Phyllis N. Mrosco
R.D.#1, Box 261P
New Stanton, PA 15672-9608
412-580-6940

October 31, 2002

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

Dear Teleta Nevius:

My uncle lives in a personal care home, which accepts SSI as full payment. He has no assets and very little family. The staff at the home takes excellent care of Jerry, but I'm very concerned about the new regulations, which have been proposed.

Because of the increased training requirement, the requirement for an RN or LPN to pass meds, the provision for free local phone calls, and the support plans, there will be increased costs. It is irresponsible for you to say otherwise.

How should we begin to prepare for the eventual closing of all the SSI facilities throughout the state? Are you prepared to relocate the 10,000+ SSI residents? What is the emergency plan? I work for a facility as an administrator, but we are unable to accept SSI residents because of the very low reimbursement. Where do we go from here?

Please respond.

Sincerely,

Phyllis N. Mrosco

Phyllis N. Mrosco
R.D.#1, Box 261P
New Stanton, PA 15672-9608
412-580-6940

October 22, 2002

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

Dear Teleta Nevius:

In 2600.57 Administrator Training, you are requiring us to get 24 CEU's a year. While this is admirable, but with the requirement for all the training necessary for staff, support planning and basic responsibilities of running a business, how and when do you suggest we get these hours? In addition, this far exceeds the nursing home requirement.

Please respond.

Sincerely,

Phyllis N. Mrosco

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R.D.#1, Box 261P
New Stanton, PA 15672-9608
412-580-6940

October 22, 2002

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

Dear Teleta Nevius:

In the detailed review of the published regulations, I fear we are now faced with a similar problem than was faced several years ago. We will once again have the dreaded "Interpretive Guidelines".

While you may think I am overstating the obvious, after reading several sections of the "proposed regulations" several of us (administrators/providers) called DPW's regional offices to ask their thoughts about some of the regulations.

Believe it or not, they read it completely differently than you thought it was written. Believe it or not, we actually agree that there are many items, which need to be rewritten and updated. But we ask, no beg, that we be a part of the process.

Pease respond on the idea of the Interpretive Guidelines.

Sincerely,

Phyllis N. Mrosco

Phyllis N. Mrosco
R.D.#1, Box 261P
New Stanton, PA 15672-9608
412-580-6940

October 22, 2002

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

Dear Teleta Nevius:

Once again, referring to the idea that the proposed regulations will not cost the personal care homes any additional money, I would like to review the staff training requirements. Under you propose 40 hours training before the new staff person does any direct care.

Last year, due to turnover I hired 79 employees. They were all trained for a minimum of three (3) days, but doing actual work for at least a day and a half (while supervised). Therefore the new regulation would have cost me approximately $20,935.00.

In addition, I will have the cost of an employee to actually be with these employees to do the training for those 40 hours. If we consider we would do this training monthly, this cost would be approximately $5,832.00 annually.

Who will cover this additional cost of $26,767.00? Obviously, the elderly cannot afford this. Is the state going to consider providing additional funding for the personal care homes?

Please respond.

Sincerely,

Phyllis N. Mrosco

Dorothy "Tracey" Krotseng
Amber Glen at Forest Hills
107 Fall Run Road, Room 203
Pittsburgh, PA 15221

October 22, 2002

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

Dear Teleta Nevius:

I personally know of many small personal care homes in Westmoreland and Fayette Counties who are doing a marvelous job caring for residents. These homes would be forced to close if the new proposed regulations pass.

I am opposed to these regulations.

Sincerely,

Dorothy U. Krotseng

Dorothy Krotseng

Original: 2294

COMMENTS ON THE PROPOSED CHAPTER 2600 PCH REGULATIONS

The proposed Chapter 2600 Regulations were drafted in order to comply with the Governors Executive Order of February 6, 1996. However, the Proposed Chapter 2600 Regulations do the exact opposite!

If these Regulations become effective, there is no way a small home like ours can survive. We are SO proud of our beautiful home and the loving care we provide for our residents. Everyone who sees our home (including the inspectors), compliment us. Striving to maintain this quality home and atmosphere is already a financial struggle. The added costs these new regs would inflict on us would shut us down.

GENERAL REQUIREMENTS OF GOVERNOR'S EXECUTIVE ORDER

The Governor's Executive Order established very specific General Requirements that all agencies must meet before regulations are drafted. I strongly feel that the Proposed Chapter 2600 Personal Care Home Regulations contradicts nearly every item in the General Requirements for writing new regulations.

-Regulations shall address a compelling public interest. .
-Costs of regulations shall not outweigh their benefits. ...
-Regulations shall be written in clear, concise, and when possible, non-technical language.
-Regulations shall address definable public health, safety or environmental risks. .
-Where federal laws exist, Pennsylvania's regulations shall not exceed federal standards
-Compliance shall be the goal of all regulations.
-Where viable non-regulatory alternatives exist; they shall be preferred over regulations.
-Regulations shall be drafted and promulgated with early and meaningful input from the regulated community.
-Regulations shall not hamper Pennsylvania's ability to compete effectively with other states.
-All agency heads shall be held directly accountable for regulations promulgated by their respective agencies.

PURPOSE OF REGULATION

The Office of Licensing and Regulatory Management states that PCHs are a vital and important component of the continuum of community-based long-term residential care services. In fact , PCHs are an alternative, not a part of the continuum. PCHs receive no financial support from community-based residential services. The regulations have changed the current purpose of PCH from preventing unnecessary institutionalization to making PCHs into institutions. A large portion of the regulations are institutional and have been taken from health care regulations, including mental health treatment.

COST ESTIMATE

The proposed regulations make it totally impossible to assess any estimate of cost. It will double or even triple operating costs for our Home. There is no factual evidence that the regulations will only cost us $680. We DO know if these cost producing regs go thru, our Home will be forced to shut down.

RESEARCH

There is no research to prove the need for these changes to the current regulations. There is no evidence that these changes will improve health and safety for the residents. There is no research to document that these regulations place Pennsylvania in line with other states and the personal care home industry nationwide.

COMPONENTS OF THE PROPOSED REGULATIONS THAT WILL INCREASE COST

1. Implementing safe management techniques and training for such and the expanded potential of being required to retain persons who need the services of a mental health treatment center.
2. Design and implement new resident contract, resident health forms, and assessment forms.
3. The inability to use third party billing for personal care services for SSI recipients.
4. The potential need to refund money before a room is vacated.
5. The responsibility to insure access to medical, behavioral, rehabilitation services and dental treatment.
6. The responsibility to insure the resident has seasonal clothing that is age and gender appropriate.
7. The responsibility to relocate a resident who needs a higher level of care.
8. The limited ability to cancel a resident contract. A contract can only be terminated for nonpayment, higher level of care needs, or if the resident is certified by a doctor to be a danger to self or others.
9. Increased qualification for administrators and direct care staff.
10. Increased staff ratio.
11. Increased training & continuing education requirements and the increased paperwork for staff training plan.
12. The potential need to relocate smoke detectors that have been placed to comply with L&I regulations.
13. Increased liability exposure and insurance policy costs.
14. New and increased responsibility in providing transportation.
15. New assessment requirements that are not coordinated with assessment procedure already being done by local AAA.
16. A support plan that will increase responsibility and liability exposures.
17. Excessive record keeping requirements.

COMMENTS ON THE PROPOSED CHAPTER 2600 PCH REGULATIONS

The confusing language of the regulations might have been caused by the multiple changes in personnel doing its drafting. It is quite clear that the authors had no prior experience in personal care or in writing regulations. Many of the standards are completely inappropriate and look as though much of the language has been taken from regulations for those that receive public funds.

The Proposed Chapter 2600 PCH Regulations are flawed. I suggest that instead of trying to fix the proposed regulations, that we instead view the current regulations and identify any problem areas. It makes much better sense to fix the current regulations than to try to make the proposed regulations work. The current regulations are basically good and appropriate. It is completely wrong to totally change the entire regulation and destroy what is good and what is working.

Resident funds - 2600.20

PCHs are not financial advisors and should not be providing financial counseling sessions. The PCH should only control the funds entrusted to the PCH to ensure that they are used for the resident's own benefit.

Resident Contract-2600-26

It would be very costly to write new contracts for every resident. The current DPW-approved contract was developed after years of research. It serves both the home and resident well. There is no evidence showing the need to change the existing contract.

SSI Recipient - 2600.28(d) (3)

This regulation prohibits third party billing for personal care service. SSI falls far short of paying for personal care services. PCHs should be able to seek private third party payment for a service that is not funded by public dollars. DPW should not restrict the right of families to assist towards the well being of their family member. Third party payment for personal care services enables individuals that do not have personal resources the opportunity to live in a quality personal care home with access to services.

Refunds - 2600.29 (e)
This language has the potential of requiring the home to submit a refund upon notification from the facility where the resident is transferred to before the room is even vacated.

Specific Rights - 2600.42
(i) A resident shall receive assistance in accessing medical, behavioral, rehabilitation services and dental treatment.
It is cost prohibitive for a PCH to be responsible to assure the residents receives these services. Behavioral health, rehabilitation services and dental treatment are not available or accessible to many PCH residents. The responsibility to insure this right should be delegated to the advocates and the community social service agencies that receive public funds to provide those services.
(j)A resident shall receive assistance in attaining clean, seasonal clothing that is age and gender appropriate.
It is cost prohibitive for a PCH to be responsible for residents clothing. A PCH cannot be the total provider of goods and services to the poor.
(n) A resident shall have the right to request and receive assistance from the home in relocating.
It is cost prohibitive for a PCH to be the case-manager and placement agency for relocation of residents. This responsibility should be delegated to a community social service agency or a qualified placement agency that is funded to provide this service. We cannot be held to being the sole party accountable for this.

(u) A resident shall have the right to remain in the home, as long as it is operating with a license, except in the circumstances of nonpayment following a documented effort to obtain payment, higher level of care needs, or if the resident is a danger to self or others.
The cost, turmoil, and liability of not being able to terminate an agreement for a resident who will not honor or abide to the home rules, will not respect the rights and dignity of staff or other residents, who physically, sexually or verbally abuses staff and other residents, who is a nuisance within the neighborhood, or is incompatible with other residents, and refuses to follow or cooperate with a treatment plan, **is not acceptable**.

(z) **A resident shall have the right to be free from excessive medication**.
The PCH has no control over the amount of medication prescribed by a doctor and cannot be made responsible to provide this right.

Staff titles and qualification for administrators - 2600.53
This requirement of the administrator to have 60 credit hours from an accredited college could more than double the cost of an administrator. Administrators for small independently operated homes do not need this level of education. The increased cost would force many homes to close and would displace many low-income residents.

Staff titles and qualification for direct care staff - 2600.54
The proposed staff titles and qualification for direct care staff are not appropriate for personal care. They will not improve the quality of care but will increase operational costs. There is no research to verify that a high school diploma or a GED will improve the quality of care.

Staff Ratio - 2600.56
The increase in staff ratio is not appropriate for a personal care home. Staff should be available to provide the care and services to meet the needs of all residents. The words "resident with special needs" alone, could easily double the cost of care.

2600.58
Staff Training and Orientation & Continuing Education -
The level of training proposed is not warranted for the resident served in personal care homes. It would take valuable time away from resident care and increase the liability and the insurance premiums for the PCH. It also seems absolutely absurd to say that staff in training cannot be in contact with residents! Our staff in training are never left alone with residents, but meeting them and assisting regular staff is essential.

Staff Training Plan - 2600.59
There is no basis to determine the need for a staff-training plan with so many requirements. The increase in paperwork for a staff-training plan will increase operational cost and divert valuable time away from resident care.

Individual staff training plan - 2600.60
There is no need for an annual written individual staff-training plan for each employee, appropriate to that employee's skill level with a plan to identify the subject areas and the potential training resource. The increase in paperwork for an individual staff training plan will increase operational costs and will diverts time from resident care.

Bathrooms – 2600.102
The requirement to provide each resident with soap, toothbrush, toothpaste, shampoo, deodorant, comb and hairbrush should be eliminated. The personal needs allowance (lots of times taken away from the PCH) was increased to $60 so that residents would have the funds to buy personal needs supplies. It is not right that the PCH not only has to take a $60 cut, but then also has to spend additional monies for personal items the resident could well pay for with the $60!

Smoke detectors and fire alarms - 2600.130
The Pennsylvania Department of Labor and Industry and the Fire and Panic Act of 1927 regulates the installation, location, and type of Smoke Detectors and Fire Alarms in PCHs. It is not appropriate for DPW to include a regulation regarding the placement of smoke detectors and fire alarms.

Fire extinguishers - 2600.131
The Pennsylvania Department of Labor and Industry and the Fire and Panic Act of 1927 regulates the installation, location of fire extinguishers in PCHs. It is not appropriate for DPW to include regulations about fire extinguishers.

Resident health exam and medical care - 2600.141

The PCH cannot be responsible to ensure access to any medical care. The PCH can assist with securing an appointment, assisting in arranging transportation and reminding the resident that they have an appointment. In case of an emergency the PCH can call the ambulance and arrange immediate transportation to the hospital. Access to medical care is dependent on the insurance company. PCH residents have very limited access to mental health and drug and alcohol services.

Physical and behavioral health - 2600.142
It is not right to delegate the PCH to provide dental, vision, hearing and mental health or other behavioral services. Providers of these services should be licensed as a health care facility. The PCH should assist in scheduling appointments and reminding the resident of appointments. It is not appropriate to require the PCH to

train residents about the need for health care. It is not appropriate to require the PCH to obtain consent for Health care treatment. The health care vendor should obtain his or her own consent. Personal care homes are not guardians and should not provide the function of the guardian. A resident that refuses health care could be referred to Adult Protective services or the Ombudsman. A Guardianship program is needed for residents who is not able to make appropriate treatment decisions.

Emergency medical plan – 2600.143
Our PCH can provide first aid and call an ambulance but we cannot **ensure** immediate and direct access to emergency medical care and treatment.

Supervised care –2600.145
We do not know that any such assessment agency exists.

Nutritional Adequacy – 2600.161
(f) Therapeutic diets – Not every personal care home can provide every service. A PCH that does not have a dietitian on staff could elect not to accept a resident who requires a monitored therapeutic diet. PCH residents have the right to come and go at will and the PCH has no way to ensure that the therapeutic diet is followed.

(g) The requirement that a beverage be offered every two hours is absolutely ridiculous! Our home has water fountains for the residents and we also have pitchers of water in their rooms. To tell us that we have to go to each resident every two hours to ask if they want something to drink is absurd! Our residents are free to roam about. How would we ever have enough staff available to track them all down every two hours! This alone could be a fulltime job for someone! Our residents are independent and capable of getting their own beverages.

Safe Management Techniques - 2600.201
This regulation has been extracted from institutional regulations of mental health treatment centers and could cost several hundred dollars per day. Residents with behavior that endangers other residents, staff or others belong in a mental health treatment center and are not appropriate for a personal care home. Homes that need to use Safe Management Techniques to manage their residents should be licensed as a mental health treatment facility. This regulation will make it more difficult to relocate a resident who is not appropriate for a personal care home and should be totally deleted.

Description of services - 2600.223
The screening form lists the resident needs and the services the PCH will provide. There is no need for a written procedure for the management of services from admission to discharge. This is an unnecessary burden for a small home. The time spent on this added paperwork could be better used in providing care to the resident.

Initial intake assessment and annual assessment – 2600.225
This requirement needs to be coordinated with the Options Assessment by the Office of Aging for SSI residents.

Development of the support plan - 2600.226
Support plans are not appropriate for PCH. They change the purpose and goal of the PCH. There is no documentation regarding the need to change the screening and assessment tools currently used. A support plan will not improve the quality of care and divert staff time away from resident care. Support plans are institutional, very costly and should be deleted.

Notification of termination - 2600.228
(a) the PCH should not be made responsible to **relocate the resident to a home that meets his needs.** The PCH is not a placement agency and should not have this responsibility.

Description of services – 2600.223
The resident's contract already lists services provided. A written procedure for the delivery and management of services from admission to discharge homes is again extensive additional paperwork. It will not improve the quality of care but instead will create an added financial burden and take time away from resident.

A 30-day notice should not be required if persons have witnessed a dangerous behavior and/or have filed a petition for an involuntary commitment and/or have involved the police. The PCH must have the right to refuse to accept a resident back into the facility if the administrator is concerned about the health and safety of the other residents, staff and/or the neighborhood. It is not appropriate to require that "a physician certifies that the resident would jeopardize the health and safety of the residents or others in the home" before the home can waive the 30 day notice.

There are many reasons why a resident could lose his right to remain in a PCH. In the best interest of the entire home and other residents, the PCH should not lose its right to cancel a contract with a person who is not appropriate for the home. Examples of residents who could lose the right to remain in the home include but are not limited to the following:

The resident violates the home rules.
The resident does not respect the rights and dignity of staff and other residents.
The resident creates a disturbance or nuisance in the neighborhood.
The resident steals from staff, other residents or the neighbors.
The resident cannot get along with the other residents.
The resident will not follow their treatment plan.
The resident is destructive to the home and other people's property.
The resident causes strife and turmoil within the home and amongst residents.

Resident records.- 2600.241
Additional and excessive PAPERWORK does not make a home run better. It only adds increased costs and takes time away from resident care. Duplicate paperwork causes confusion. PCH records should not contain a mass of highly confidential information and should not be subjected to regulations as such.

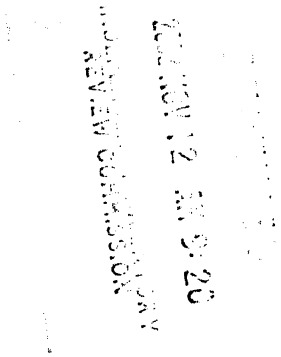
Contents of records – 2600.242
There is no documented need to increase the current record keeping requirements. Excessive paperwork detracts from resident care. Duplication of paperwork causes confusion. The purpose of a recent photo in the resident's record may be needed in large homes for identification purposes. This could be an option but it should not be a regulation. It could be offensive to the resident. Not everyone likes having his or her picture taken. Physician's examinations and medical evaluation forms should be retained in the record until the resident leaves the PCH. Medical transfer & hospital discharge summaries should be provided to the PCH on the "need to know" basis. Medical records should be provided to the medical personnel who will be providing treatment to the resident and have the ability to interpret the information. The extensive record keeping required by the proposed regulations will move the PCH caregiver from resident care to a record keeper.

Penalties – 2600.252

Penalties for violations of reasonable regulations that have an effect on the health, safety and wellbeing of the resident are appropriate. There should be no penalty for violations that do not effect the health, safety and wellbeing of the residents or if they can be corrected in a reasonable time.

Revocation or non-renewal of licenses – 2600.253
Many of the proposed regulations do not meet the standard of reasonable. Revocation should only be implemented for violation of uncorrected regulations that have an effect on the health, safety and wellbeing of the resident.

Prepared By:
Carl P. Giorgio, Administrator
Golden Ridge, Inc.
Personal Care / Assisted Living Home
404 South Church Street
Robesonia, Pa. 19551
610-488-7498



Original: 2294

NorthEast Treatment Centers NET

ADMINISTRATIVE OFFICE
Chairman
Lawrence J. Devlin
President
Terence McSherry

499 North Fifth Street
Philadelphia, PA 19123
TEL: (215) 451-7000
FAX: (215) 451-7110

BEHAVIORAL HEALTHCARE SERVICES

PHILADELPHIA AREA

Adult Services

- Wharton Residential
- Community Counseling
- Intensive Outpatient
- Ambulatory Medical Stabilization

Youth & Family Services

- Children & Youth Dependent Services
- Juvenile Justice Treatment Services
- Mental Health Services

DELAWARE STATE

Adult Services

- Recovery Center of Delaware
- Kirkwood Detox Center
- Alternatives
- NET Counseling Center
- Continuum for Recovery
- Reflections Women's Program
- CJS Outpatient Services
- Glasshouse Men's Program

Youth & Family Services

- Kacy Church Day Treatment Center
- Iron Hill Residential Treatment Services
- Red Lion Residential Treatment Services
- Treatment Foster Families

November 11, 2002

Robert E. Nyce, Executive Director
Independence Regulatory Review Commission
333 Market Street, 14th Floor
Harrisburg, PA 17101

Dear Mr. Nyce:

I am writing to you as a member of the provider community in Pennsylvania regarding proposed regulations pertaining to Personal Care Homes, # 14-475 (2294), PA Bulletin, October 5, 2002.

Specifically, we are concerned with the requirement outlined in section §2600.51 Staffing Requirements. In this section, as I understand it, individuals who are in recovery from alcohol and/or drug addiction would be permanently barred from employment in Personal Care Homes without regard to when the conviction/addiction occurred or circumstances of the individual's recovery.

We believe that regulations protecting the elderly is of the highest concern, however we should not create permanent restrictions to individuals who have experienced a solid recovery. We believe that regulatory restrictions be reasonable and realistic and not discriminate against those who have demonstrated a clear commitment to recovery.

Sincerely,

Terence McSherry
President

cc: PA Senate Public Health and Welfare Committee
PA House Health and Human Services Committee
PA Recovery Organizations-Alliance (PRO-A)

Nov. 12, 2002

Original: 2294

To the Independent Regulatory Review Commission,

Writing letters to government officials is something I rarely do. However, at this time, as a registered voter and tax paying citizen, I must write to you.

I was recently informed that new regulations for personal care homes are pending. These "new rules" would definitely hurt the operations of many homes without their raising their prices.

I would like to tell you something to seriously think about. My mother is in a Personal Care Home and has been for over a year. I chose this home because I wanted her to have a smaller "homey" atmosphere. The care she receives there is excellent. It is small and looks like a home and not an institution as many of the nursing

homes are.

What qualifications do I feel are necessary for her care? A staff who loves helping people do the every day things, such as dressing, bathing, getting her medicines on schedule, getting her meals ready for her, just being there to help her when needed. A staff who keeps her living quarters clean. A staff who is there and can call medical help when needed. She doesn't need doctors and nurses there 24 hours a day. She doesn't need graduates of college for administration duties. All she needs is tender loving care, given by loving people with common sense.

I am opposed to the proposed changes and I am asking you to oppose them also. Keep our Personal

Care Homes open and affordable. So we, as family, can give our loved ones the choice of going to a "home-like" environment.

Remember, please, bigger is not always better.

Thank you for accepting my letter and giving me an opportunity to express my hopes to you.

Sincerely,
Dolores H. Jackson
1137 Ross Ave.
Ford City, PA 16226
Phone 724-763-1364

Original: 2294

2002 NOV 19 AM 9:01

REVIEW COMMISSION / SECRETARY

Independent Regulatory Review Commission
333 Market St.
14th Floor
Harrisburg, Pa. 17101

I am not in the habit of writing or calling members of the state or local government but at this time I feel compelled to do so by personal need. I am a registered voter in your district and I have a relative in what is termed a Personal Care Home. These homes provide a steady controlled environment and supervised care for my relative who, though not critically ill, does need a small amount of help and supervision to accomplish some tasks that they used to be able to perform for themselves.

I was recently informed that some new pending regulations could put this care beyond my reach financially. And possibly lead to the closure of many such facilities in my local area. What I have discovered is that some people have thought that by increasing the amount and type of staff that personal care homes have they could better help the residents. They seemed to have forgotten that the extra help will cost extra money, enough money that my family will not be left with a care option that meets our needs and our budget.

I am hoping this letter will enlighten you to the proposed changes and you will do your part to help keep Personal Care Homes an affordable and readily available option for families that want to be able to frequently visit loved ones who need a little extra help as they mature.

Sincerely Yours

Eugene Waugaman
113 Lower Hays Run Rd.
Hollidaysburg, Pa. 16648

Original: 2294

14-475 (726)

2026 Cocalico Rd.
Birdsboro, Pa. 19508
Nov. 6, 2002

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

To Whom It May Concern:

I've been made aware of new regulations facing the personal care homes. I feel many of these new proposed regulations are excessive and an undo burden on personal care homes.

I personally have a mother in one of these homes because my need to work leaves me no time for her care. I visit this home often and am more than pleased with the care she receives.

My fears with all the proposed regulations may cause some good personal care homes to close down because the government regulations prohibit them from continuing operation.

Also, if these regulations go into effect many residents will not be able to afford the increased costs that will be added to their monthly bills which jeopardizes the working ability of families looking after their loved ones.

This industry does not need more regulations but to enforce the ones that have already been in effect!

Yours truly,

Donna M. Aulenbach

Donna M. Aulenbach

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.

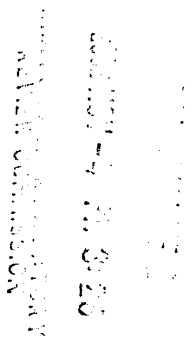
I don't fully understand your commissions goals, but the number one criteria listed on your publication is the economic or fiscal impact of the regulations. The impact to the private citizen seeking Personal Care Services will be devastating.

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

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

Dear Ms. Nevius:

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

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

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

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

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

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

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

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

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

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

Sincerely,

Tom Volkert
Director of Mental Health/Aging Advocacy

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

IRRC

From: Tom Volkert [tvolkert@mhasp.org]
Sent: Monday, November 04, 2002 3:50
To: IRRC
Subject: letter on PCH regulations

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
Gwen Yackee Lehman
777 East Park Drive
P.O. Box 8820
Harrisburg, PA
17105-8820

(800) 422-2900
(717) 558-7750
FAX (717) 558-7841
E-mail glehman@pamedsoc.org

Membership Office (888) 861-1181

www.papsych.org

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,

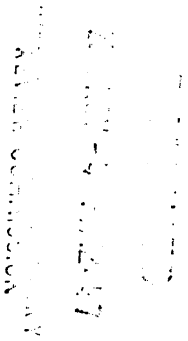
Kenneth M. Certa, MD
President

Govt/pch regs

Original: 2294

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

PERSONAL CARE HOMES



COMMENTS AND OBSERVATIONS

LIZA'S HOUSE PCH

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

NOVEMBER, 2002

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

CONTENTS

EXECUTIVE SUMMARY

Discussion:

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

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

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

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

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

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

Options:

Three basic courses of action are available:

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

Recommendations:

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

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

OVERVIEW

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

"The Man in the Arena"

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

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

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

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

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

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

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

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

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

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

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

Medication Administration:

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

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

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

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

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

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

PERCENT OF INCOME; **51.6%**

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

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

PROJECTED COST IMPACT ON 1,786 LICENSED PERSONAL CARE HOMES

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

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

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

PERCENT OF INCOME; **51.6%**

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

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**

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

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

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

RED FLAGS

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

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

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

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

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

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

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

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

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

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

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

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

MAGNITUDE COST IMPACT PROJECTIONS

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

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

FIXED	**ANNUAL**
$ 6,250.00.	

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

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

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

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

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

	FIXED	**ANNUAL**
		$ 12,500.00

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

	FIXED	**ANNUAL**
		$ 49,920.00

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

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

	FIXED	**ANNUAL**
		$ 1,350.00

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

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

FIXED	**ANNUAL**
	$ 79,560.00

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

FIXED	**ANNUAL**
	$ 3,680.00

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

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

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

FIXED	**ANNUAL**
	$ 9,504.00

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

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

• 36 management hours at $ 37.50 per hour:	$ 1,350.00
• 24 universal care giver hours at $ 12.00 per hour:	288.00
Total costs to develop the staff training plan per cycle:	$ 1,638.00

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

FIXED **ANNUAL**
$ 6,552.00

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

FIXED **ANNUAL**
$ 109,200.00

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

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

• (15 days per staff (15) X $ 12.00 per hour X 8 hours a day)	$ 21,600.00
• (1/2 half trainer, same time @ 17.50 per hour)	15,750.00
Total initial costs per staff:	$ 37,350.00

Maintenance training, Annual:

• 12 staff X 52 hours per year X $ 12.00 per hour:	$ 7,488.00
• trainer X 52 hours per year/staff (12) X $17.50 per hour:	10,920.00
Annual maintenance costs per staff:	$ 18,408.00

FIXED **ANNUAL**
$ 55,758.00

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

Cost projections:

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

	FIXED	ANNUAL
		$ 13,500.00

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

CURSORY OVERVIEW MAGNITUDE COST IMPACT

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

PROJECTED COST IMPACT ON 1,786 LICENSED PERSONAL CARE HOMES

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

GENERAL COMMENTS:

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

What is the desired outcome of the PROPOSED RULEMAKING:

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

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

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

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

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

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

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

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

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

PROPOSED QUALITY MANAGEMENT

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

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

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

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

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

PARAGRAPH SPECIFIC COMMENTS AND OBSERVATIONS

26000.1 Purpose:

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

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

2600.3 Inspections and licenses or certificates of compliance

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

conflicts with 2600.11(c).

2600.4 Definitions:

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

ADD:

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

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

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

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

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

2600.16 Reportable Incidents.

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

2600.26 Resident/home contract; information on resident rights.

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

* See MAGNITUDE COST IMPACT PROJECTIONS, above.

2600.27 -- Quality management.

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

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

* See MAGNITUDE COST IMPACT PROJECTIONS, above.

RESIDENT RIGHTS

2600.41 -- Notification of rights and complaint procedures

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

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

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

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

2600.42. Specific rights.

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

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

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

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

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

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

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

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

prescribing cycle.

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

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

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

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

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

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

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

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

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

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

and the list goes on.

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

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

2600.53 Staff titles and qualifications for administrators.

* See MAGNITUDE COST IMPACT PROJECTIONS, above.

2600.54 Staff titles and qualifications for direct care staff

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

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

* See MAGNITUDE COST IMPACT PROJECTIONS, above.

2600.56 -- Staff ratios .

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

2600.57 Administrator training and orientation

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

* See MAGNITUDE COST IMPACT PROJECTIONS, above.

2600.58. Staff training and orientation.

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

* See MAGNITUDE COST IMPACT PROJECTIONS, above.

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

actually take longer to complete the mandated training.

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

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

2600.59 Staff Training Plan

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

* See MAGNITUDE COST IMPACT PROJECTIONS, above.

2600.60 Individual Staff Training Plan

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

* See MAGNITUDE COST IMPACT PROJECTIONS, above.

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

2600.85. Sanitation.

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

2600.98. Indoor activity space.

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

2600.100. Exterior conditions.

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

2600.101. Resident bedrooms,

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

2600.102 Bathrooms

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

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

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

2600.103. Kitchen areas.

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

2600.105. Laundry.

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

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

2600.107. Internal and external disasters.

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

2600.126. Furnaces.

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

2600.132 Fire Drills

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

2600.141. Resident health exam and medical records.

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

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

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

2600.161 Nutrition

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

2600.181 Self Administration

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

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

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

26000.182. Storage and disposition of medications and medical supplies.

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

2600.186 Medication records

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

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

2600.201. Safe management techniques.

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

* See MAGNITUDE COST IMPACT PROJECTIONS, above.

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

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

2600.223. Description of services.

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

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

2600.225 Initial intake assessment and the annual assessment

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

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

2600.226 Development of the support plan

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

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

* See MAGNITUDE COST IMPACT PROJECTIONS, above.

2600.228 Notification of termination

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

* See MAGNITUDE COST IMPACT PROJECTIONS, above.

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

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

Replace section with:

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

(a) Classification of violations: Copy in current 2600.31

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

2600.262. Penalties.

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

2600.263. Revocation or nonrenewable of licenses.

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

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

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

Original: 2294

IRRC

From: msbear [msbear@wpa.net]
Sent: Monday, November 04, 2002 3:26
To: IRRC
Subject: ch 2600

Dear I.R.R.C.

Concerning Chapter 2600 proposed regulations and The Pennsylvania Health Law Projects input. These proposed regulations will ultimately close all small Personal Care Homes. We would like you to be aware that nearly 70 thousand elderly and disabled residents of this state will be homeless.

"Of all tyrannies, a tyranny exercised for the good of its victims

may be the most oppressive.

It may be better to live under robber barons than under

Omnipotent moral busybodies. The robber Barron's cruelty may

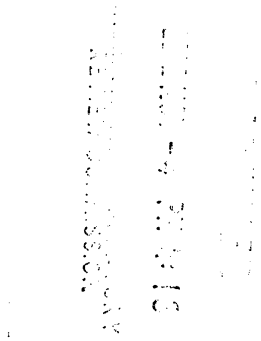
Sometimes sleep, his cupidity may at some point be satiated; **but those**

Who torment us for our own good will torment us without end, for they

do so with the approval of their own conscience."

C.S.Lewis

Cynthia A.P.Sayre
Greensburg, Pa.



PO Box 689
Duncansville PA 16635
814-695-1665

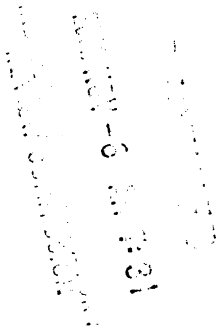
Blair County Area Providers Association

November 4, 2002

Original: 2296

Teleta Nevius, Director
Office of Licensing and Regulatory Management
Department Of Public Welfare
316 Health & Welfare Building
PO Box 2675
Harrisburg PA 17101-2675

Re: Proposed Personal Care Home Regulations



Dear Ms. Nevius:

Our organizations like others across the state have some serious concerns regarding the proposed regulations. If the regulations were adopted as they are currently written many of the smaller and medium size homes would be forced to close. Those providers who care exclusively for SSI recipients would be a thing of the past. So how will new unfunded mandates will ever improve the health safety and welfare of any personal care home residents?

Perhaps the time has come for the department to become realistic and responsible through this process. First and foremost every personal care home across this state should have been notified and provided a copy of the proposed regulations from DPW the licensing authority. Being recognized as a true stakeholder would enable every provider a fair opportunity to comment on proposed regulations that could have a devastating impact on their homes, residents and staff.

The regulations as they are currently written have ignored the overall input that has been given for the majority of this process. Instead DPW has reacted to the Auditor Generals Report and is looking for a quick fix to resolve some of the problems that exist within its own department. Current regulations should be enforced and consistent across the state. There should not be an appearance of a double standard existing from one home to another.

Our provider organization represents more than 100 personal care homes. Some of our homes represent the small basic personal care home (Mom & Pop) and other are much larger and provide a wide range of services. What is needed is to recognize each home for their potential and to

encourage them to provide the best services possible for their residents. The Department of Public Welfare needs to make a serious effort to work with providers and not against them, especially when they are trying to do a good job. These regulations as proposed have significant costs associated with them. Our Association agrees with the comments PHCA/Calm has included in its comment document to you. Also we believe that many of the Labor & Industry standards should remain under their licensing authority. Their should not be a duplication of regulations.

Our Association is requesting that these proposed regulations be withdrawn until such time that financial impact statements can included for any potential costs that may be incurred because of the new regulation. After all what good are new regulation when they do nothing more than creates a new homeless population?

Sincerely,

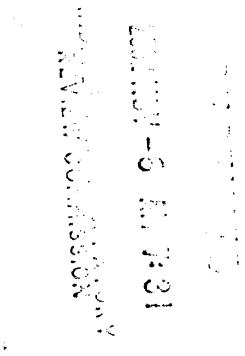
Neil A Robertson
President, BCAP

IRRC

From: Robbie3333@aol.com
Sent: Monday, November 04, 2002 10:51 PM
To: IRRC
Subject: Proposed Personal care Home Regulations

Original: 2296

Chapter 2600 Proposed Regulations



Original: 2294

Michaux Manor
Quality In Assisted Living

November 4, 2002

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

Re: Proposed Personal Care Home Regulation Comments

Dear Mrs. Nevius,

I am attaching comments regarding the proposed CH. 2600 regulation. The comments I have attached are those developed by CALM and PHCA. I have served on the Board of CALM for several years, and have been very involved in the drafting of these comments.

From a provider standpoint, I have a great many concerns about the proposed regs. While I recognize the need for regulations that are more contemporary and reflective of what the market has actually become, I do not feel that 2600 in its current form is the answer. We are a small, independent Personal Care Home, serving approximately 25 residents. When I read the proposed regs, as well as all of the supplemental information provided by DPW, my primary concern if the gross underestimation of the costs for implementation.

For virtually every aspect of CH 2600, DPW mandates that some "policy" or "procedure" be developed. For a small independent home such as ours, the cost of developing these is prohibitive due to the sheer magnitude that are required. In addition, once these are developed, there will be significantly more paperwork and documentation required. The added staffing costs to keep current with the expanded documentation requirements alone would far exceed DPW's annual cost projections for implementing this chapter.

11302 South Mountain Road Fayetteville, PA 17222
Ph. 717-749-5000 Fax 717-749-5852

I also have grave concerns regarding the medication sections. Given the shortage of RN's and LPN's, and the problem we have of getting any qualified staff in the first place, the issue of medications must be addressed in a more realistic way. DPW and any other appropriate Departments must join together to develop some kind of training program. I need to be able to have staff in my building who are capable and competent to do Medication passes, or assist our residents in taking their meds. This program must be a "Train the Trainer" model to ensure the constant supply of staff, so as not leave a facility subject to the whims of when the next training program is scheduled to begin.

Existing homes must also be grandfathered under any new regulations. One model of Personal Care or Assisted Living does not suit everyone. Our small rural home (a converted 1950's elementary school) has issues and concerns that the large corporate chains don't, but that is most often what attracts a client to us. I would encourage you to maintain a set of regulations that allow for a six-bed facility as well as a two hundred-bed facility. More often than not, this will come down to the issue of Grandfathering. Our residents and customers seek us out because of the environment and community that we offer. However, unless we are grandfathered (especially with respect to physical plant issues), I cannot imagine being able to remain in business.

Personal Care is a vital and important part of the aging continuum, and must be protected. We are not Nursing Homes, nor do we wish to become SNF's. My family and our facility have been caring for our area's aging population for over 16 years. Our residents have become our family, and we look forward to continuing to do so. I would be more than happy to discuss some of our specific concerns with you or your office. Thank you for your consideration of our comments.

Sincerely,

Sean McFarland
Business Manager

CC: Robert E. Nyce, Executive Director, IRRC

Original: 2294

November 4, 2002

Independent Regulatory Review Commission
333 Market Street, 14th Floor

Re: Proposed Regulations, Title 55 Pa. Code Chapter 2600, Personal Care Homes

To whom it may concern,

In my heart, I feel that the folks who authored these regulations had the best intentions for the health, welfare and safety of the residents. However, I think they may have been hampered in achieving those goals because they have only ***visited,*** but have never ***lived,*** in a personal care home. They have never seen these homes through the eyes of the providers, the people who are actually responsible for making the entire home, (residents, families and staff,) work together.

My parents started our family business 32 years ago when my mom, who was then a home care RN, brought home a couple of little old ladies. They had nowhere to go and no one to take care of them. My mom didn't even charge them until my dad suggested that maybe they could pitch in for food and utilities. About a year later in 1971, my folks bought a ranch house and made it into a **home** for 8 older adults. They then hired a husband and wife team to live-in, making their **family concept** complete. More of these small homes were added over the next 10 years.

In the late 70's, the need for regulations soon became apparent as more homes, with more problems, emerged throughout the Commonwealth. I remember driving to Harrisburg numerous times with my mom and other providers to meet with Representative Joe Rhodes to hammer out some of the details. Unfortunately, those regulations mandated zoning approval. As a result, half of our small homes closed because we could not obtain it. It was sad that many older adults then had to move from neighborhoods they either raised their families in, or their children were currently living in. Way back then, communities didn't even know what a personal care home was, let alone provide for it in their zoning ordinances.

In 1981, we opened a 48-bed personal care facility for older adults with Alzheimer's Disease. (In those days it was called senility or chronic organic brain syndrome). Prior to home care, my mom was a RN at a nursing home. She knew how important it was to provide different areas for alert and confused residents; she observed firsthand how they can get on each other's nerves! I was only 22 when my folks gave me the keys to an old convent and some start-up

money. (In hindsight, I was surprised that they trusted me; I had already quit the family business twice, and I was fired twice as well!) Anyway, I learned everything about people-management the hard way, trial and error. And, some things I had to learn a couple of times.

Around 1984, we became the first personal care facility to join the Pennsylvania Health Care Association. PCH memberships grew to the point that a "personal care section" was added, and I had the privilege of serving as one of the first vice presidents. This information is not so much as to blow our own horn, but rather to explain that it put me in the position to be very involved with the regulations, again, but this time with their revision.

So, here we are once more, preparing to revise the PCH regulations. It would be nice to take all 1800 homes (is that what the count is up to?), lump them together and stick them into one neatly organized box. Nothing is ever easy, is it? **They are all so different!** It's too bad that we can't keep the current regulations, but be more focused on **enforcement,** so that the unsatisfactory homes are brought into compliance or closed. Oh well, just a thought.

By now, you must be dying to hear my specific comments on the draft regulations. The biggest concerns involve the administrator and staffing, specifically qualifications, ratios and training.

2600.53 Staff Titles and Qualifications for Administrators
(a)(2) The home administrator shall meet one of the following: an associate's degree or 60 credit hours from an accredited college or university with major emphasis in human services, administration or nursing.

Although this may be easily accomplished by larger homes with more resources at their disposal, this will be cost prohibitive for smaller homes. Furthermore, does it guarantee that the quality of care will be higher for the residents? There are many small home administrators who may have "come up through the ranks", who are very capable and caring individuals, who would not even be offered such an advancement due to this requirement.

In 1993, I think the requirements for nursing home administrators were amended to include that applicants must have 60 college credits prior to becoming a nursing home administrator. If that is the case, who thinks that managing a personal care home is as complicated as managing a nursing home?

Recommendation
Eliminate this regulation and keep the current 2620.72 (a) for administrator qualifications. My second choice would be to require administrators to have 30 college credits or one year of prior personal care experience. Then place more emphasis on continuing education so that administrators grow in areas that specifically pertain to their responsibilities.

2600.54 Staff Qualifications
(2)Have a high school diploma or GED.

Does a diploma or GED guarantee that staff will provide, or be capable of providing, quality care? Maybe it should up to the administrator to determine, for example, if a potential housekeeper can handle the responsibilities of that specific job, not a piece of paper.

Please keep in mind that the job market has changed considerably. People are not banging down the doors looking for this level of work like they used to in years past. And many of the folks that do apply are turned away because of the criminal background checks. Do you realize that if a person is convicted of 3 misdemeanors, say shoplifting when they were 18, they cannot work in personal care for the rest of their life?

So, now the regulations will say I can't hire someone without a diploma or GED. What about the 55 year old widow who needs a job to support herself, who has a clean record, but no diploma or GED? Just who is left out there to care for our residents?

Recommendation
Eliminate this and keep the current regulation.

2600.56 Staffing Ratios
(a)The administrator is required to be present in the home at least 20 hours per week of an average workweek or their designee must meet all of the qualifications and training of the administrator.

I'm not sure why this particular regulation was introduced, perhaps because there are complaints of "absentee" administrators? I am the administrator of four small **8-bed** homes; a live-in adult or couple serves as managers in each home. They shop for and prepare meals, order and offer medications, assist with bathing, clean the inside and outside of the house, etc.

Generally speaking, there are 1 or 2 additional (qualified) folks in the manager's family, who provide relief for them. The residents are alert, ambulatory, continent and primarily care for their own personal care needs.

I am responsible for each home; I hire, orientate and train each manager, arrange for their OJT at one of the other small homes, see that they receive/ maintain their CPR/first aide, and that they complete the training/ pass the test for the Allegheny County Health Department's food handler's certificate. As administrator, I handle any problems, 24 hours a day/ 7 days a week, when the managers call. I am either working at our main office, (sometimes from my own home,) or making rounds to the homes, either way I'm only a phone call away.

Spending 20 weeks per week at these small homes would not only be physically and financially impossible for me, (20 hours x 4 homes = 80 hours per week), I think the residents and managers would get tired of me getting in the way and probably toss me out!

It doesn't make sense for these managers to complete the administrator's training; there aren't any staff to manage or budgets to juggle. (Can you imagine how challenging it would be to find, and afford to pay, some one with an associate's degree?) They do receive training in the other areas that are currently required for staff. Finally, it would be a financial burden to pay for their training and pay for relief at the home, and what about turnover? (One of my managers has been with us for 7 years, one for 2 ½ years, but the other 2 are just coming up on their 1st year anniversary.)

Recommendation

I think this should be eliminated and *the administrator should be held accountable for their home* as they are charged with in the current regulations. Whether they are physically present or not, it is still their responsibility to ensure the home is in compliance with the regulations.

2600.57 Administrator Training and Orientation

(c) The 60 hours of competency-based training shall include, but not be limited to: (2) first aid training and CPR.

The current regulations require that someone who is first aid and CPR certified be in the home at all times. If the administrator delegates this responsibility to a qualified staff member, why should they have to spend the additional hours engaged in this certification process? There are certainly other topics worthy of their time.

2600.57 Administrator Training and Orientation

d) The 80 hours of competency-based internship in a licensed home under the supervision of a Department-trained administrator shall include, but not be limited to: (1) (v) marketing

Who actually is a "Department-trained" administrator? Is this special?

This internship is a wonderful idea for the chain homes, who can mentor their own administrators. But how well will it be received when the new home provider knocks on the door of his competitor and says, "Hi, will you train me in all of your management secrets, and please don't forget to show me all of your swell marketing strategies. Oh, by the way, I'm sorry but I can't pay you for any of your time."? This regulation will prohibit the small, independent homes, (especially those caring for low-income older adults,) from opening!

Furthermore, how does marketing tie into the health, welfare and safety of the residents? How, or even if, a provider chooses to market their home should be their own business and not required training.

Recommendation

Eliminate this proposed regulation.

2600.57 Administrator Training and Orientation
(e) An administrator shall have at least 24 hours of annual training relating to his job duties, which shall include, but not be limited to: topics (1) through (11) are listed.

Twenty-four hours of annual training is 4 **times** what the current regulations require, which seems to be quite a jump. Then the wording of this regulation indicates that **all** 11 topics are to be covered in the 24 hours. Both of these factors will prove to be hardships for small providers, who must not only pay to attend training, but they must pay for their coverage in the home. Training this specific will be difficult to find, and more importantly, will be grossly ineffective for administrators.

It is important to note that not all administrators have the same responsibilities. Generally speaking, administrators in small homes have more resident care issues, while administrators in larger homes deal with more staffing (who work with the residents) issues.

Recommendation
Modify this regulation to 12 hours and allow the administrator to select the area(s) they feel they need training on out of the 11 topics listed.

2600.58 Staff Training and Orientation
(c) Prior to direct care contact with the residents, all direct care staff shall successfully complete and pass the following competency-based training.

Training might be more effective if staff actually had "hands on" with the residents, under supervision, prior to passing it. (How exactly does one **pass** competency-based training?)

Recommendation
Change to "prior to unsupervised direct care with the residents..."

2600.58 Staff Training
(f) Training topics for the required annual training for direct care staff: first aid, CPR, medication self-administration, assessments and support plans, dementia, infection control, personal care services, safe management techniques and mental illness/ mental retardation.

All direct care staff *should* receive training in the infection control areas, personal care services and safe management techniques because these areas are directly related to their jobs and appropriate no matter what population is being served.

Not all direct care staff, however, need to have first aid, CPR, and medication administration unless these areas are part of their job duties. The current regulations require that there is a certified person in the home at all times, and that certification is typically good for 2 years. We have shift supervisors who carry this certification and are also responsible for medication self-administration.

The proposed regulations qualify that mental illness/ mental retardation is required only if that population is served in the home, and it should be likewise with dementia.

Recommendation
Keep all of the topics, but add that the training is required **only** if it pertains to the duties of the direct care staff. Keep the regulation requiring 1 certified person to be in the home at all times. Clarify that first aid and CPR need to be updated as determined by the holder's card, which may be annually or every 2 years.

2600.59 Staff Training Plan
2600.60 Individual Staff Training Plan

Although these are wonderful concepts, they are quite a jump from the current regulations. Both require a substantial amount of time for preparation and execution. The list of proposed topics that would be required annually is rather extensive and doesn't leave much room for additional "identified needs". Then to suggest that facilities need to have separate training programs for different staff based on their experience, education, current job function and job performance is much too complicated for smaller homes. Depending on the number of staff, it sounds as though a full time training coordinator would be needed.

I would hope that the ultimate purpose of these proposed regulations is to improve the quality of care for the residents. If so, there will be a greater degree of success if the standards are raised gradually, allowing everyone the opportunity to adjust psychologically, operationally and financially.

Recommendation
Keep the current general training topics in 2620.73 (e) and add the topics in the proposed regulations 2600.58 (c) and (f), but allow administrators flexibility in meeting these training requirements in a fashion that satisfies the needs of their individual homes. All training will be documented and maintained in each staff member's file.

Additional items of concern

2600.16 Reportable Incidents
(a) (18) A termination notice from a utility.

Utility companies now send out termination notices if payment is late. We start receiving payments from the residents around the 25th of each month, then we pay our bills. This does not always coincide with their due dates, so we get a computer-generated shut-off notice. A few days later, we receive a letter thanking us for payment. It's seems to be our cycle of life!

Recommendation
Change this to read "a second warning termination notice from a utility."

2600.20 Resident Funds
(4) The resident shall be given their funds that they request within 24 hours, and immediately if the request is for $10 or less. This service shall be offered on a daily basis.

In our facility, the administrator has the sole responsibility of distributing these funds. She works Monday through Friday, 8:30 am to 4:30 pm; this is when the residents can request and receive their money. If the money is to be made available immediately or within 24 hours, especially on the weekends, this opens the possibility of mismanagement or theft.

Recommendation
Change to "the resident shall request their funds during business hours and receive it immediately if the request is for $10 or less, if more then $10, they will receive it on the following business day".

2600.20 Resident Funds
(6) There may be no commingling of the resident's personal needs allowance with the home's or staff's personal funds or the home's operating funds.

Is this suggesting that separate checking accounts need to be maintained for each resident? Don't banks charge for checking accounts? What about the additional time it will take providers to maintain all of these accounts? When we receive checks, they are deposited into the home's general account; cash then is withdrawn and distributed to the residents. All of the appropriate documentation is kept as per the current regulations.

Recommendation
Eliminate "or the home's operating fund" from this regulation.

2600.20 Resident Funds
(8) Personal care homeowners, administrators and employees are prohibited from being representative payee.

Does this prohibit *the facility* from becoming rep payee? The only reason we agreed to be representative payee (and we do it for free,) is because no one else would agree to assume the responsibility. On rare occasion, we will find an agency or individual willing to be rep payee, but then the resident gets charged $10 - $15 a month out of their personal needs allowance.

Recommendation
Eliminate "representative payee" from this regulation.

2600.32 Specific Rights
(g) The resident shall have the right to remain in the home, as long as it is operating with a license, except in the circumstances of nonpayment following a documented effort to obtain payment, higher level of care needs, or if the resident is a danger to himself or others.

There are some reasons for discharge that do not fit neatly into 1 of these 3 categories, such as personality conflict, (specifically between residents, between residents and staff, or between residents and family members.) This is particularly a problem in smaller homes where there are not as many options available, such as different living spaces to separate residents who do not get along.

Or, its sad to say, but sometimes residents/families are unhappy with the skin color of the staff providing care. In a small home, there usually isn't a big roster of choices to offer. Then, there are the rare occasions when residents and their families are dysfunctional and feel the need to drag everyone into their world. The key to this discussion is that all of these situations are disruptive to the **other** residents. The provider may feel that the resident responsible for the conflict is an "emotional" danger, and would find their needs better met in another home.

Recommendation
Expand this regulation to allow the provider some leeway to discharge residents when they are responsible for unmanageable conflict in the home that is psychologically damaging to the other residents.

2600.101 Resident bedrooms
(r) The resident shall determine what type of chair is comfortable.

In a world where finances are unlimited, the residents' choice would be the electric recliner, the one that heats, vibrates and lifts your butt out of the seat! We can't afford those, but some of our residents bring their own chairs and place them either in their bedroom or in the living room. It is unreasonable to think that providers, especially those caring for low-income residents, can manage this one!

Recommendation
Eliminate this proposed regulation.

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 ½ minutes or within the period of time specified in writing within the past year by a fire safety expert.

Currently, the inspectors have interrupted a safe fire evacuation time to be under 5 minutes. In our 48-bed home, we can evacuate 3 floors close to 5 minutes during the 11-7 shift. It does take older adults a little while to get everything moving, so to speak.

It would be impossible for us to comply with the 2 ½ minutes required. In this day and age, there is absolutely no way anyone would assume the liability of signing anything, such as a fire evacuation time, contrary to the regulations.

Recommendations

Maintain the current inspectors' interruptions.

2600.161 Nutritional Adequacy

(b) Each meal shall include an alternative food *and* drink item from which the resident shall choose.

I grew up in a pretty traditional family; my mom prepared and served the meals. If we didn't like a particular item, mom gave us more of something else she was serving. (Ok, as kids we certainly had to eat our share of vegetables!) Family style cooking is the same principle we use in our homes. Preparing 2 different "food items" is cost prohibitive and time consuming.

Recommendation

Keep the wording the same as in the current regulation 2620.40 (a).

2600.161 Nutritional Adequacy

(d) Each meal shall contain at least one item from the dairy, protein, fruits and vegetables and grain groups.

We serve bacon or sausage maybe twice a week, but to consider serving a protein for breakfast every day is cost prohibitive and time consuming. Plus the *Daily Food Guide* only recommends 2 per day.

Recommendation

Keep the wording the same as in the current regulation 2620.40 (b).

2600.161 Nutritional Adequacy

(g) Drinking water shall be available to the residents at all times. Other beverages shall be available and offered to the residents at least every 2 hours.

We offer "other beverages" at meal times, and our 3pm and 8pm snack times. It is unrealistic to expect small homes, especially those caring for low-income older adults, to have the resources to supply a variety of beverages throughout the day, not to mention pushing a beverage cart around every 2 hours. The wording suggests that we should wake the residents up every 2 hours to ask them if they'd like something to drink. I'm sure that will go over big with them!

2600.181 Self-Administration
(e) The resident shall be able to recognize and distinguish the medication and knows the condition or illness for which the medication is prescribed, the correct dosage and when the medication is to be taken.

All I can say is, from the residents' perspective, "Are you joking?" Sometimes those pills are so small, and a lot of them look alike! Sometimes, I can't remember what I had for lunch, but our residents are expected to know the correct dosage? And I won't even try to explain how a resident with even mild Alzheimer's is supposed to comply with this one!

2600.225 Initial Intake Assessment and Annual Assessment
(d) (4) The resident shall have additional assessment at the time of a hospital discharge.

This will certainly be time-consuming. The proposed regulations already address in (2) that the resident shall be assessed *if their condition materially changes.*

Recommendation
Eliminate this regulation.

2600.229 Secure Units
(e) If the home initiates a discharge or transfer of a resident...the administrator shall give a 60 day notice to the resident...

Why is there a 60 day, not a 30 day, notice for secure units? Should the providers then expect the resident and/or their responsible party to give *them* a 60 day notice when they are planning to leave? That's a lot of time for either party to plan around.

Recommendation
Change 60 day notice to 30 days and keep it consistent with regulation 2600.228
(b) in Notification of termination.

I couldn't help but feel that many of the suggestions for these proposed regulations came from consumer advocates, which I heard are actually federally and state funded. If that is true, I think it's kind of ironic that our tax dollars are being used to put us out of business.

Anyway, this was a labor of love just writing these 9 ½ pages.. Thank you in advance for considering my recommendations. If I can answer any questions, or somehow be of assistance, please don't hesitate to call me at (412) 787-1720.

Sincerely,

Jane Dotter, Ed.D.
Executive Vice President
Dotter Family Corporation
Autumn Lane Assisted Living & Personal Care Facilities

IRRC

From: DrDotter226@aol.com
Sent: Monday, November 04, 2002 4:59 PM
To: IRRC; PMcNamara@PHCA.ORG; Robbie3333@aol.com
Subject: Comments on Proposed Personal Care Home Regulations

IRRC- Proposed Regs Comments.d...