DOES NOT COMPLY WITH HOME RULES. Add (8) IF RESIDENT INTERFERES WITH OTHER RESIDENTS' QUIET ENJOYMENT OF THE PREMISES. Current requirements for discharge are a 30-day notice. Requiring homes to retain residents who will not comply with home rules or disturb the other residents may be very detrimental to the home and the other residents who live there.

SECURED UNIT REQUIREMENTS

In general, PANPHA is pleased to see that the requirements for secured units would be described in regulation rather than continuing to be guided only by DPW policy.

Section 2600.231 – Doors, Locks and Alarms.
Change .231(3) to read: "A mechanical device, such as a key, deadbolt or sliding bolt lock may not lock exit doors EXCEPT THAT RRESIDENTS SHALL BE PREVENTED ACCESS TO THE ENCOSED AREAS AFTER DUSK AND DURING INCLEMENT WEATHER."

Delete .231(10) – Illumination is already covered in 2600.87. It is difficult to determine what is meant by "providing light sufficient to maximize vision." If retained, put elsewhere since it is not a door, lock or alarm.

Delete .231(11) – The home is already required to minimize hazards by another requirement in the regulations. If this requirement is kept, it should be moved because it doesn't fit in this section on doors, locks, and alarms.

Section 2600.235 – Discharge Standards. Change this section to delete notice to the referral agent and to take into account instances where a resident must be discharged without a 60-day notice due to a need for a higher level of care to meet the resident's needs.

Section 2600.236 – Administrator Training. On .236(1), recognize that the current policy in place for secured units requires additional training for administrators and staff, but that the current policy is based on current regulations that do not require 60 hours initial administrator training, an 80 hour internship and 24 hours annual continuing education. Given the proposed increases in training requirements, some of the topics addressed in the current policy and the concept of requiring administrators and staff of these units to have additional education are not necessary. Again, please note that this is an added expense.

Change .236(2), to read: "Ongoing education ~~shall be competency-tested training~~ MAY includE~~ing~~ the following content areas specific to the state of dementia and addressing issues particular to the resident:...". (Discussion: NHAs are not required to have competency-tested continuing education and the population served in nursing homes is more vulnerable that that served in a PCH. The list should be suggestions of topics to be covered, not a requirement that those particular topics in the list be covered. Clarify that these topics are not in addition to the 24 hours required continuing education required in section 2600.57(e).)

Section 2600.237 – Staff Training on Dementia. On .237, recognize that the current policy in place for secured units requires additional training for administrators and staff, but that the current policy is based on current regulations that do not require 24 hours of annual continuing education for staff. Given the proposed significant increases in training requirements, some of the topics addressed in the current policy and the concept of requiring administrators and staff of these units to have additional education are not necessary. Again, please note that this is an added expense.

Change .237 to read, "~~In addition to the training requirements in 2600.58 (relating to staff training and orientation),~~ all staff of a secured unit shall receive ~~and successfully pass competency based~~ training related to dementia, ~~to~~ THAT MAY include the following:

Section 2600.239 – Programming Standards. It would read more clearly if it was changed to:

~~Programming standards include the following:~~

~~(1)~~ Activity programming SHALL:~~in the secured unit, which shall~~ (1) maximize independence while focusing on strengths and abilities.

(2) ~~General activity programming, which shall~~ be offered with a frequency that meets the individual needs of the resident.

~~(3) Resident participation in general activity programming, which shall:~~

~~(i)~~ (3) Have a purpose that the resident can appreciate and endorses.

~~(ii)~~ (4) Be done voluntarily.

~~(iii)~~(5) Respect the resident's age and social status.

~~(iv)~~ (6) Take advantage of the resident's retained abilities.

Section 2600.240 – Notification to Department.

Change .240(3)(iv) to read, "The total resident population of the PROPOSED secured unit."

Delete .240(3)(vii). This is redundant; covered in .240(3)(xi).

Change .240(3)(viii) to read, "INFORMATION ABOUT emergency egress."

Change .240(3)(x) to read, "~~Verification of~~ PLAN FOR completion of ~~additional~~ training requirements." (Discussion: Homes should not be required to hire and train staff, more than 60 days in advance of opening the unit.)

.240(3)(xvii) – A sample activity calendar would be more useful than a list of activity standards.

.240(3)(xx) – Delete "and cost".

Section 2600.241 - Mobility Standards. Why is this discussion included in the Secured Unit section? .238 already discusses mobility in the secured unit.

RESIDENT RECORDS

Section 2600.251 – Resident Records.

.251(b) – Add a comma between the words permanent and legible.

Section 2600.252
.252(a)(3) – Take into account the residents' wishes about photos: (3) "A current photograph of the resident that is no more than 2 years old, IF THE RESIDENT AGREES TO BE PHOTOGRAPHED."

.252(b)(6) – Incident reports should not be part of the resident's record. Delete this.

.252(c) – Should it be "contacts" rather than "contents"?

.252(d)(1) – May want to change the word "assessment" to something that doesn't imply that it is done by an RN.

.252(d)(2) – Change to read, "A support plan, IF APPLICABLE."

.252(d)(9) – Change to read, "The reason for termination of services or transfer of the resident, the date of transfer and the destination, IF KNOWN."

Delete .252(d)(12) – These notifications are not reasonable for a home to obtain and are not a very efficient way to determine compliance with notifying residents of their rights, since DPW or any visitor to the home can simply look for whether the required posting of the notification is there.

Delete .252(d)(14). A list of services to be provided is already included in the contract.

Section 2600.253 – Record Retention and Disposal.
Please change (2) to read "The resident's record ~~shall~~ MAY be destroyed 4 years after their discharge from the home. The records shall be destroyed in a manner that protects confidentiality."

Section 2600.254 – Record Access and Security.
Note that having and utilizing a policy and procedures addressing record accessibility, security, storage, authorized use and release, and who is responsible for the records, will take time for the administrator to develop, adding costs to the care provided.

Change .254(c) to read: "Resident identifying information shall be stored in locked containers or a secured, enclosed area ~~used solely for record storage~~ and be accessible at all times to the administrator or a designee."

Section 2600.261-.264 – Enforcement.
It is disappointing that the regulations do not attempt to make changes to improve the ability of DPW to enforce the current regulations on homes that are consistently not in compliance with the regulations. How will the proposed regulations improve conditions for residents in marginal homes if DPW's enforcement abilities are not enhanced. Without needed changes in this area, the entire package simply imposes additional requirements on homes that are already in substantial compliance, but does nothing to improve conditions of residents in marginal homes. Given the specificity of

the statute on enforcement and penalties, it may be difficult for DPW to address these issues without the assistance of the General Assembly, but it is disappointing that no attempt was made to make improvements in this crucial area.

In addition to recommending that DPW review the enclosed recommendations of the DPW Personal Care Home Advisory Committee on enforcement, we suggest that sections be added to this section:

II. To describe how frivolous complaints will be handled by the department;
III. To develop an informal dispute resolution process that can be entered into prior to the facility receiving a deficiency;
IV. To describe necessary initial training and continuing education for licensing inspectors.

Final Remarks

PANPHA suggests that a better way to approach the personal care home regulations, especially if the basic population served and definitions of the regulated entity are unchanged, is to look at the current regulations and address only the portions of the current regulations that need to be addressed rather than to wholesale reorganize them and come up with new ones. There are many new requirements in the proposed regulations that do not appear to address problems with the current regulations. Sections that PANPHA knows various constituencies have asked DPW to address are enforcement, staffing, education, the definition of personal care home (to include nursing home eligible people) and secured units. Some of these issues are addressed, but so are many others that have not been problematic. By taking a more limited approach, DPW could effect needed change without creating the disruption and economic distress that would be imposed by the proposed regulations.

Again, thank you for the opportunity to comment on the proposed regulations. PANPHA looks forward to working with you as the proposed regulation moves through the formal regulatory process.

Sincerely,

Christine F. Klejbuk
Vice President & Chief Public Policy Officer
chris@panpha.org

cc: Susan Collins, Chair, PANPHA Assisted Living Issues Task Force
John Schwab, Personal Care Home Representative to the IntraGovernmental Council on Long-Term Care
Julie Hull, Member, DPW Personal Care Home Advisory Committee/PANPHA Member

Jim Bernardo, Chair, PANPHA Public Policy Committee
Independent Regulatory Review Commission
The Honorable Hal Mowery, Chairman, Senate Public Health and Welfare Committee
The Honorable Vincent J. Hughes, Minority Chair, Senate Public Health and Welfare Committee
The Honorable George Kenney, Chairman, House Health and Human Services Committee
The Honorable Frank Oliver, Democratic Chairman, House Health and Human Services Committee

Enclosures:

Appendix A: Background information on Personal Care Homes
Appendix B: Costs of Providing Housing and Services in Personal Care Homes in Pennsylvania
Appendix C: *Government Affairs* article on the U.S. Supreme Court's *Olmstead* decision.
Appendix D: Comments received from individual PANPHA members.

APPENDIX A
Background Information on Pennsylvania Personal Care Homes

Background on Personal Care Homes in Pennsylvania

- The infrastructure of personal care homes operating under the current 2620 personal care home regulations currently provides housing, supervision and care for 53,234 personal care home residents.

- 10,507 of these residents depend on the federal Supplemental Security Income (SSI) benefit plus the state supplement to SSI for personal care home residents to pay for their care. The maximum benefit available to these people (if they have no income of their own) is $939.30 per month, of which the resident retains $60 per month as a personal needs allowance. If a resident has income, the SSI benefit is reduced by nearly the full amount of the resident's income, so that if a resident has $500 in income the SSI benefit she receives is $459.30 per month.

- The costs of providing care -- $1825 average statewide in 1999 and more than $2120 per month for PANPHA members -- already far exceeds the amount these residents and many other low- and moderate-income residents can pay. The state has made no meaningful attempt to address this problem and the proposed regulations would exacerbate the already-desperate situation of low-income personal care residents and the homes that serve them. PANPHA anticipates that one of the outcomes of the proposed regulation would be a significant reduction in access to personal care homes for low-income consumers since the costs of providing care would increase significantly and the personal care home supplement to SSI would not increase at all. (See the enclosed Personal Care Home Cost Study for additional information on costs of providing personal care and payments available for residents to purchase these services.)

- In January 2002, 41% of the 1,786 licensed personal care homes in the Commonwealth had 20 or fewer licensed beds. Many of the requirements will especially impact these smaller homes and it should be anticipated that many smaller homes will close rather than comply with the proposed rules.

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PANPHA, An Association of Pennsylvania Nonprofit Senior Services

Pennsylvania Assisted Living Association

Pennsylvania Catholic Conference

Pennsylvania Council of Churches

Pennsylvania Jewish Coalition

Pennsylvania Catholic Health Association

Affordable Housing and Services in Pennsylvania: Current Funding System

Nearly 50,000 adults depend on the care offered by the more than 1,800 personal care homes in Pennsylvania licensed by the Pennsylvania Department of Public Welfare. Typically, just over 10,000 of these residents depend on public funding to pay for the housing and services they need.

Very low income residents of personal care homes may receive federal Supplemental Security Income (SSI) *along with a state supplement to SSI* if they:

- Have less than $2000 in countable assets, excluding the home a person lives in, a car (depending on use or value), burial plots, burial funds of up to $1,500, life insurance with face value of $1,500 or less.
- Are assessed by the County Office of Aging as needing a personal care home.
- Reside in a licensed personal care home.
- Are determined by the County Assistance Office to be financially eligible for the personal care home supplement (have less than $959.30 monthly income).

Total SSI payment (federal plus state supplement) is offset by the income a recipient can contribute. In 2002, a personal care home resident who has no income other than SSI qualifies for the entire payment, which is:

- $545 per month from the federal SSI payment, which is increased each year with a cost of living adjustment.
- $394.30 in the state personal care home supplement to SSI.
- SSI recipients qualify for Medical Assistance benefits for physician, hospital and pharmacy needs.
- With the exception of one small pilot program, SSI recipients in personal care homes **are not** eligible to receive Medicaid waiver benefits. Only people who do not need the services in, or of, a nursing facility are allowed to reside in personal care homes; Medicaid waivers are only available to people who need nursing facility care and choose to remain at home.
- Most states provide funding for personal care services for low-income citizens through a combination of Medicaid plus SSI, but Pennsylvania uses only federal SSI plus the state SSI supplement to fund housing and services for poor people who need to reside in personal care homes.

Of the total $939.30/month payment, the resident may retain $60/month as a "personal needs allowance," leaving $879.30 available to the personal care home *for all housing and services required by the resident*. This amounts to $28.90 per day.

The costs of personal care homes have been documented as follows:

- $76 per day (PANPHA survey of member personal care homes, 2000.)
- $60 per day (DPW Personal Care Home Advisory Committee survey, 1999.)
- $32 per day (Center for Health Policy Studies survey, funded by DPW, 1990.)

For additional information on SSI, see the Social Security Administration's website, www.ssa.gov. From the home page, scroll down to click on "Supplemental Security Income."

February 1, 2002

The SSI Network is a group of statewide and regional organizations representing consumers and providers concerned about affordable housing and services for Supplemental Security Income (SSI) recipients. SSI is the state-federal assistance program for very low income elderly, disabled, and blind Pennsylvanians. For more information about the Network, contact Beth Greenberg at PANPHA, beth@panpha.org or PANPHA, 1100 Bent Creek Blvd., Mechanicsburg, PA 17050.

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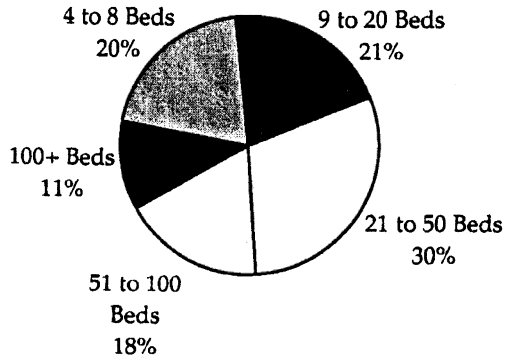
Assisted Living/Personal Care Home Provider Trends

Most Assisted Living providers in the Commonwealth are personal care homes (PCHs), licensed by the Department of Public Welfare (DPW). A review of PCHs in the Commonwealth shows that, as of December 2001, there were 1,786 licensed homes, with 53,234 residents; 10,507 of the residents received SSI or the State PCH Supplement to SSI. Over 3,000 people residing in PCHs in 2001 did not need or receive PCH services, but may have moved into a PCH with their spouse or to be prepared when they need services. Most PCHs (78%) are proprietary rather than non-profit entities.

Many personal care homes are small, with 4-8 bed homes comprising 20% of the homes and 9-20 bed homes making up another 21%. Only 11% of the homes have more than 100 licensed beds. Over the past 7 years, smaller homes have been closing and larger ones opening. In 1994, more than half of the 1,443 personal care homes had less than 20 licensed beds and under 6% had more than 100 beds.

Personal Care Homes by Number of Beds, 2002
(Total Homes = 1,786)



Some providers have developed secured units as an option for providing additional safety for residents with dementia within a PCH setting. The number of homes with these units has been increasing and in December, 2001, the number of these units was 203, with a capacity for 7,739 residents.

DPW inspects each home annually before renewing the home's license. DPW also has the authority to enter and inspect homes whenever necessary to assure compliance with regulations. Last year, 10 homes closed due to DPW action and 111 closed voluntarily. More than one-quarter (26%) of the homes that closed in 2001 had a significant percentage (more than half) of residents using SSI and the State Personal Care Home Supplement.

April 5, 2002

The SSI Network is a group of statewide and regional organizations representing consumers and providers concerned about affordable housing and services for Supplemental Security Income (SSI) recipients. SSI is the state-federal assistance program for very low income elderly, disabled, and blind Pennsylvanians. For more information about the Network, contact Beth Greenberg at PANPHA, beth@panpha.org or PANPHA, 1100 Bent Creek Blvd., Mechanicsburg, PA 17050

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What are Medicaid Waivers?

Q: What is Medicaid?
A: Medicaid is a jointly funded Federal-State health program for certain low-income and needy people. It covers approximately 36 million people and is the major source of public funding for long-term care services.

Q: What is a Medicaid Waiver?
A: When it began in 1965, Medicaid provided services in institutional settings. In 1981, Congress authorized the Medicaid 1915(c) Home and Community-Based Services (HCBS) Waiver program to allow states flexibility to offer different types of services to individuals with chronic disabilities. The waiver allows states to waive Medicaid requirements so that, for waiver programs,

- Services do not have to be provided statewide;
- States can use more liberal financial eligibility criteria; and
- Designated groups can be given benefits that other groups don't receive.

Q: Must a person go into a nursing home to qualify for a Medicaid waiver?
A: No. Although functional eligibility criteria for most waivers are similar to eligibility for nursing home care, a person need not have resided in a nursing facility at any point in order to qualify.

Q: What are the eligibility requirements in Pennsylvania?
A: To be eligible for the Pennsylvania Department of Aging (PDA) Waiver, a person must have income less than $1,593/month (as of August 2001) and less than $2,000 in assets. In addition, the person must be age 60 or older and either disabled or nursing home eligible. The person must be able to be appropriately served in the community at a cost not to exceed 80% of the average Medical Assistance payment for nursing facility services in Pennsylvania and must choose to receive services in their own home or a community setting. There are other waiver programs in Pennsylvania that target other groups and have different eligibility requirements.

Q: If a person qualifies for the waiver, what services can he or she receive?
A: A broad variety of services may be provided through waiver programs and can be tailored to fit the needs of targeted populations. The services offered through the PDA Waiver include: personal care services, respite care, transportation, specialized medical equipment and supplies, personal emergency response systems, companion services, older adult daily living centers, home support (housekeeping and maintenance), home health care, counseling, extended physician services, attendant care, environmental modifications, and home delivered meals.

Q: Can a person receive these services in a personal care home?
A: Although there is one small pilot project to study the concept of allowing residents of personal care homes to use waivers, current policy is that Pennsylvanians who reside in personal care homes cannot receive waiver services.

May 3, 2002

The SSI Network is a group of statewide and regional organizations representing consumers and providers concerned about affordable housing and services for Supplemental Security Income (SSI) recipients. SSI is the state-federal assistance program for very low income elderly, disabled, and blind Pennsylvanians. For more information about the Network, contact Beth Greenberg at PANPHA, beth@panpha.org or PANPHA, 1100 Bent Creek Blvd., Mechanicsburg, PA 17050

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What Are Other States Doing to Help Low-Income People with Personal Care Needs?
States provide funds to assist low-income people with personal care needs in a variety of ways. Some of the government programs that are used are the:

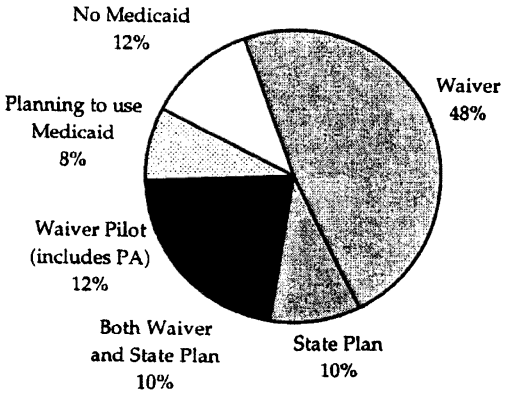
- federal SSI payment,
- state supplements to SSI,
- state general funds,
- Medicaid state plan services, and
- Medicaid Home and Community-Based Services waivers.

Pennsylvania uses both the federal SSI payment ($545/month in 2002) and the state supplement to SSI ($394.30/month in 2002) to pay for housing and personal care services people receive in a personal care home. This comes to $29 per day, which is less than half of the funding needed to provide adequate services for personal care home residents in our Commonwealth. Because many personal care facilities are finding it difficult to continue to provide services at less than those services cost, many low-income seniors are finding it increasingly difficult to find a personal care home that can accept them. For those people, it is a constant struggle to obtain the basic necessities of life -- if they can find them at all.

Many states, including **Arizona, Florida, Maryland, Michigan, New Jersey,** and **New York** provide both a state supplement to the federal SSI rate and Medicaid reimbursement to help low-income people stay in a residential care setting. Florida and New Jersey have programs for subsidized housing tenants to help them successfully age in place.

How Do Most States Fund Assisted Living Services in Residential Settings?

Most States Use Medicaid to Fund Assisted Living Services in Residential Settings



Source: State Assisted Living Policy: 2000, National Academy for State Health Policy.

- States can use Home and Community Based Services (HCBS) Waivers or fund assisted living/personal care services through the Medicaid state plan; some states do both.
- Two states use Medicaid managed care programs that cover assisted living.
- Pennsylvania has a pilot program that uses a HCBS waiver for personal care home residents, limited to 17 personal care homes and 375 people in Philadelphia.

June 7, 2002

The SSI Network is a group of statewide and regional organizations representing consumers and providers concerned about affordable housing and services for Supplemental Security Income (SSI) recipients. SSI is the state-federal assistance program for very low income elderly, disabled, and blind Pennsylvanians. For more information about the Network, contact Beth Greenberg at PANPHA, beth@panpha.org or PANPHA, 1100 Bent Creek Blvd., Mechanicsburg, PA 17050

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Funding Gap in Pennsylvania Identified as Major Access Barrier for Low Income Elderly Tenants of Supportive Housing in Need of a Personal Care Home

In 2000, PANPHA, an Association of Pennsylvania Nonprofit Senior Services, asked its 50 members with government-subsidized supportive housing for the elderly about tenants who needed a personal care home in the past year. Fourteen properties, representing various areas of the state, responded to the survey. The average tenant's age was 76 and the average annual income was $11,349.

Most of these housing developments are atypical in that they provide services such as meals, laundry, and housekeeping and employ service coordinators to help tenants access community services. Perhaps because of the many services available on-site, less than 10% of these tenants needed a personal care home. For those who did, however, finding an acceptable situation was difficult:

- "For those who have needed personal care homes in the past year, several are still in their apartment, "getting by" with services from the AAA, etc., one lives in an assisted living facility in Florida, and several went to nursing facilities instead. The difficulties are all related to finances. Services that become difficult to manage in the housing setting are when there is dementia or when the resident needs assistance monitoring their medications."
- "...the main issue for our residents rests with income. A higher level of care is required but there is no source of funding available to pay for it. We try to provide assistance through various sources, however, this assistance is usually minimal and often limited. Some residents have a minimum of support from family but in most cases, the support is just not enough. Fellow residents will "help out" for a period of time but in some respect that seeks to "mask" conditions and circumstances that really need to be dealt with. In the end, many people remain in independent living until they can "qualify" for nursing home placement thus reducing the quality of life substantially....this level of assistance [personal care home] is just not available to our resident population at this time."
- Last year, five tenants needed the services of a personal care home, "all were women in their 90s; three were mentally impaired, two were physically impaired. They needed personal care, medication assistance, cleaning assistance and meals." Property staff is not available to handle these kinds of services, but a service coordinator does assist tenants to access home health and other outside services. Tenants are accommodated with needed services until they reach a point that it becomes obvious that they need round the clock care, then the family, responsive church organizations and the local Area Agency on Aging are called in to find placement. Unfortunately, SSI beds are few and far between and often the tenant's physical or mental condition precipitates an emergency situation that lands them in the hospital. From there the hospital social worker becomes responsible for placing the tenant in a round the clock care facility.
- "Tenants who need a greater level of care than we can provide, or they can arrange for, invariably move to nursing facilities, spending down until they are Medicaid-eligible. One recent tenant who moved ...spent all of her modest savings on one month of care at a private assisted living facility until the county bed opened."
- "Our residents have an extremely limited income and assisted living is expensive. People who cannot afford at least $1200 per month have a limited choice." "We had an 80-year old female resident who became frightened of being alone following a stroke. She needed assistance in dressing, bathing, making meals and cleaning. Her son lived with her but his care-taking was inconsistent and unreliable. She became panicked that she could not manage her life and had to be re-hospitalized. At that time she and her family were offered a boarding home placement. Her family looked at it, was very disappointed and refused to allow her to go there. She was re-evaluated and found to need nursing home placement. She will be long term."

These stories and statistics illustrate that in spite of the presence of a rich service package, some tenants need the 24-hour care provided by a personal care home. They are frail, impoverished 70, 80 and 90 year olds, typically women, who need supervision due to serious health conditions, dementia or mental illness and they are not receiving the care they need because the current funding system does not provide for them.

July 5, 2002

The SSI Network is a group of statewide and regional organizations representing consumers and providers concerned about affordable housing and services for Supplemental Security Income (SSI) recipients. SSI is the state-federal assistance program for very low income elderly, disabled, and blind Pennsylvanians. For more information about the Network, contact Beth Greenberg at PANPHA, beth@panpha.org or PANPHA, 1100 Bent Creek Blvd, Mechanicsburg, PA 17050

Appendix B
Costs of Providing Housing and Services in Personal Care Homes in Pennsylvania

Costs of Providing Housing and Services in Personal Care Homes in Pennsylvania

A study conducted for
The Department of Public Welfare's
Personal Care Home Advisory Committee
June 17, 1999

By
The Pennsylvania Association of Non-Profit Homes for the Aging
and Shippensburg University's
Center for Applied Research and Policy Analysis

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This cost study was accomplished with the tremendous cooperation and support of many people and organizations. The study could not have been undertaken without the support of the Department of Public Welfare (DPW) Personal Care Home Advisory Committee, its chairs Bill Yovanovich, then Director, Division of Personal Care Homes, Bill Keane, The Whitman Group, and Pam Walz, Elderly Law Project, Community Legal Services, and the cooperation of William Gannon, Deputy Secretary, DPW Office of Social Programs, Carolyn Chester, Director, DPW Bureau of Social Services, Patsy Taylor Moore, Director, Division of Personal Care Homes, and the personal care licensing staff, in promoting dialog on important issues affecting personal care homes in the Commonwealth.

Listed in the Appendices are some of those whose efforts were crucial to accomplishing this study, including members of the Department of Public Welfare Personal Care Home Advisory Committee, members of the Advisory Committee's Cost Study Work Group, and Sara Grove, Ph.D. and Shippensburg University's Center for Applied Research and Policy Analysis. In addition to these individuals, this study received input and support from the Pennsylvania Association of Non-Profit Homes for the Aging (PANPHA), the Association of Personal Care Administrators (APCA), the Center for Assisted Living Management (CALM), the Pennsylvania Assisted Living Association (PALA) and the Personal Care Resource Center.

The cost study project was managed by Beth Greenberg, Public Policy Analyst, PANPHA. Members of the personal care committees of PANPHA and CALM pilot tested the initial draft of the questionnaire, monitored the study's progress, and provided valuable advice throughout the study. Special thanks are due to committee chairs John Schwab, The Hickman and Dan Snyder, Pleasant View Retirement Community of PANPHA's Personal Care Subcommittee and Harvey Everett, Country Meadows, and Pat McNamara, chairman and staff, respectively of CALM's Assisted Living Specialty Council. Additional assistance was received from Bill Keane, Chair of the DPW Personal Care Home Advisory Committee and Vice President of the Whitman Group, who assisted in the formatting and development of the questionnaire. Donna Roe, Office of Income Maintenance, and Dale Laninga, IntraGovernmental Council on Long-Term Care, provided important historical perspectives on the personal care home licensing program and the use of the State Supplement to SSI for personal care homes and domiciliary care homes. Finally, the study could not have been completed without the efforts of those that volunteered and took the time to complete and return the cost study questionnaire.

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EXECUTIVE SUMMARY

In 1997, the Department of Public Welfare Personal Care Home Advisory Committee concluded there was a need to conduct a cost study of personal care homes and authorized a work group to provide assistance on the study. The initial draft of the questionnaire was based on the form used by the Center for Health Policy Studies, and modified based on comments from the Cost Study Work Group and participants who pilot tested the questionnaire.

Since voluntary cost studies have historically had tremendous difficulty in recruiting participants, the current cost study attempted a unique research design, using a small, recruited sample of homes. The goal was to collect five sites in each of the following categories, so that a range of different types of homes would be represented and that the results would be based on more than anecdotal, site-by-site data. The number of cases finally included in the study is indicated following the category name.

Rural (15 cases)
Urban (9 cases)
Suburban (18 cases)
Small to Medium (4-20 beds) (5 cases)
Medium to large (21-50 beds) (14 cases)
Large (over 50 beds) (23 cases)
Philadelphia (5 cases)
Serving residents primarily with mental illness (7 cases)
Special program serving residents with dementia (5 cases)

The data presented below is from the 43 completed, returned and verified questionnaires.

All Homes

Average Number of Years in Operation	28
Organizational Structure	
% Independent/Free-Standing	51%
% Part of Continuum of Residential Services	37%
% Other	12%
Number of Licensed Beds	74
Number of Set-up/Staffed Beds	60
Census	54
% with a Defined Program/Service Package for Special Need Population	28%
Average percentage of residents receiving assistance with:	
Bathing	63%
Dressing	33%
Medications	83%
Toileting	18%
Transferring	8%
Eating	6%
Average percentage of residents who have an outside support person to help with:	
Activities of Daily Living	5%
Financial matters	49%
Socialization/Recreation	13%
Other	3%
Costs	
Total Housing and Services Package	$ 59.65
Food	$ 4.71
Gross Salaries for Dietary Staff	$ 6.00
Dietary Supplies & Other Food Service Components	$ 2.27
Direct personal Care Staff Salaries	$ 14.09
Other Components of Direct Resident Care	$ 4.22
% Anticipating Unusual Capital Costs	66%
Total Respondents	43

Source: DPW Personal Care Home Advisory Committee Personal Care Home/Assisted Living Cost Study Survey, 1998 data.

Literature Review

LITERATURE REVIEW

Demand for Long-Term Care and Services Increasing

With the realization that the baby-boomers will begin turning age 65 by the year 2010, there has been an increase in research regarding the impact the growing over-65 population will have on society. "Today's 65+ population is the largest in U.S. history, over 33 million or almost 13 percent of all Americans. This number will grow to over 69 million by the year 2030 (20 percent of all Americans), and almost 80 million by 2050." (Gulyas, 1997, p. 12.) While growing older does not necessarily mean that a person will become disabled, the probabilities tend to go up. The *1997 Profile* notes that the percentage of persons needing assistance with activities of daily living (ADLs) is as follows:

Age	Percentage with ADL* Needs
15-64	2%
65-69	9%
70-74	11%
75-79	20%
80-84	31%
85 and over	50%

(*Activities of Daily Living are generally thought to include activities such as eating, dressing, bathing, toileting and transferring.)

The Urban Institute states that:

- 20 percent (7.1 million) of people age 65 and older were disabled in 1994
- About 5 percent of people age 65 and older (1.7 million) lived in nursing homes and other institutional settings in 1994
- 3.5 million older people used Medicare-covered home health services in 1995
- Half a million older people used Medicaid home and community-based care services.
- A quarter of all adults who have trouble performing ADLs are under the age of 65.

(The Urban Institute, 1999.)

With the aging of the baby boom generation and an increasing number of people living into their eighties and nineties, effective ways of providing services for disabled individuals have become essential. One component of long-term care and services – assisted living -- has received an enormous amount of attention in recent years. According to a 1997 General Accounting Office report, consumer demand for assisted living services is on the rise nationally. In addition, the number of assisted living beds is increasing, according to a survey conducted in 1997. (Hersch and Asper, 1997.) The survey revealed that there was a 58% increase in resident capacity (assisted living beds) over the previous year. Estimates of the number of assisted living facilities nationwide

and the number of assisted living residents vary widely depending upon the definition of assisted living used. The Assisted Living Federation of America's (ALFA's) 1996 study estimated that the number of assisted living residents was between 250,000 and one million people. (ALFA, 1996.)

The recent increase in demand for and supply of assisted living services and residences has prompted a closer look at their costs. Pennsylvania does not have a definition of assisted living, but many facilities that market themselves as providing assisted living are licensed as personal care homes. The focus of this study is the cost of providing care and services in Pennsylvania personal care homes. Where information is available on a national level, it is used for comparative purposes.

Assisted Living: A National Perspective

Before examining the costs of care, it is important to differentiate among the many services and levels of care that are available. In examining the term assisted living, there are several interpretations, ranging from a consumer's residence to a residential facility to somewhere in between. According to the U.S. General Accounting Office (GAO), assisted living is one type of long-term care. (U.S. GAO, 1997.) No matter where the care is provided, long-term care is a general term describing care and services for individuals who need assistance with activities of daily living (ADLs) such as eating, dressing, bathing, toileting, and transferring, or with instrumental activities of daily living (IADLs) such as shopping, tending to financial matters, making and keeping appointments or with correspondence. Long-term care is often thought of as only needed by elderly people, but it is also a service necessary for younger people who are physically or mentally challenged.

According to the American Association of Homes and Services for the Aging (AAHSA), assisted living is "characterized by a philosophy of service provision that is consumer driven, flexible and individualized and maximizes consumer independence, choice, privacy and dignity." (Gulyas, 1997, p. 1.) Assisted living is a rapidly growing area that emphasizes the autonomy, privacy and dignity of the residents. (Blanchette, 1997.)

According to AARP, most consumers want to be able to remain in their own homes as long as possible and to enter a residential setting only when substantial need arises. The primary goal for assisted living is to keep the elderly person or persons in their residence while providing the necessary services to help them function. Some of the services provided include meals, personal care, walking assistance, medication distribution, shopping, transportation, laundry, and health services. (Crystal, 1996.)

Other sources view assisted living as a residential program. According to the United States General Accounting Office, assisted living is a combination of housing, personalized support services, and health care. (U.S. GAO, 1997.) It is viewed as a specific residential care setting along the continuum between independent living and nursing home care. Kane and Wilson define assisted living as any group residential program other than a licensed nursing home that provides personal care for persons

with impairments in performance of activities of daily living and has the capacity to meet unscheduled needs for assistance. (Kane and Wilson, 1993.)

Whether the concept is that assisted living is a set of services available to a person in their home or whether assisted living is defined as a residential program, several of the goals and services remain the same. The concept of "aging in place" (minimizing a person's need to move to a different setting to access services) is in place in both conceptual frameworks. Additionally, the types of services to be available would be similar under either framework to those described by Crystal. In addition, the assisted living literature stresses that an assisted living setting should emphasize the consumer's dignity, autonomy, independence, privacy and choice.

Although a great deal of discussion has taken place about assisted living, there is no national consensus definition for assisted living. One definition broadly agreed upon was adopted in August 1998 by the Assisted Living Quality Coalition (ALQC), which consists of the Alzheimer's Association, The American Association of Homes and Services for the Aging (AAHSA), AARP (formerly the American Association of Retired Persons), the American Health Care Association/Center for Assisted Living (AHCA/NCAL), the American Seniors Housing Association (ASHA) and the Assisted Living Federation of America (ALFA).

The Assisted Living Quality Coalition believes that, more than any other type of long-term care services, assisted living must be driven by a philosophy of service that emphasizes personal dignity, autonomy, independence and privacy in the least restrictive environment. Further, it should enhance a person's ability to age in place in a home like setting while services intensify or diminish according to the individual's changing needs.

According to the Coalition, an assisted living setting is:

- a congregate residential setting that provides or coordinates personal services, 24-hour supervision and assistance (scheduled and unscheduled), activities, and health-related services;
- designed to minimize the need to move;
- designed to accommodate individual residents' changing needs and preferences;
- designed to maximize residents' dignity, autonomy, privacy, independence, and safety; and
- designed to encourage family and community involvement. (ALQC, p. 65)

The U.S. General Accounting Office (GAO) provided the following definition of assisted living in its May 1997 report, *Long-Term Care: Consumer Protection and Quality-of-Care Issues in Assisted Living*.

> Assisted living may be defined as a special combination of housing, personalized supportive services, and health care. It is designed to respond to the needs of individuals who require help with activities of

> daily living (ADL), but who may not need the level of skilled nursing care provided in a nursing home. However, there is no uniform assisted living model, and considerable variation exists in what is labeled an assisted living facility. (GAO, 1997, p. 2.)

States define assisted living settings in a variety of ways, typically limiting who may reside in assisted living settings and describing appropriate screening and discharge criteria. States also use various ways of providing public funding for assisted living. Several studies have been published that provide information about the ways states regulate and finance assisted living settings, including several National Academy for State Health Policy studies, reports by the American Health Care Association and by the American Association of Homes and Services for the Aging. (See Bibliography.)

Who Resides in Assisted Living?

A number of studies have been conducted to ascertain who lives in assisted living settings. Some of the studies have had divergent results, depending on the definition of the setting and the sample used in the study.

One of these, a 1996 survey by ALFA, found that the typical assisted living resident is a single or widowed female, age 83 or older, needing assistance with three ADLs. This survey also found that 48 percent of residents had some cognitive impairment and 38 percent used walkers or wheelchairs. (ALFA, 1996.)

While the most common assisted living resident is an older woman with mobility and/or cognitive impairments, younger individuals with disabilities also reside in assisted living settings. The 1995 Department of Health and Human Services (DHHS) study, *Analysis of the Effect of Regulation on the Quality of Care in Board and Care Homes,* found that the population in the study sample was overwhelmingly elderly (78 percent), female (66 percent), Caucasian (91 percent) and widowed, divorced, or never married (85 percent). However, 22 percent of the residents in the sample were non-elderly (age 18 to 64). Excluding Alzheimer's Disease and other dementias, about one-third of the residents reported a mental, emotional, or nervous condition. More than one-third (39%) of the residents in the sample had moderate or severe cognitive impairment. In this study, 15 percent of the residents used a wheelchair. Approximately 10 percent of the residents in the sample had a diagnosis of mental retardation or developmental disabilities. (DHHS, 1995.)

The 1995 DHHS study defined board and care as "nonmedical community-based residential settings that house two or more unrelated adults and provide some services such as meals, medication supervision or reminders, organized activities, transportation, or help with bathing, dressing, and other activities of daily living (ADLs)." (DHHS, 1995.) The study notes that board and care homes may also be known as personal care homes, rest homes, domiciliary care homes, residential care homes, homes for the aged, and assisted living facilities. (DHHS, 1995.) This study found that residents of board and care homes were significantly more impaired than the residents described in studies conducted during the 1980s, (Dittmar & Smith, 1983) but significantly less impaired than nursing home residents. (DHHS, 1995, p. 19.)

In 1996, the DHHS published a *National Study of Assisted Living for the Frail Elderly: Literature Review Update* that provided a summary of research to date on the characteristics of assisted living residents. Their summary is as follows.

> The ALFAA [Assisted Living Facilities Association of America, now known as Assisted Living Federation of America] study provides a resident profile drawn from the assisted living facilities responding to their survey: 79 percent of residents are female with an average age of 85; male residents average 83 years (ALFAA and Coopers & Lybrand, 1993). In their national study, Kane and Wilson (1993) found that the average age for residents was 83 years....
>
> In addition to the aforementioned studies, Coopers & Lybrand in conjunction with the American Seniors Housing Association have produced *The State of Seniors Housing 1994* (1995), a project that surveyed senior housing executives in congregate housing, CCRCs [continuing care retirement communities], and assisted living facilities for information on financing and development, resident characteristics, and financial performance indicators. This study found that assisted living facilities generally serve a population of single females in their early 80's. The prototypical assisted living resident was an 81.8 year-old female. In fact, only 19 percent of assisted living residents were male, according to the findings of this study.
>
> Finally, the vast majority of residents (more than 97 percent) in these facilities are unmarried or are not living with their spouse.
>
> The ALFAA study found that assisted living residents have a mean number of 3.06 ADL impairments and 42 percent have some cognitive impairment. The also found that typical residents were females needing "moderate or heavy care." The residents frequently needed help with ambulating, medicines, bathing and/or dressing and were forgetful. DHHS, 1996.)

Typically an assisted living setting provides services to assist residents with activities of daily living (ADLs) or instrumental activities of daily living (IADLs). Many states restrict the types of services that may be provided in assisted living settings. For example, some states regulate assisted living settings so that they provide only ADL and IADL service, but not health-related services. Some states allow persons to receive health-related services in an assisted living setting for a certain period of time. Such restrictions define who can reside in an assisted living setting and the constellation of services that may be provided.

Who Pays for Assisted Living?

Despite a commonly held misperception that Medicare pays for long-term care, fundamentally Medicare covers only short-term nursing home and home health care services after a serious illness or accident. (The Urban Institute, 1998.) Assisted living is most typically acquired through the private pay market, with residents and sometimes families making payments directly to the assisted living provider.

Despite its benefits and cost-effectiveness, assisted living requires most residents to privately finance their stay (Clipp, 1995.) According to a 1997 National Academy for State Health Policy (NASHP) study, rates in the private market range from $1,500 to over $3,500 per month. (Mollica, 1997.) The NIC study found that the average monthly fee charged was $67 per day or over $24,000 annually. (Kramer, 1999.) The Penn State Data Center (PSDC) 1995 Current Population Survey estimates that only 12.6% of persons 65 or older who live alone have incomes of $25,000 or more; only 68.6% have incomes over $15,000 annually. (PSDC, 1995.) Although some consumers with lower incomes may have assets that can be converted to sustain them in assisted living for a period of time, many do not have income or assets available to provide care in this setting. Accordingly, assisted living is not readily affordable to a significant segment of the population. See table below for more comprehensive income estimates.

Estimated Number of Persons Age 65 and Older
Household Income of Persons Living Alone

Household Income	Percentage	Accumulative Percentage	Estimated Number
$0-$2,499	2.9%	2.9%	14,316
$2,500-$4,999	3.7%	6.6%	18,266
$5,000-$7,499	16.2%	22.8%	79,975
$7,500-$9,999	18.6%	41.4%	91,823
$10,000-$12,499	15.5%	56.9%	76,519
$12,500-$14,999	11.7%	68.6%	57,760
$15,000-$17,499	7.6%	76.2%	37,519
$17,500-$19,999	4.4%	80.6%	21,722
$20,000-$22,499	3.3%	83.9%	16,291
$22,500-$24,999	3.5%	87.4%	17,279
$25,000 or more	12.6%	100%	62,203
Total	100%	100%	493,671

Source: Penn State Data Center, 1995 Current Population Survey (CPS) for the Mid-Atlantic Census Region.

For persons who cannot afford assisted living through the private market, there may be some public subsidies available, depending on the state in which one resides. The NASHP study found that: "During 1997, 24 states covered, or planned to cover, services

in assisted living facilities through Medicaid and eight states covered personal care services in board and care facilities, which is sometimes considered assisted living. States most often use the Home and Community Based Services Waiver (1915(c)), however, a few states use Medicaid State Plan services, typically personal care." (NASHP, 1997, p. 1.) In addition, the study notes that "As the private assisted living market expands, state policy concerning rates will determine the extent to which low income residents have access to this residential option. Rates must be high enough to encourage facilities to contract with Medicaid, yet lower than the cost of a nursing facility." (NASHP, 1997, p. 12.)

Some states utilize Supplemental Security Income (SSI) to provide for the room and board component of assisted living, since Medicaid does not pay for room and board except in nursing homes and hospitals. Massachusetts has established a separate SSI payment category as a supplement to the federal SSI to pay for personal care and administrative costs in assisted living, according to AAHSA's *Medicaid as a Financing Source for Assisted Living Services*, 1998. In Pennsylvania, residents of personal care homes are eligible for the State Personal Care Home Supplement to SSI, which is $334.30 per month and is intended to pay for personal care services. (Department of Public Welfare, 1999.)

The Assisted Living Quality Coalition discusses the contribution of third party payers to quality assurance in the following paragraphs.

> In introducing assisted living coverage, third party payers, both public and private, should reward outcomes consistent with the philosophy of assisted living - especially those related to consumer satisfaction and quality of life. In particular, third party payers should reimburse services at a level that permits private rooms for all consumers who want them and assures adequate reimbursement for the services provided.
>
> ....Past experience demonstrates the huge impact that third party reimbursements can have on service delivery and quality control. In the public sphere, Medicaid entitlements have shaped the nursing home industry for good and ill. Unfortunately, the conflicting roles that states play - as overseers of quality and payers with fiscal constraints - often makes services inaccessible, expensive, and unresponsive to consumer preferences.
>
> Concerns are growing about how private insurance will affect assisted living's distinctive character. Consumer advocates and providers worry that health plans will be most interested in cutting costs, a goal that could reduce quality. Some advocates also fear that the growth of integrated service models could lead to the medicalization of assisted living where clinical outcomes may be emphasized to the detriment of quality of life dimensions such as the independence, autonomy and privacy of the individual consumer. (ALQC, 1998, p. 51-52.)

One of the purposes of the Assisted Living Quality Coalition's efforts has been to "promote the highest possible quality of life for older persons and consumers with disabilities by advocating for the assisted living philosophy of independence, privacy, dignity and autonomy." (ALQC, 1998, p. 5.)

What are the Costs of Assisted Living?

When information regarding the costs of personal care homes and assisted living is provided, there are tremendous inconsistencies in what is included and what is excluded in various studies.

Personal care homes have many factors that contribute to the cost of running the home and these factors can be categorized in a variety of ways. Some of the categories used in prior studies include administration, nursing, personal care, dietary, housekeeping, laundry, activities, social service, and maintenance/building costs. (Ross, 1998.) Some of the services provided include meals, personal care, walking assistance, medication distribution, shopping, transportation, laundry, and health services. (Crystal, 1996.) Facility costs are added on to these costs to arrive at the total cost of operation per day. Additionally, the Pennsylvania Association of Non-Profit Homes for the Aging (PANPHA) 1996 survey included costs such as taxes and insurance. (PANPHA, 1996.) These costs may be included within the administration costs in other studies. Another survey divides costs into the following categories: payroll, fringe benefits, food, utilities, taxes, and insurance (PANPHA, 1992.) One of the primary ways that costs are segmented is into operating costs and capital costs, with a variety of subcategories like those noted above. It is important to understand that the rates charged probably are not equal to the costs of providing the services. The rates paid by the consumer may be higher or lower than the total cost of providing service in a personal care home.

Rates Consumers Pay for Assisted Living

Several national studies have attempted to estimate the cost of assisted living, some of these have focused on the rate consumers pay, while others focus on the costs of providing the needed care and services. Several publications put the price to the consumer of assisted living in the range from $1,000 to $3,500 per month or more. Blanchette notes that assisted living is typically paid for by private payers at a rate of $1,000 to $3,000 per month. (Blanchette, 1997.) The National Academy for State Health Policy puts the range between $1,500 to $3,500. An article by Harris Meyer, entitled "The Bottom Line on Assisted Living," in the July 20, 1998 *Hospitals and Health Networks*, states that basic annual fees in newer facilities average $28,000, and add-on services can double that." (Meyer, 1998, p. 22.) A 1996 ALFA/ Coopers & Lybrand study found that the average daily rates charged by assisted living providers are $71 for a studio and $73 for a one-bedroom apartment. (ALFA, 1996.) An AAHSA study, *The Not-for-Profit Assisted Living Industry: 1997 Profile* found that the average monthly rate for a private unit in a stand-alone facility was $1,674 (or $55.05 per day.) (AAHSA, 1997.)

Rates Consumers Pay for Assisted Living

Source	Annual	Monthly	Daily
Meyer, 1998	$28,000.00	$2,333.33	$76.75
National Academy for State Health Policy	$18,000–$42,000	$1,500-$3,500	$49.34-$115.13
AAHSA, 1997	$20,088	$1,674.00	$55.05
Blanchette, 1997	$12,000-$36,000	$1,000-$3,000	$32.89-$98.68
ALFA/Coopers & Lybrand, 1996	$25,915 (studio)	$2,158.40 (studio)	$71.00

Costs of Providing Assisted Living

An early study of the costs of board and care homes stated that "The extensive attempts to characterize board and care facilities have not generated much information regarding the costs incurred by board and care operators. Generally, housing costs are comprised of three elements: The acquisition cost - the cost of obtaining title to the physical structure; the start-up cost - the cost associated with preparing the structure for occupancy; and the operating cost – the cost of providing housing services needed by the occupant." (AARP, 1988, p. 62.) This study, based on the income statements of 13 facilities of differing sizes, found that food, labor and debt service comprise the major portions of board and care facility budgets. It observes that "Larger facilities have lower per capita employment costs, enabling them to charge less per person than smaller facilities can; smaller facilities attempt to manage costs by using unpaid members of operators' families." Finally, the study found that "Board and care homes are not highly profitable businesses" and that "Resulting small profit margins do not permit the accumulation of capital reserves for future maintenance and repair of aging facilities..." (AARP, 1988, p. 61.) This study also provides information about the costs of improving energy efficiency and accessibility as well as a review of three cost studies published in

the early 1980s.

The State of Seniors Housing, 1997, a survey conducted by the American Seniors Housing Association (ASHA) and Coopers and Lybrand, found the following costs associated with the assisted living providers in its sample. It breaks the costs into operating expenses, debt/lease payments, and replacement reserve.

Operating Expense Categories (Annual Cost per Resident)

Labor Related	
Administrative Labor	$1,150
Dietary Labor	$1,385
Housekeeping Labor	$582
Maintenance Labor	$319
Assisted Living Labor	$3,488
Skilled Nursing Labor	$2,530
Other Labor	$675
Payroll Taxes	$891
Benefits	$674
Non-Labor Related	
Property Taxes	$520
Property Insurance	$169
Raw Food	$1,456
Utilities	$864
Marketing/Advertising	$354
Repairs/Maintenance	$337
Management Fees	$1,398
All Other Expenses	$1,559
Total Operating Expenses	$17,444
Debt Service/Lease Payments	$4,224
Replacement Reserve	$236

(Source: *The State of Seniors Housing, 1997.* American Seniors Housing Association and Coopers & Lybrand)

The figures provided by ASHA work out to approximately $1,454 per month (or $47.79 per day) for operating costs plus $372 per month (or $12.22 per day) for debt service/lease payment costs and replacement reserve. This works out to an average of $1,825 per month or $60.00 per day in total costs.

Several additional resources provide anecdotal information about the cost of providing assisted living. In an interview for *Nursing Homes* magazine, Jim Moore, provided information on basic operating costs (not including debt service). Moore is President and founder of Moore Diversified Services, Inc., is recognized as a national expert on long-term care and has authored many industry papers and trade journal articles. He states: "If we look at the basic costs involved in providing basic assisted living services (shelter, food, reasonable help with ADLs), they come to about $40 per resident day (if you're fortunate). Multiply this by 30.4 days, and the basic outlay is between $1,200 and

$1,300 a month. There is simply no escaping this. Even if someone were to give the developer the land and the building, which seems unlikely, these are the basic costs that must be recovered for the operator to break even." (Moore, 1998.)

Capital Research Group found that in their sample of over 200 assisted living facilities, *operating expenses* averaged $49.83 per resident per day. Average total development cost per unit was $93,600 nationally and $114,600 in the Northeast. Additionally, the operating expense components for this study are categorized as follows:

Expense Categories	Salaries and Benefits (Per resident per day)	Supplies and Other (Per resident per day)
General and Administrative	$4.45	$3.69
Dietary	$4.14	$4.83
Housekeeping and Laundry	$1.84	$0.60
Personal Care	$14.99	$0.67
Ancillary	$1.27	$1.02
Property	$0.83	$7.10
Management Fee	$-----	$4.39
Category Total	$27.53	$22.31
Overall Total		$49.83

(Capital Research Group, 1998.)

The U.S. Department of Housing and Urban Development (HUD) began funding assisted living projects under its Section 232 Mortgage Insurance program in 1995. In Notice H 97-01, it provided some guidance for its staff on industry statistics and "rules of thumb." They are as follows:

1. According to an April 1996 survey of 120 projects by Capital Valuation Group, the average freestanding Assisted Living Facility (ALF) project costs $6.4 million and generates $2.3 million in annual revenues.
2. The care in an ALF is delivered at approximately 70 percent of the cost of care in a nursing home.
3. The average operating expenses are approximately 55 percent of the cost of care.
4. The resident turnover is approximately 40 percent per year.
5. The income estimate (for qualification purposes) should take into account that the resident will spend approximately 75 percent of income on the monthly ALF costs.
6. The resident will need an income of approximately $25,000 per year to reside in an ALF.
7. The average admission per month after the initial fill-up is three to four residents per month.
8. The typical fill up takes 10-12 months for experienced operators. The overall industry absorption rate is three net admissions per month.
9. The average construction cost is $85 per square foot.
10. The profit margin is 35-40 percent before debt service coverage.

(HUD Notice H 97-01, February 5, 1997.)

Recently, HUD has issued Notices regarding the use of certain properties to support assisted living services. Notice H 98-12, Use of Section 202 Projects to Support Assisted Living Activities (ALAs) for Frail Elderly and People with Disabilities, and the subsequent reinstatement (Notice H 99-10), describe the authority and background supporting this use of Section 202 properties. Additionally, the notice provides a useful comparison of supportive housing with assisted living activities and assisted living facilities.

HUD recognizes in this notice that portions of the project designated for ALAs may need licensure as housing, by State and/or local bodies, however, the licensure cannot be as a care facility. HUD requires that the acceptance of any supportive services by a resident be totally voluntary and that there be a services agreement, separate from the lease.

A project contemplating ALAs must have a service coordinator. According to the notice, examples of typical supportive services for ALAs are: a meals program; personal assistance with Activities of Daily Living (ADLs); laundry, transportation and other forms of mobility assistance or escort service; recreational activities; medication monitoring consistent with State law; and, emergency response systems. Depending on State law, 24 hour oversight may qualify as a supportive service. HUD does not typically provide supportive services in 202 or 202/8 projects and the notice suggests several outside resources that may be able to provide services.

Notice H 99-12, issued May 17, 1999, expanded the use of Notice H 98-12 to cover additional non-profit projects for elderly and disabled people.

Assisted Living and Personal Care in Pennsylvania

ASSISTED LIVING AND PERSONAL CARE IN PENNSYLVANIA

Assisted Living and Personal Care

In Pennsylvania, there is no statutory definition or regulatory framework for entities called assisted living; however, many of the entities marketing themselves as assisted living are licensed as personal care homes. While many questions remain concerning what assisted living is in Pennsylvania, how quality should be assured for this level of services, and how services should be financed, personal care homes have been operating in Pennsylvania for many years and have, since 1980, been defined in statute.

Personal care homes were defined by Act 105 of 1980, and further oversight was provided by Act 185 of 1988. The final regulations governing personal care homes were published in the September 21, 1991 *Pennsylvania Bulletin*. In addition, a Social Programs Bulletin was issued July 1, 1992 offering interpretive guidelines for the personal care home regulations.

Act 185 of 1988 defines personal care homes as "any premises in which food, shelter and personal assistance or supervision are provided for a period exceeding twenty-four hours for four or more adults who are not relatives of the operator, do not require the services in or of a licensed long-term care facility but who do require assistance or supervision in such matters as dressing, bathing, diet, financial management, evacuation of a residence in the event of an emergency or medication prescribed for self administration." (Act 185 of 1988.)

In November, 1998, the Department of Public Welfare's (DPW's) Personal Care Home Advisory Committee forwarded to DPW the Report of the Subcommittee on Future Directions, a series of recommendations for changes to the personal care home regulations in order to facilitate personal care home residents' increased access to services. The Personal Care Home Advisory Committee has also held many discussions regarding assisted living and the future of personal care homes, comparing its views with those of the Assisted Living Work Group of the IntraGovernmental Council on Long-Term Care.

The Personal Care Home Advisory Committee also recently recommended to the Governor an increase in the State Personal Care Home Supplement to SSI to provide $1300/resident/month, in addition to the federal monthly SSI benefit of $500. (Since the current level of state public funding available for a consumer in a personal care home is $334.30 per month, the increase requested in state funds would amount to $965.70 per resident per month.) The total public funding (state and federal funds) currently available to residents of personal care homes is $834.30 per resident per month; the total public funding (state and federal) requested by the Personal Care Home Advisory Committee is $1800 per resident per month. (DPW Personal Care Home Advisory Committee, January 8, 1999.)

In addition to the work of the DPW Personal Care Home Advisory Committee, the efforts of the Cross Systems Licensing Project to consolidate and update regulations are expected to focus on Adult Residential Facilities, a category that would include personal care homes, in late 1999. The Cross-Systems Licensing Project is comprised of the Departments of Aging, Health and Public Welfare.

Also, in September 1998, the Alzheimer's Association Coalition of Pennsylvania Chapters (AACPC) issued recommendations for Dementia Capable assisted living in Pennsylvania, which seek to modify the current personal care home regulations to increase the education of personal care home staff and the number of staff per resident, among other recommendations. (AACPC, 1998.)

Discussions of assisted living are ongoing in the Commonwealth, with the Assisted Living Work Group Report, issued May 27, 1999, under final review by the IntraGovernmental Council on Long-Term Care. The report is expected to be published in the near future.

Still in question is whether personal care homes in Pennsylvania would meet any new definition of assisted living that would be adopted.

The IntraGovernmental Council on Long-Term Care has adopted the following statement of philosophy and definitions for assisted living residence and assisted living services.

Statement of Philosophy

Assisted living starts with a philosophy that encourages and supports individuals to live independently.

Assisted living provides individuals privacy and dignity.

Assisted living maximizes consumer choice to promote and support an individual's changing needs and preferences. Consumer choice includes individuals' rights to make decisions about their own care and to take responsibility for certain risks that may result from their decision, consistent with the individual's capacity to make decisions and the provider's exercise of prudent risk management through negotiated risk agreements.

Assisted living supports living in the residential environment of the consumer's choice.

Assisted living promotes integration and mainstreaming.

Assisted Living Residence

An assisted living residence:

- is a residential setting that offers, provides and/or coordinates a combination of personal care services, 24-hour supervision and assistance (scheduled and unscheduled) activities, and/or health related services;
- has a service program and physical environment designed to minimize the need for tenants to move within or from the setting to accommodate changing needs and preferences;
- has an organizational mission, service programs, and a physical environment designed to maximize residents' dignity, autonomy, privacy, and independence;
- encourages family and community involvement; and
- will disclose services offered, provided, and/or coordinated and the costs thereof.

Assisted Living Services

Assisted living services is a combination of supportive services, and personalized assistance services designed to respond to individual needs of those who need assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs).

(In the definitions above and in the Assisted Living Work Group Report, references to consumer mean the consumer, or the consumer with assistance from responsible persons or family when the consumer's cognitive impairment is severe enough to substantially interfere with functioning or when freely requested by the consumer.) (Pennsylvania IntraGovernmental Council on Long-Term Care, Assisted Living Work Group Report, June 1998. pp. 8-10.)

At its December 18, 1998 meeting, the IntraGovernmental Council on Long-Term Care heard a report from the Assisted Living Work Group and requested that the Departments of Aging, Health, and Public Welfare respond to the recommendations of the Assisted Living Work Group. The Departments met and provided guiding principles and their views on the recommendations of the Assisted Living Work Group at the February 16, 1999 meeting of the LTC Council. At that time, the Departments also stated that they would develop a work plan to study the issues identified by the Assisted Living Work Group and the effects the suggested changes may have on long-term care programs.

On November 17, 1998, Auditor General Robert P. Casey, Jr. released a follow-up report to the Auditor General's audits of state oversight of the Commonwealth's nursing facilities. One chapter of this report, entitled *Improving the Quality of Care: A Plan of Action to Improve Long-Term Care in Pennsylvania*, includes a discussion of assisted living

and the work of the IntraGovernmental Council on Long-Term Care's Assisted Living Work Group. The report makes several recommendations, including a recommendation that "...the Ridge Administration apply to HCFA to amend Pennsylvania's current HCBS [Home and Community Based Services] waiver to include a limited number of "slots" for home- and community (facility)-based assisted living, study the fiscal impact, and then, if feasible, gradually make assisted living available to more and more interested citizens." The report further recommends that "The Ridge Administration and the General Assembly should remove any obstacles in state law to using the HCBS waiver to fund assisted living services provided in assisted living facilities, so that Pennsylvania can take full advantage of the waiver program." (Casey, 1998.)

Legislative Activity

There has been discussion of the need to work on this issue among some members of Pennsylvania's General Assembly, but no bills have been introduced to define or fund assisted living in Pennsylvania.

Who Pays for Personal Care Homes/Assisted Living in Pennsylvania?

In Pennsylvania, personal care homes/assisted living are largely funded through the private pay market, although some public subsidies are available.

Pennsylvania has Medicaid waiver programs that provide publicly funded services in a person's residence, although these waivers are not available if a person lives in a personal care home or domiciliary care home[1]. (See page 25 for a definition of domiciliary care home.) Persons who are financially and functionally eligible may receive services under one of Pennsylvania's waivers. These waivers provide Medicaid funding for services, capped at 80% of the average nursing home per diem cost, for people who need nursing home level services. Instead of moving into a nursing home, people can access services in their home. In some counties, however, there is a waiting list to receive these services.

In addition to the services funded by the waiver programs, there is an array of services (called OPTIONS) provided through the Area Agencies on Aging (AAAs). There are no income restrictions on these services and persons with functional needs lower than a nursing home level are eligible, however, due to scarcity of resources, many AAAs have waiting lists and establish prioritizing mechanisms for these services. Additionally, only persons age 60 or above are eligible to receive OPTIONS services. These services, in addition to PACE, the Pennsylvania subsidized pharmaceutical program for low-income elderly people, are funded through the Pennsylvania lottery. The federal Older Americans Act also provides funding for services (meal programs, senior centers, etc.) for older persons. In addition to programs for older persons, some of the waivers provide services for disabled people younger than 60 years of age. In addition, there are agencies providing publicly funded services, including information and referral

[1] There are pilot programs in progress in personal care homes and domiciliary care homes to introduce waiver services into these settings, but the current law and regulations do not allow people who are nursing home eligible to reside in these settings, making them typically ineligible for waiver services.

services, for this population, including the Centers for Independent Living, and County Mental Health and Mental Retardation agencies.

Supplemental Security Income and the Pennsylvania State Supplement to SSI for Residents of Personal Care Homes

The Social Security Amendments of 1972 initiated the program of Supplemental Security Income for the Aged, Blind, and Disabled (known as SSI), under Title XVI, which became effective January 1, 1974. The purpose of the section was to establish a national program to provide supplemental security income to individuals who have attained age 65 or are blind or disabled, and to authorize sums to be appropriated sufficient to carry out this title. (Title XVI - Supplemental Security Income for the Aged, Blind, and Disabled; SEC. 1601 et seq. [42 U.S.C. 1381].)

Sections 1616 and 1618 describe optional state supplementation, noting that state supplementation must be made through an agreement with the Commissioner of Social Security and a State. The State is required to establish or designate a State or local authority to establish, maintain, and ensure the enforcement of standards for any category of institutions, foster homes, or group living arrangements in which a significant number of recipients are likely to reside. The State must certify annually to the Commissioner that it is in compliance with this requirement. In order to be eligible for Medicaid reimbursement, States are also required to continue making payments and must pass along to SSI recipients the cost-of-living increases to the federal benefit rate.

The use of the State Supplement to SSI for individuals with personal care needs began as a public funding source for individuals in *domiciliary care* settings in 1976 under the Supplemental Assistance Plan No. 1 of 1975, with a state supplement of $147.30 per eligible individual per month. Domiciliary care is a setting certified by an Area Agency on Aging (AAA), for the purpose of providing a supervised living arrangement in a homelike setting for a period exceeding 24 consecutive hours to clients placed there by the AAA. Domiciliary care homes provide housing and services to consumers who have demonstrated difficulties in accomplishing activities of daily living, but do not require skilled or intermediate nursing care, or general or special hospital care on a 24-hour residential basis. Persons in this setting must be mobile or semi-mobile. The AAA provides assessment, case management and placement support for the domiciliary care home provider, who typically provides housing and services to three or fewer residents (6 Pa. Code Chapter 21.) A state supplement to SSI is available to residents of domiciliary care homes in the amount of $329.30 per month in 1999. The supplement is provided by the Commonwealth under 55 Pa Code Chapter 297 and Public Welfare Code 62 P.S. Section 432(2).

When the State Supplement to SSI for domiciliary care began, the Commonwealth also increased from $20.00 to $32.40 per month the amount of state supplement to SSI for all eligible individuals receiving the federal SSI benefit. This state supplement was decreased by $5.00 per month in 1996 to reflect the increased cost charged to the Commonwealth by the Social Security Administration for processing the SSI supplement

checks. The current state supplement to SSI for eligible individuals who do not reside in domiciliary care or personal care homes is $27.40.

According to Income Maintenance Bulletin 297-82-73 dated December 30, 1982, the General Assembly appropriated money to the Department of Public Welfare in the 1982-83 budget to provide a state supplement to SSI recipients residing in licensed personal care boarding homes. According to the bulletin, the supplement was intended to meet the cost of personal care services needed because of a functional disability. The supplement was increased by $5 per month through the 1989-90 General Appropriations Act to increase the personal needs allowance from $25 to $30 per month. (Letter from Michael Hershock, Secretary, Office of the Budget, April 3, 1992.) The supplement and personal needs allowance were increased to their current levels in 1993 through the intergovernmental transfer agreement and the budget, according to DPW's Office of Income Maintenance. Chapter 391 of the Medical Assistance Eligibility Handbook, issued December 20, 1995 describes the process for accessing the State Personal Care Supplement to SSI.

Since 1982, individuals who are assessed as needing to reside in personal care homes, have incomes of less than $834.30 per month, and meet the Supplemental Security Income (SSI) asset requirements are eligible for the state personal care home supplement to SSI - or a portion of the supplement -- to bring their income level up to $834.30. The maximum state supplement that can be received is $334.30 per month, which, combined with the 1999 federal SSI benefit of $500.00 per month, would bring a person's income up to $834.30 per month. Residents who receive the State Personal Care Home Supplement to SSI keep $60.00 per month for a personal needs allowance and the rest is available to the personal care home operator to pay for room, board and services.

Monthly Public Funding Levels for Residents of Personal Care Homes, 1999

Federal SSI Supplement	$500.00 per month
State Personal Care Home Supplement to SSI	$334.30 per month
Maximum public funding for personal care home resident	$834.30 per month
Personal Needs Allowance	$ 60.00 per month
Maximum funding available to SSI recipient to pay for personal care home	$ 774.30 per month

Under the SSI program, $20 of earned or unearned income may be excluded per month. Therefore, an individual who has income in addition to the SSI benefit retains an additional $20 per month, meaning that some individuals who receive SSI benefits and reside in personal care homes have incomes of $854.30 per month. These individuals must also retain $60.00 as a personal needs allowance, leaving $794.30 (total private and public funds) available to pay for a personal care home.

An additional potential resource for SSI recipients is available through third party payments made directly to the provider. In general, third party payments made directly