



*Compassionate Care for the Aging*

November 4, 2002

**VINCENTIAN HOME**

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

Dear Ms. Nevius,

I am a nursing home administrator. I have a 217-bed nursing home and a 52-bed personal care home attached to the nursing facility. I'm very concerned about these newly proposed regulations as posted from October 5, 2002, for the personal care industry. I fear that these regulations are excessive and may jeopardize the very existence of the smaller provider.

**Proposed regulation 2600.53 (a) 1-4** - administrator qualifications will add an undue burden on small homes. It will be very difficult for a small facility to pay a competitive salary to attract a person with those qualifications. I think the proposed 2600.57 regulation subsection (b) through (J) should suffice for the administrator qualification.

**Proposed regulation 2600.57** - annual training of an administrator is excessive and is equivalent to the requirements for a licensed nursing home administrator. I think 12 hours would be sufficient, which increases from the current 6 hours.

**Proposed regulation 2600.57 (f)** - verification of annual training. I support, but would suggest that the department conduct random checks or the administrators can provide the verification on request at the time of the annual inspection.

**Proposed regulation 2600.58 (e)** - annual training of direct care staff. The 24-hour training annually is greater than hospital or nursing home facilities. Again, this would put undue financial hardship on smaller homes, and those who serve only SSI residents, to pay for additional staffing hours while training is in process. I propose 6 hours of annual training for personal care staff.

**Proposed regulation 2600.58 (f)** - topics required for training direct care staff, (2) and (3) should be deleted. The direct care staff does not normally deal with those issues, unless it is consistent with their job responsibilities.

**Proposed regulation 2600.58 (g)** - training for volunteers is not required in nursing homes. Again, this is going beyond reasonable. Volunteers are not normally solely responsible for the direct care of residents. It is also very difficult to even get volunteers and if they have to spend time in inservices, it takes away from their activity with the resident. Due to their limited time, they probably would not attend the inservices.

**Proposed regulation 2600.60** - individual staff training plan. I see as excessive over-regulation and is going over and beyond what is being done in the nursing home industry. I propose keeping records of who attends the inservices and what topics are covered and handouts given would suffice for these two regulations. These regulations are going from one extreme to another and are not practical for this level of care provider.

**Proposed regulation 2600.182 (e)** - self-administration of medications. It is likely that few people residing in personal care homes would qualify to self-administer medication under 2600.182 (e). Nurses would be needed according to this regulation. The nursing home industry

(Vincentian Home Continued)

2.

and hospitals are struggling with providing nurses, plus the cost of a nurse would be cost prohibitive to a personal care home. I suggest providing a medication training program that will enable a non-professional to administer medications safely.

There can be a hundred regulations to try and improve the care in personal care homes, but unless the providers are descent caring people, there will always be those bad actors that render poor care and take advantage of the helpless elderly. There are hundreds of regulations in the nursing home industry and have any of these regulations prevented what occurred at the Atrium nursing facility in Allegheny County last year? I don't think so. According to statistics, there are more nursing homes in the country out of compliance with state and federal regulations than ever before. This is because the industry is totally over regulated and no one can keep up with the plethora of regulations that are constantly barraging the long-term care industry.

Another problem, is the cost of the personal care service. When the SSI resident is only given 28 dollars a day for care, how can the regulator demand that the provider comply with all these costly regulations? The personal care industry is in my opinion doing what it can do for the little remuneration that is given. Instead of improving the care of the personal care resident, it may cause many providers to go out of business. Then who will take care of these residents? While improvements are certainly needed, the excessiveness of these regulations must be stayed.

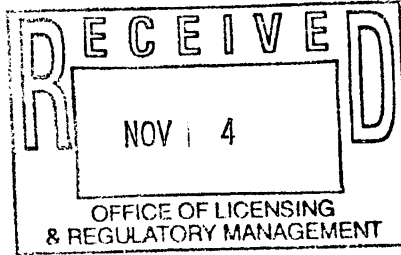
I'm concerned that these personal care regulations as presently written may break the back of the personal care provider – especially the small homes and those caring for all SSI residents.

Sincerely,

*Sister Anne Kull, V.S.C., N.H.A.*  
Sister Anne Kull, V.S.C., N.H.A.  
Administrator

Original: 2294

"The future of long term care"



14-475 (454)



November 4, 2002

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

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

Dear Ms. Nevius:

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

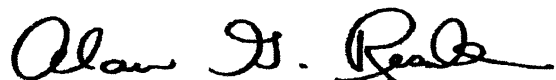
We have attached general overview comments and observations and also line-by-line comments for only the areas in the proposed regulations where would like to see changes made.

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

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

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

Sincerely,

A handwritten signature in black ink that reads "Alan G. Rosenbloom". The signature is written in a cursive style with a large initial 'A' and a long, sweeping underline.

Alan G. Rosenbloom  
President

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

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

**Economic or fiscal impact of the regulation**

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

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

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

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

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

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

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

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

- Additionally, we strongly recommend that the Department, together with stakeholder groups through the DPW Personal Care Home Advisory Committee (PCHAC) develop *sample* policy and procedures and staff training curriculum for new requirements. This would help assure standardization and provide some monetary relief to the homes who cannot afford to do this on their own.
- Grandfathering provisions must be in place for physical sites (buildings) doing business as a personal care home prior to the date of implementation of the regulations. We are not aware of any other facility regulation that has changed that does not make provisions for existing buildings.
- Further, we believe that DPW has a moral obligation to address the public funding issue for the more than 10,500 residents in personal care homes who receive SSI and the State Supplement *at the same time they are implementing new regulations*. DPW must recognize the real costs to providers which were \$60 per day on the average in 1999<sup>1</sup> to care for residents in this setting. DPW must increase the State Supplement for SSI residents in PCHs to a total benefit of at least \$60 per day in addition to their personal needs allowance. New government mandates cannot be implemented until this is accomplished or we fear that these 20% of the total personal care home residents will be displaced and find it nearly impossible to access the level of care they require.

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

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

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

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

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

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

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

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

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

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

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

## **Conclusion**

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

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



# Specific Comments and Language Change Suggestions in the Proposed Regulations

## Key:

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

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

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

## PROPOSED RULEMAKING

DEPARTMENT OF  
PUBLIC WELFARE

[55 PA. CODE CHS. 2600 AND 2620]

### Personal Care Homes

## GENERAL PROVISIONS

### § 2600.4. Definitions.

*Direct care staff--*

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

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

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

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

*Personal care resident or resident*--A person, unrelated to the licensee, who resides in a personal care home and who may require and receive personal care services but does not require the level of care provided by a hospital or long-term care facility. In references to the resident's involvement in decision-making, this term may also refer to the resident's power of attorney or legal representative or responsible party if the resident is incapable of understanding or making decisions on their own behalf.

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

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

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

## GENERAL REQUIREMENTS

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

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

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

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

### § 2600.16. Reportable incidents.

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

(18) A final termination notice from a utility.

### § 2600.17. Confidentiality of records.

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

### § 2600.19. Waivers.

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

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

### § 2600.20. Resident funds.

- (12) Upon discharge or transfer of the resident, the administrator shall ~~immediately~~ return the resident's funds being managed or being stored by the home to the resident in accordance with the terms outlined in the resident contract, not to exceed 30 days.

(Rationale: The home should be given a reasonable amount of time to determine whether the resident has outstanding charges and also nursing facility requirements in PA allow for a 60 day refund period.)

### § 2600.24. Tasks of daily living.

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

### § 2600.25. Personal hygiene.

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

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

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

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

find alternative placement but not the full 30 days they would otherwise have. This is for the welfare of the resident as well.

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

**§ 2600.29. Refunds.**

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

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

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

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

## RESIDENT RIGHTS

**§ 2600.41. Notification of rights and complaint procedures.**

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

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

**§ 2600.42. Specific rights.**

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

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

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

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

*Please add:*

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

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

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

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

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

## STAFFING

**§ 2600.53. Staff titles and qualifications for administrators.**

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

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

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

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

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

Direct care staff shall have the following qualifications:

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

*Please add:*

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

### **§ 2600.55. Exceptions for staff qualifications.**

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

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

### **§ 2600.56. Staffing.**

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

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

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

### **§ 2600.57. Administrator training and orientation.**

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

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

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

...

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

#### § 2600.58. Staff training and orientation.

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

(c) Training of direct care staff hired after \_\_\_\_\_ (*Editor's Note: The blank refers to the effective date of adoption of this proposal.*) shall include a demonstration of job duties, *(Note: In discussion with the Department of Public Welfare's Personal Care Home Advisory Committee task groups, this demonstration was intended to be a check list of tasks that a supervisor would have the trainee perform in a satisfactory manor. This was not intended to be a written exam. We would just like this to be clarified here)* followed by guided practice, then proven competency before newly-hired direct care staff may provide unsupervised direct care in any particular area. Prior to direct contact with residents, all direct care staff shall successfully complete and pass the following competency-based training including the following specific job duties and responsibilities (1) Resident care.

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

(e) Direct care home staff shall have at least 24 12 hours of annual in-house training relating to their job duties. Staff orientation shall be included in the 24 12 hours of training for the first year of employment. On the job training for direct care staff may count for 12 6 out of the 24 12 training hours required annually. *(Rationale: The DPW*

PCH Advisory Committee task groups had recommended this be changed to 12 hours and DPW has verbally agreed but was unable to make the change prior to publication. Note also that nursing assistants in nursing facilities are only required to have 12 hours of continuing education a year).

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

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

(2) Medication self-administration training.

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

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

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

(6) Personal care service needs of the resident.

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

## **§ 2600.59. Staff training plan.**

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

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

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

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

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



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

**§ 2600.60. Individual staff training plan.**

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

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

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

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

**PHYSICAL SITE**

**§ 2600.81. Physical accommodations and equipment.**

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

**§ 2600.83. Temperature.**

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

**§ 2600.85. Sanitation.**

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

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

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

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

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

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

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

### **§ 2600.90. Communication system.**

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

### **2600.93. Handrails and railings.**

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

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

### **§ 2600.94. Landings and stairs.**

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

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

### **§ 2600.96. First aid supplies.**

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

### **§ 2600.98. Indoor activity space.**

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

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

### § 2600.99. Recreation space.

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

### § 2600.101. Resident bedrooms.

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

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

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

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

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

### § 2600.102. Bathrooms.

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

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

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

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

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

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

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

### **§ 2600.103. Kitchen areas.**

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

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

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

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

### **§ 2600.104. Dining room.**

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

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

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

### **§ 2600.105. Laundry.**

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

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

### **§ 2600.107. Internal and external disasters.**

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

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

- (c) Disaster plans shall include at a minimum:
- (1) Contact names.
  - (2) Contact phone numbers of emergency management agencies and local resources for the housing and emergency care of residents affected.
  - (3) Alternate means of supply of utilities shall be identified and secured. Excessive cost for small providers if they need to purchase a generator.
  - (4) The home shall maintain at least a 3-day supply of nonperishable food and drinking water or plan for obtaining a supply of drinking water for all residents and personnel. *(drinking water may be a problem to store 3-day supply) We need some reasonableness here. 1 gallon per resident per day is the standard.*
  - (5) The home shall maintain at least a 3-day supply of all resident medications or have identified an alternate plan for obtaining meds. (e.g., delivery systems are sometimes weekly only)

### FIRE SAFETY

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

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

#### § 2600.123. Emergency evacuation.

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

#### § 2600.130. Smoke detectors and fire alarms.

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

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

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

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

### **§ 2600.132. Fire drills.**

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

## **RESIDENT HEALTH**

### **§ 2600.141. Resident health exam and medical care.**

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

### **§ 2600.143. Emergency medical plan.**

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

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

## NUTRITION

### § 2600.161. Nutritional adequacy.

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

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

### § 2600.162. Meal preparation.

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

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

### § 2600.163. Personal hygiene for food service workers.

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

### § 2600.164. Withholding or forcing of food prohibited.

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

### 2600.171. Transportation.

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

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

## MEDICATIONS

### § 2600.181. Self-administration.

- (e) A resident is capable of self-administering medications if the resident can use the medication as prescribed in the manner prescribed. The resident shall be able to recognize and distinguish the medication and know the condition or illness for which the medication is prescribed, the correct dosage and when the medication is to be taken. Examples include being capable of placing medication in the resident's own mouth and swallowing completely, applying topical medications and not disturbing the application site, properly placing drops in eyes, correctly inhaling inhalants and properly snorting nasal therapies. We recommend that this be defined as being the physician's determination as to whether the resident is capable of self-administering medications.
- (f) The appropriate state agency shall develop a medication assistive personnel (MAP) training program that will permit trained staff to assist with administration of medications. (Rationale: With the severe nursing shortage and high cost of care to consumers when you are required to provide professionally licensed services, it makes good sense to train unlicensed staff to assist where needed. This should be a "Train the trainer" model).
- (g) Medication assistive personnel (MAP) may administer medications after successfully completing a state approved and appropriate training course that includes a written and performance-based competency examination. To qualify for training as a MAP, the individual must be a high school graduate and have English language proficiency.

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

- (a) Prescription, OTC and ~~CAMs~~ shall be kept in their original labeled containers and may not be removed more than 2 hours in advance of the scheduled administration. Assistance with injections and sterile liquids shall be provided immediately upon removal of the medication from its container. Many homes do not have the room to store CAMs and CAMs are not always labeled correctly when received by the home.
- (b) Prescription, OTC, ~~CAM~~ and syringes shall be kept in an area or container that is locked.
- (c) Prescription, OTC and ~~CAM~~ stored in a refrigerator shall be kept in a separate locked container. What if refrigerator is in the med room that is locked? Permitted?
- (d) Prescription, OTC and ~~CAM~~ shall be stored separately. Clarify that you mean each resident's meds are stored apart from each other? (e.g., does a divider in med drawer work?)



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

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

### § 2600.183. Labeling of medications.

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

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

(d) Sample medications shall be identified by the physician with the dosage, time and resident's name. the particular resident's use and accompanied by a physician's order.

Note: It's not always possible for provider to get this from the physician. Let home determine whether they will store sample meds whether they take them and how many and frequency or in resident contract.

### § 2600.184. Accountability of medication and controlled substances.

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

### § 2600.185. Use of medications.

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

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

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

## § 2600.186. Medication records.

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

- (1) The prescribed dosage.
- (2) Possible side effects as provided by pharmacy.
- (3) Contraindicated medications as provided by the pharmacy.
- (4) Specific administration instructions.
- (5) The name of the prescribing physician.
- (6) Drug allergies identified on med eval.
- (7) Dosage, date, time and the name of the person who helped with the self-administration of the medication. This is not self-administration if we are doing all this. Contradicts definition of self-administration.

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

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

## SAFE MANAGEMENT TECHNIQUES

### § 2600.201. Safe management techniques.

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

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

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

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

**SERVICES**

**§ 2600.222. Community social services.**

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

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

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

- ~~— (1) The scope and general description of the services provided by the home.~~
- ~~— (2) The criteria for admission and discharge.~~
- ~~— (3) Specific services provided by the home.~~

**§ 2600.225. Initial assessment and the annual assessment.**

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

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

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

- (1) Annually within 30 days before or 30 days after the resident's anniversary date of admission.
- (2) If the condition of the resident materially-substantially changes prior to the annual assessment, the review shall be completed and updated on the current version.

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

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

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

### **§ 2600.226. Development of the support plan.**

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

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

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

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

(3) The home staff.

(4) Family or advocates.

(5) Doctors.

(6) Other interested persons designated by the resident.

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

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

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

### **§ 2600.228. Notification of termination.**

(b) If the home initiates a discharge or transfer of a resident, or if the legal entity chooses to close the home, the home shall provide a 30-day advance written notice to the resident, the resident's legal representative, and the referral agent citing the reasons for the discharge or transfer. This shall be stipulated in the resident-home contract signed prior to admission to the home. A 30-day advance written notice may not be given if a delay in discharge or transfer would jeopardize the health or safety of the resident or others in the home, ~~as certified by a physician.~~ This shall occur when the

resident needs psychiatric or long-term care or is abused in the home, or the Department initiates a closure of the home. The home should be able to determine this without a physician certification.

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

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

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

(6) If closure of the home is initiated by the Department.

(7) Violation of home rules.

(8) Repeated violation or disruption of the home's harmony.

## SECURED UNIT REQUIREMENTS

### § 2600.231. Doors, locks and alarms.

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

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

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

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

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

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

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

### **§ 2600.232. Environmental standards.**

Environmental standards include the following:

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

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

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

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

### **§ 2600.233. Admission standards.**

Admission standards include the following:

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

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

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

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

### **§ 2600.234. Care standards.**

Care standards include the following:

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

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

#### **§ 2600.235. Discharge standards.**

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

#### **§ 2600.236. Administrator training.**

Administrator training includes the following:

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

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

- (i) Psychosocial issues.
- (ii) Specific cultural issues.
- (iii) Psychological changes.
- (iv) Functional consequences of other age-related diseases.
- (v) Interpersonal skills in communications and team building.
- (vi) Care-giving strategies.
- (vii) Sexuality issues.
- (viii) Nutrition issues.
- (ix) Communication issues with residents and family and therapeutic activities, techniques and strategies.
- (x) Medication use, effects and side effects.
- (xi) Abuse prevention and resident rights consistent with the Older Adult Protective Services Act (35 P. S. §§ 10225.101--10225.5102).

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

#### **§ 2600.237. Staff training on dementia.**

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

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

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

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

(4) Communication techniques.

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

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

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

(8) Working with family members.

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

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

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

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

#### **§ 2600.239. Programming standards.**

Programming standards include the following:

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

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

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

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

(ii) Be done voluntarily.

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

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

#### **§ 2600.240. Notification to Department.**

Notification to the Department is required as follows:

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

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

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

(iii) The total resident population of the home.

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

(v) A building description and general information.

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

(vii) The type of locking system.



- (viii) Emergency egress.
- (ix) A sample of a 2-week staffing schedule.
- (x) Verification of completion of additional training requirements.
- (xi) The operational description of the secured unit locking system of all doors.

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

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

(xxi) A description of environmental cues being utilized.

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

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

## RESIDENT RECORDS

### § 2600.251. Resident records.

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

### § 2600.252. Content of records.

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

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

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

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

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

### § 2600.253. Record retention and disposal.

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

**§ 2600.254. Record access and security.**

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

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

**ENFORCEMENT**

**§ 2600.261. Classification of violations.**

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

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

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

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

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

Where are paper violations/errors classed?

**§ 2600.262. Penalties.**

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

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

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

**§ 2600.263. Revocation or nonrenewal of licenses.**

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



Original: 2294

14-475 (503)

*Fax*

*Vincentian Assisted Living*

To	<u>Department of Public Welfare</u>
Attn	<u>Teleta Nevius</u>
Fax #	<u>717-705-6955</u>
From	<u>SISTER Kelly O'Mahony</u>
Fax #	<u>412-366-3266</u>
Date	<u>11-4-02</u>
Number of pages (including this cover) <u>12</u>	

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 COMMUNICATIONS SECTION  
 14-475-1

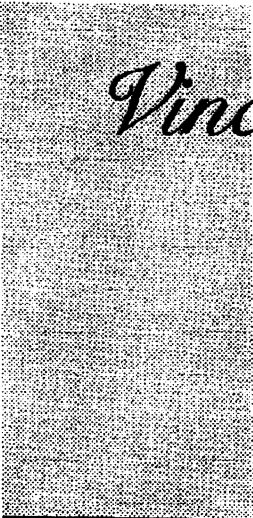
Sr Kelly O'Mahony, VSC  
Administrator

111 Perrymont Rd

Pittsburgh, PA 15237

Phone: 366-1039

Fax: 366-1397



# Vincentian Assisted Living

November 4, 2002

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

111 Perrymont Road

Dear Ms. Nevius,

Pittsburgh, PA 15237

I am the administrator of a 53 bed personal care home on the campus of a nursing facility and I hold a license as a nursing home administrator. I have given much thought to the proposed regulations as posted on October 5th. First, I am happy to see that some changes have been made from the draft regulations posted earlier this year; however, I still have several recommendations that I urge you to consider.

Tel: 366-1039

Overall, I believe several provisions in the proposed regulations are excessive for the personal care industry. Please refer to the following pages which explain my concern and offer solutions.

Fax: 366-3266

Thank you for your attention to my concerns.

Sincerely,

*Sister Kelly Ann O'Mahony, VSL*  
Sister Kelly Ann O'Mahony, VSC  
Director of Assisted Living

Vincentian Assisted Living does not discriminate in providing its services, and its doors are open to applicants regardless of race, color, religious creed, disability, ancestry, national origin, age or sex

Of primary concern are the qualifications and training of administrators and staff.

**Proposed in 2600.53(a), administrator qualifications:**

- " (1) A valid license as a registered nurse from the Commonwealth.
- (2) An associate's degree or 60 credit hours from an accredited college or university.
- (3) A valid license as a licensed practical nurse from the Commonwealth and 1 year of work experience in a related field.
- (4) A valid license as a nursing home administrator, from the Commonwealth."

**Problem/Rationale:**

These qualifications are excessive and unnecessary if the training and orientation of administrators under 2600.57 are adopted.

**Suggested solution:**

Remove 2600.53 (a) and allow subsections (b) through (j) to suffice as qualifications.

**Proposed in 2600.57, annual training for administrators:**

"24 hours of annual training relating to the job duties"

**Problem/Rationale:**

Twenty-four hours of training is equivalent to requirements for licensed nursing home administrators, though NHAs are allowed 48 hours in 2 years. Current regulations require just six hours annually. I support raising the required number of hours, but disagree with 24 hours.

**Suggested solution:**

"12 hours of annual training relating to the job duties"

**Proposed in 2600.57(f), verification of annual training:**

"(f) An administrator who has successfully completed the training in subsections (a)--(e) shall provide written verification of successful completion to the appropriate personal care home regional field licensing office designated by the Department."

**Problem/Rationale:**

I support requiring verification of qualifications/initial training of administrators (subsections (a) through (d)), however, subsection (e) regarding verification of annual training, will create burdensome paperwork for the administrator and the Department. Rather than requiring verification of annual training be forwarded to the Department, the Department can conduct random checks or require that administrators produce the verification on request during an inspection.

**Suggested solution:**

Let 2600.57 (f) read: "An administrator who has successfully completed the training in subsections (a)--(d) shall provide written verification of successful completion to the appropriate personal care home regional field licensing office designated by the Department. The Department will conduct random audits to ensure annual training requirements are met."

**Proposed 2600.58(e), annual training of direct care staff:**

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

**Problem/Rationale:**

Nursing homes must have 12 hours annually for nurse aides, hospitals are required to have only 8. The proposed regulations go beyond either of these. Given that residents of personal care homes do not need the services of a hospital or nursing home, the annual requirements for staff training should not be as extensive. Also, the training cost plus the cost for additional staffing hours while training is in progress would be a financial burden to smaller homes and homes that serve only SSI recipients.

**Suggested solution:**

Change 2600.58(e) to read

“(e) Direct care home staff shall have at least 6 hours of annual training relating to their job duties. Staff orientation shall be included in the 6 hours of training for the first year of employment.”

**Proposed 2600.58(f), topics required for training direct care staff:**

“(2) Medication self-administration training.

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

**Problem/Rationale:**

Direct care staff training should be consistent with their job responsibilities.

**Suggested solution:**

Change 2600.58(f) to read

“(f) Training topics for the required annual training for direct care staff shall include the following if relevant to their job functions:”

**Proposed 2600.58(g), training for volunteers:**

“(g) Full-time, part-time and temporary staff persons and volunteers shall be trained annually on:

(1) Fire safety. Training in fire safety shall be completed by a fire safety expert or, in personal care homes serving 20 or fewer residents, by a staff person trained by a fire safety expert.

Videotapes/DVD's prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.

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

(3) Resident rights.

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

(5) Falls and accident prevention.

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

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

**Problem/Rationale:**

Persons giving freely of their time should not be required to attend training sessions unless they intend to work as direct care staff. Further, it is unlikely that persons who volunteer only on a monthly basis or less frequently will take the time to attend training.



**Suggested solution:**

Change 2600.58(g) to read

“(g) Full-time, part-time and temporary staff persons and volunteers *used as direct care staff* shall be trained annually on.”

**Proposed 2600.59, staff training plan:**

“The administrator shall ensure that a comprehensive staff-training plan is developed and conducted annually for the development and improvement of the skills of the home's direct care staff. The staff training plan shall include the personal care home's policies and procedures for developing and conducting the staff training plan, indicating who is responsible and the time frames for completion of the following components:

- (1) An annual assessment of staff training needs shall include questionnaires completed by all staff with data compiled, or a narrative summarizing group discussion of needs.
- (2) An overall plan for addressing the needs identified in paragraph (1). This plan shall be based on the assessment of staff training needs, and shall indicate training content, trainers and proposed dates of training.
- (3) A mechanism to collect written feedback on completed training.
- (4) An annual evaluation of the staff-training plan, including the extent to which implementing the plan met the identified training needs.”

**Problem/Rationale:**

This provision is over-regulation. I support the addition of a staff training plan. It is sufficient to require that the administrator develop a staff training plan and conduct it annually.

**Suggested solution:**

Change 2600.59 to read

“The administrator shall ensure that a comprehensive staff-training plan is developed and conducted annually for the development and improvement of the skills of the home's direct care staff. The staff training plan shall include the personal care home's policies and procedures for developing and conducting the staff training plan, indicating who is responsible and the time frames for completion.” Delete the rest of the statement and subsections (1) through (4).

**Proposed 2600.60, individual staff training plan:**

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

- (1) The plan shall be based upon an employee's previous education, experience, current job functions and job performance.
- (2) The employee shall complete the minimum training hours as listed in § 2600.58(d) (relating to staff training and orientation) with the subject selections being based upon the needs identified in the training plan.
- (3) Annual documentation of the required training in the individual staff-training plan shall be maintained for all staff.”

**Problem/Rationale:**

An individual staff training plan is an excessive requirement. It is time consuming for administrators who also function as direct care staff to develop individualized plans for each staff member. Supervisors and direct care staff must be paid for planning and paperwork rather than for giving care. Substitute staff need to be paid while two employees plan and generate paperwork. Therefore, it is potentially cost prohibitive for facilities serving only SSI recipients and for smaller homes. It is sufficient to require that staff be trained annually.

**Suggested solution:**

Remove 2600.60. Language from the current 2620.64 (e) (8) should be added to 2600.59 as amended above:

"The administrator shall ensure that a comprehensive staff-training plan is developed and conducted annually for the development and improvement of the skills of the home's direct care staff. The staff training plan shall include the personal care home's policies and procedures for developing and conducting the staff training plan, indicating who is responsible and the time frames for completion. *Documentation of training shall be maintained which indicates the type of training received by each staff person.*"

\* \* \* \* \*

Next, I want to address the provisions for self-administration of medications. Section 2600.182 describing a resident who is capable of self-administering medications conflicts with Section 2600.4, the definition of an Immobile Resident. On the one hand, the proposed regulations state:

**Proposed 2600.182(e), self-administration of medications:**

(e) A resident is capable of self-administering medications *if the resident can use the medication as prescribed in the manner prescribed. The resident shall be able to recognize and distinguish the medication and know the condition or illness for which the medication is prescribed, the correct dosage and when the medication is to be taken.* Examples include being capable of placing medication in the resident's own mouth and swallowing completely, applying topical medications and not disturbing the application site, properly placing drops in eyes, correctly inhaling inhalants and properly snorting nasal therapies.

Yet, the definition of an immobile resident states:

**Immobile resident--**

- (i) An individual who is unable to move from one location to another, or *has difficulty in understanding and carrying out instructions without the continual and full assistance of other persons*, or is incapable of independently operating a device, such as a wheelchair, prosthesis, walker or cane to exit a building.
- (ii) The term does not mean that an immobile resident is incapable of self-administering medications.

**Problem/Rationale:**

To assert (ii) above, "the term does not mean that an immobile resident is incapable of self-administering medications" is illogical. An "individual who has difficulty in understanding and carrying out instructions without the continual and full assistance of

other persons" would not be able to "use the medication as prescribed in the manner prescribed" or "recognize and distinguish the medication, know the condition or illness for which the medication is prescribed, the correct dosage and when the medication is to be taken."

Clearly, the two sections above are in conflict. It is likely that few people residing in personal care homes would qualify to self-administer medications under 2600.182 (e). Therefore, the regulations are calling for nursing personnel or other professionals qualified to administer medications. To require that nurses assist with medications presents two problems. (1) The cost to hire nurses is prohibitive for facilities serving only SSI recipients and for smaller facilities capable of successfully managing medications for their residents, and (2) nurses are not available in today's economy.

I support the development of a medication training program that will enable non-professional staff to administer medications. Until this program is developed and implemented, I recommend the following:

**Suggested solution:**

Remove 2600.182 (e)

\* \* \* \* \*

My next concern is with regard to emergency evacuation of the building.

**Proposed 2600.132(d), fire safety:**

"(d) Residents shall be able to evacuate the entire building into a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert, within 2 1/2 minutes or within the period of time specified in writing within the past year by a fire safety expert. The fire safety expert may not be an employee of the home."

**Problem/Rationale:**

Evacuating residents in a larger, fully sprinkled facility with fully functioning fire alarm system within a 2 1/2 minute time period is unnecessary, impossible and unsafe. Also, if the fire safety expert has already approved evacuation to a safe staging area and no structural changes have been made to the building, there is no need to have the expert sign off every year. This is unnecessary paperwork.

**Suggested solution:**

"(d) Residents shall be able to evacuate the entire building quickly and safely into a public thoroughfare, or to a fire-safe area designated in writing by a fire safety expert. The fire safety expert may not be an employee of the home."

\* \* \* \* \*

The section on Secured Units needs clarification.

**Problem/Rationale:**

It is possible that persons who do not require a secured unit may want to live in the unit. In my case, the entire facility was designated a Secure Unit through waiver process because of the presence of magnetic locks installed during the construction of the building. Currently none of my residents needs to be in a secure unit but they appreciate the security of knowing the doors are locked. As part of waiver compliance already approved by the

Department, the locking system is explained to the resident and they sign a paper acknowledging that it was explained to them. No one in my resident population require environmental cues or special training for the staff. To provide for these types of special needs would be an unnecessary expense.

**Suggested Solution:**

Create a section 2600.230:

"The provisions under Secured Unit Requirements are to be met when residents requiring a secured unit are admitted to the secured unit."

\* \* \* \* \*

Next, I'll address services and resident rights. From the business perspective, the proposed regulations are heavily biased toward the customer (resident) and do not allow business owners (facilities) choice in developing and marketing their own product, namely the services they offer.

**Proposed 2600.42(i), resident rights:**

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

**Problem/Rationale:**

I agree that persons should not be denied access to these services. However, I have a concern that, narrowly read, this section will hold owners responsible for paying for the services and providing transportation, special services, (i.e. Interpreters for Deaf and Hard of Hearing), etc.

**Suggested solution:**

"A resident shall receive assistance in accessing medical, behavioral health, rehabilitation services and dental treatment. Assistance means contacting the appropriate professional or agency to arrange for the services. It does not hold the facility financially responsible for payment of the services or for related costs."

**Proposed 2600.42(f), resident rights, mail:**

"(f) A resident shall have the right to receive and send mail."

**Problem/Rationale:**

This is a change from the current regulations which state the resident "has access to the United States mail and can write and send mail, at the Resident's own expense". The proposed regulation could be interpreted to mean the facility is responsible for the cost.

**Suggested solution:**

"(f) A resident shall have the right to receive and send mail at the resident's own expense."

**Proposed 2600.42(j) resident rights, clothing:**

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

**Problem/Rationale:**

I agree with what I believe to be the intent of the regulation, however, again it can be misinterpreted to mean that the facility is financially responsible."

**Suggested solution:**

"(j) A resident shall receive assistance in attaining clean, seasonal clothing that is age and gender appropriate. Assistance does not imply financial responsibility."

**Proposed 2600.42, resident rights, personal belongings:**

"(l) A resident shall have the right to purchase, receive and use personal property."

**Problem/Rationale:**

In some circumstances, use of personal property may present a safety problem for the resident, violate the rights of other residents or destroy property of the home.

**Suggested solution:**

"(l) A resident shall have the right to purchase, receive and use personal property as space permits, the rights of other residents are not infringed upon and the home's property is not damaged in its use."

**Proposed 2600.42(u), resident right, remain in the home**

"(u) A resident shall have the right to remain in the personal care home, as long as it is operating with a license, except in the circumstances of: (1) nonpayment, (2) higher care needs, (3) resident is a danger to himself or others.

And 2600.228(h) services, only grounds for discharge:

"(h) The only grounds for discharge or transfer of a resident from a home are for the following conditions: (1) danger to himself or others, (2) voluntary home closure, (3) higher care needs, (4) resident needs require alteration in facility program or site, (5) nonpayment (6) involuntary home closure.

**Problem/Rationale:**

These state the resident's right to live in the home and limit the grounds for discharge without any regard for the facility owner's rights. Sometimes a resident and the home are just not a good fit, or the resident is destroying property or is a higher level of personal care than the facility chooses to provide. These regulations are forcing facilities into providing services they don't want to provide. The resident has the right to stay or leave and the facility has no right to determine or limit its services. The current regulations have a provision for the home initiating a discharge or transfer. The proposed regulations have similar wording in 2600.228(b) that also stipulate notice be given, but (h) limits the reasons for the home to initiate.

**Suggested solution:**

Change 2600.228(h) to read  
"(h) Grounds for discharge or transfer of a resident include."

**Proposed 2600.42 resident rights, immediate payment"**

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

**Problem/Rationale:**

Confused residents can claim stolen money when they never had it in the first place. An investigation will need to be made to determine if the money has actually been stolen or if it has only been misplaced by the resident.

**Suggested solution:**

Change 2600.42(x) to read

"(x) A resident shall have the right to payment by the personal care home to resident's money stolen or mismanaged by the home's staff. Payment will be made immediately after investigation substantiates theft or mismanagement."

**Proposed 2600.101(r) building, resident's chair:**

"(r) There shall be a minimum of one comfortable chair per resident per bedroom. The resident shall determine what type of chair is comfortable."

**Problem/Rationale:**

Residents can require the home to buy recliners or lift chairs or other therapeutic chairs if those are what they determine is "comfortable."

**Suggested solution:**

Change 2600.101(r) to read

"(r) There shall be a minimum of one comfortable chair per resident per bedroom."

**Proposed 2600.102(g) building, toiletry items:**

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

**Problem/Rationale:**

These are amenities and the regulation implies financial responsibility on the part of the facility to provide them for all residents. I can understand providing them for SSI recipients but not for residents who have the means to purchase their own.

**Suggested solution:**

"(g) Individual toiletry items including toothpaste, toothbrush, shampoo, deodorant, comb and hairbrush shall be made available to SSI recipients at no extra charge."

**Proposed 2600.104(d) building, adaptive equipment:**

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

**Problem/Rationale:**

This regulation can be interpreted to mean that the facility is financially responsible for providing the equipment.

**Suggested solution:**

“(d) Special provisions shall be made, when necessary, to assist residents in eating at the table.”

**Proposed 2600.161 resident health, dietary alternatives:**

“(e) Dietary alternatives shall be available for a resident who has special health needs, religious beliefs regarding dietary restrictions or vegetarian preferences.”

**Problem/Rationale:**

Accommodating special diets can be costly and require special skills or machines to prepare. (Mechanical soft diets, Kosher preparation) This should be left to the policy of the facility and known by potential residents up front, who are then free to choose whether or not to live at the facility.

**Suggested solution:**

Remove 2600.161(e)

**Proposed 2600.81 building, physical accommodation:**

“The home shall provide or arrange for physical site accommodations and equipment necessary to meet the health and safety needs of a resident with a disability and to allow safe movement within and exiting the home.”

**Problem/Rationale:**

The facility could be required to make extensive and expensive alterations in its physical plant. A reasonable accommodation clause needs to be inserted.

**Suggested solution:**

“In accordance with applicable laws, the home shall provide or arrange for physical site accommodations and equipment necessary to meet the health and safety needs of a resident with a disability and to allow safe movement within and exiting the home.”

**Proposed 2600.101(c) building, size of room:**

“(c) Each bedroom for a resident with a physical immobility shall have 100 square feet per resident, or allow for easy passage between beds and other furniture, and for comfortable use of a resident's assistive devices, including wheelchairs, walkers, special furniture or oxygen equipment. This requirement does not apply if there is a medical order from the attending physician that states the resident can maneuver without the necessity of the additional space.”

**Problem/Rationale:**

Specifying an exact size of room is not necessary if the last suggestion is implemented, ensuring that applicable laws (the ADA) are followed.

**Suggested solution:**

Remove 2600.101(c)

**Proposed 2600.91 building, emergency phone numbers:**

“Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control and personal care home hotline number shall be posted on or by each telephone with an outside line.”

**Problem/Rationale:**

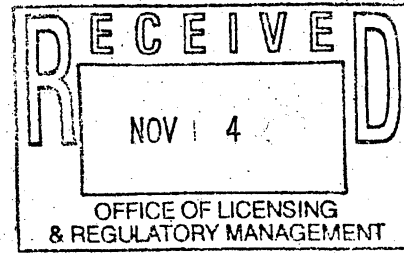
Posting 6 separate phone numbers at every phone is not practical and can lead to confusion. Where 911 service is available, only 911 and the personal care home hotline number are necessary.

**Suggested solution:**

"Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control and personal care home hotline number shall be posted on or by each telephone with an outside line. Where 911 service is available, only 911 and the personal care home hotline number are necessary."



14-475 (487)



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  
 November 4, 2002

To Whom It May Concern:

The enclosed suggestions and comments were prepared by the executive director and other staff members of the Paxton Street Home. If you have any questions regarding our suggestions, we would be happy to respond via e-mail or in person. We would also like to invite you to visit our facility and to have lunch with us. We believe that we are an example of a personal care facility that is different from the multiple assisted living facilities that are related to nursing homes. As such our needs and abilities are very different. Our financial resources are also limited because we are purposefully trying to address the needs of a population on a very limited income. That is our mission.

Thank you for consideration of our comments.

Sincerely,

Chris Book, Executive Director  
 Wanda Heise, Director of Social Services

Vertical stamp: RECEIVED NOV 14 2002

Paxton Street Home, 1

**COMMENTS ON PROPOSED CHAPTER 2600 PCH REGULATIONS**

Submitted by, Paxton Street Home, Chris Book, Administrator

November, 4, 2002

*Personal Care Home Providers*

In drafting the proposed rulemaking, the Department gave careful consideration to the effect the regulations will have on the cost of providing or receiving services. The issues that will have most potential to influence the cost of implementing Chapter 2600 are the following:

1. Mandatory costs for all personal care homes:

(a) Printing costs for policies and procedures, personnel management, quality management and other necessary documents.

(b) Reimbursement of residents' personal needs allowance within 1 week of discharge.

(c) Annual furnace inspection.

(d) Additional annual training costs due to additional required hours of training for administrators and staff.

Clearly the following additional costs will also be realized.

(e) Additional costs for additional staffing when a resident has increasing personal care needs.

(f) Additional staffing to care for residents due to the increased needs for documentation and planning meetings.

(g) Additional staffing to monitor, plan and implement increased training requirements for staff.

(h) Additional staffing with medical credentials for all shifts to implement the medication regulations.

**2600.16 Reportable Incidents**

18 (e) The personal care home shall submit a final report on a form prescribed by... Comment: The vast majority of incidents are over when the first report is made. Requiring a final report for every incident is unnecessary and should be required only at the request of the licensing inspector.

**2600.20. Resident funds.**

(a, 2) Deposits and expenditures shall be documented with written receipts. Comment: In many cases a simple passbook savings type system provides sufficient documentation without a written receipt. A receipt is not necessary.

(b, 2) The home may not prohibit the resident's right to manage his own finances Add: "unless directed by the guardian, power of attorney, or payee and documented. It is advisable for the individual with difficulty in managing finances to employ a payee." Comment: In certain cases a resident may easily be taken advantage of by others without close supervision even, at times against their will.

(b, 4) The resident shall be given funds requested Add: "at scheduled times, but no less than twice weekly. In an emergency the facility shall be prepared to honor a request for \$10 or less the same day. Comment

**The provider cannot be at the whim and fancy of each resident needing money unless it is an emergency.**

(9)The home shall give the resident an annual written account of financial transactions made on the resident's behalf. The home shall provide the resident the opportunity to review his own financial record upon request during normal working hours. A copy shall be placed in the resident's record. **Comment:**This entire section (#9) will cause an enormous amount of work for the provider, esp. those without access to computerized systems. Placing a copy in the record is unnecessary if available at the Business office.

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

(A 1)(ii) The actual amount of allowable resident charges for each service or item. The actual amount of the periodic—for example, monthly—charge for food, shelter, services and additional charges, and how, when and by whom payment is to be made. **Comment:** This section is very confusing and difficult to determine. It adds unnecessary detail to the contract.

(x)(i) A list of personal care services and their costs to be provided to the resident based on the outcome of the resident's support plan. **Comment:** In a home where the fee is already reduced and does not cover services provided but is supplemented by outside donations, why would there be a need to list the costs of individual personal care services when the individual is not being charged for them in this manner? Our facility only charges on a sliding scale according to the individual's ability to pay under the amount of our actual costs. Each individual will receive the same quality of care. This regulation and the one following it (xii) appear to be geared to assisted living and not our type of personal care home.

(d) The service needs addressed in the resident's support plan shall be available to the resident 365 days a year. **Comment:** It is not appropriate to list the personal care services in the agreement. Service needs change and the contract would need to be updated on a regular basis.

**§ 2600.27. Quality management.**

(c) If the personal care home fails to establish and implement quality assessment and management plans, the Department reserves the right to create the criteria that the home will utilize in establishing those plans. **Comment:** This plan serves no clear purpose.

**§ 2600.28. Supplemental Security Income (SSI) recipients.**

(b) The administrator may not include funds received as lump sum awards, gifts or inheritances, gains from the sale of property, but not retroactive government benefits when calculating payment of rent for an SSI recipient or for a resident eligible for SSI benefits. **Comment:** This appears contradictory to the actual way in which these funds are administered by the government. If a recipient has an excess in savings, their government SSI or other income may be effectively decreased. It appears only correct that the personal care home should take these additional funds into consideration in the same way when the individual is clearly not paying the full amount of their care to begin with.)

(d) An administrator shall provide each resident who is a recipient of SSI, at no charge beyond the amount determined in subsection (a), the following items or services as needed:

(2) Laundry services, including personal laundry **Suggested wording:** "or available washing machines and dryers", **Comment:** In order to encourage independence and self esteem building, some residents may benefit from doing their own laundry and may prefer it. but not including dry cleaning or other specialized services.

**2600.42. Specific rights.**

(l) A resident shall have the right to purchase, receive and use personal property **Add:** "within the limits of personal room space."

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

(1) Nonpayment following a documented effort to obtain payment.

(2) Higher level of care needs.

(3) The resident is a danger to himself or others.

(4)Add: "The resident refuses to follow the medical or psychiatric treatment prescribed by his/her physician". **Comment: In such a situation, a resident may become disruptive to the entire facility and require interventions not readily available at a non medical facility.**

(5)Add: "Refusal to abide by written house rules."

§ 2600.53. Staff titles and qualifications for administrators.

**Comment:** A valid nursing, LPN or other license in no way guarantees a qualified base for administering a home. With adequate training most adults can become effective administrators without post high school education.

§ 2600.56. Staffing.

(b) If a resident's support plan indicates that the resident's personal care service needs exceed the minimum staffing levels in subsection (a), the personal care home shall provide a sufficient number of trained direct care staff to provide the necessary level of care required by the resident's support plan  
**Comment:** This is unclear. How can any facility have staff on hand on a daily basis for such potential need and financially survive. If a facility provides a certain level of care for a certain fee, how can it then afford to provide additional care without an increase in fee. With SSI residents (most of ours) who are paying on a sliding scale because of their inability to pay, who would pay for the increased staffing? This seems unreasonable and without understanding of the limitations of a personal care home. This could put us out of business. If additional staffing is required, perhaps there is need for a higher level of care and the agencies involved need to immediately assist the personal care home in facilitating such a move.

(i) Additional staffing may be required by the Department, and will be based on safety, the Department's assessment of the amount of care needed by the residents as reflected in their support plans, and the design, construction, staffing or operation of the home. **Comment:** How and when would a personal care home become aware of this need? What protections does the facility have in relation to individual differences between those who would make these determinations? What principles would be used? This appears arbitrary.

§ 2600.57. Administrator training and orientation.

(b) Prior to licensure of a personal care home, the legal entity shall appoint an administrator who has successfully completed and passed a Department-approved competency-based training that includes 60 hours of Department-approved competency-based training, and has successfully completed and passed 80 hours of competency-based internship in a licensed home under the supervision of a Department-trained administrator. **Comment:** 80 hours of competency based training is arbitrary and unwieldy. Neither will it assure adequate or reliable training. Who will compensate the Department-based administrator for their time and energy? What does "passed" mean? Who will give the exam?

(e) An administrator shall have at least 24 hours of annual training relating to the job duties, which includes the following: **Comment:** The list of annual training for administrators is valid for initial training, but as an annual requirement makes no sense. Many administrators have been in their

position for many years and retraining them on the above will serve no purpose. After several years, many administrators would be well qualified to teach these topics. If annual training for administrators is necessary, they must be allowed to choose from a list of topics and customize their training on a needs basis. The cost for this type of training will be cost prohibitive for small homes, so if it is going to be required, it must be helpful to administrators. This plan is not helpful.

§ 2600.58. Staff training and orientation.

(b) Ancillary staff shall have a general orientation to their specific job functions as it relates to their position prior to working in that capacity. **Comment:** What is the difference between a part time volunteer and ancillary staff. If volunteers are considered ancillary staff, do they require the above training?

(c) Training of direct care staff hired after \_\_\_\_\_ (*Editor's Note:* The blank refers to the effective date of adoption of this proposal.) shall include a demonstration of job duties, followed by guided practice, then proven competency before newly-hired direct care staff may provide unsupervised direct care in any particular area. Prior to direct contact with residents, all direct care staff shall successfully complete and pass the following competency-based training including the following specific job duties and responsibilities: **Comment:** Who determines whether direct care staff have successfully completed and passed the training?

(e) Direct care home staff shall have at least 24 hours of annual training relating to their job duties. Staff orientation shall be included in the 24 hours of training for the first year of employment. On the job training for direct care staff may count for 12 out of the 24 training hours required annually. **Comment:** Who will define and determine what is on-the job training?

§ 2600.59. Staff training plan.

The administrator shall ensure that a comprehensive staff-training plan is developed and conducted annually for the development and improvement of the skills of the home's direct care staff. The staff training plan shall include the personal care home's policies and procedures for developing and conducting the staff training plan, indicating who is responsible and the time frames for completion of the following components. **Comment:** If each staff member requires an individual staff training plan, then a written questionnaire for each staff member is redundant and unnecessary.

§ 2600.60. Individual staff training plan.

**Comment:** The Department must choose between an individual staff training plan and a comprehensive plan, personalized for each staff member. Requiring both is confusing, unnecessary and redundant.

§ 2600.81. Physical accommodations and equipment.

The home shall provide or arrange for physical site accommodations and equipment necessary to meet the health and safety needs of a resident with a disability and to allow safe movement within and exiting the home. **Comment:** Personal Care Homes must be permitted to refuse admission to residents requiring unreasonable accommodations for their disability, or this requirement must be grandfathered for existing structures. This regulations alone will put many homes out of business. This should only be required of newly licensed facilities.

2600.85 Sanitation

(d) Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents. **Comment:** Covered receptacles will not prevent the penetration of insects. Furthermore, many disabled residents will not be able to open covered receptacles. This requirement is unreasonable.

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§ 2600.86. Ventilation.

All areas of the home that are used by the resident shall be ventilated. Ventilation shall include an operable window, air conditioner, fan or mechanical ventilation that ensures airflow. Comment: This will be impossible or cost prohibitive in many existing facilities.

§ 2600.94. Landings and stairs.

(a) Interior and exterior doors that open directly into a stairway and are used for exit doors, resident areas, and fire exits shall have a landing, which is a minimum of 3 feet by 3 feet. Comment: This regulation is impossible or cost prohibitive for many facilities. Existing facilities must be grandfathered.

§ 2600.96. First aid supplies.

(a) The home shall have at a minimum, in each building, a first aid manual, nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, tape, scissors, breathing shield, eye coverings. Delete: 'and syrup of ipecac'. Comment: Why syrup of ipecac? We are an adult personal care home. It is not recommended by the American Red Cross as part of a First Aid Kit. It outdates frequently and is expensive to replace. I recommend the use of American Red Cross recommended items.

2600.101 Resident bedrooms

(2) A mattress that is plastic-covered if supplied by the home. Comment: Plastic covered mattresses are institutional, uncomfortable and unnecessary. Homes where residents require incontinent care may simply install a plastic mattress cover.

(r) There shall be a minimum of one comfortable chair per resident per bedroom. The resident shall determine what type of chair is comfortable. Comment: Comfort is relative and many people may change their definition of comfort at any time. Providers cannot be held hostage to the changing whim of every residents.

§ 2600.103. Kitchen areas.

(e) Food shall be labeled, dated, rotated and inventoried weekly. Comment: Weekly labeling and dating makes no sense. Reword this sentence to say what you mean.

§ 2600.104. Dining room.

(c) Suggested wording: "Condiments shall be available in the dining room. Salt, pepper and sugar may be provided at the table." Comment: Providing all condiments at each individual table, including steak sauce, relish, mustard, ketchup, butter, jelly, etc. is unnecessary and expensive and wasteful for the home. It would also clutter the tables for good cleanup following meals. They can be provided at a central location in the dining room for all to help themselves.

§ 2600.105. Laundry.

(d) Suggested wording: "Bed linens and towels shall be offered to the resident at least once every week." Comment: Would it be a violation of a resident's rights and freedom of choice to insist that they change their linens and towels every week if they chose not to?

(g) To reduce the risks of fire hazards, the home shall ensure all lint is removed from all clothes. Comment: This regulation is absurd!!

§ 2600.107. Internal and external disasters.

(3) Alternate means of supply of utilities shall be identified and secured. Comment: Identified OK, secured, no! If there is an adequate plan to secure items such as LP gas if the natural gas is cut off, that should be sufficient.

(5) The home shall maintain at least a 3-day supply of all resident medications. Comment: We are not a medical facility and do not have a physician who would authorize such a supply. It is not within the parameters of a non-medical facility to storehouse such medication, especially when it is routinely changing for residents on a weekly basis. I am not aware of any insurance company who would pay for meds for their clients in this manner. We believe that having the medications available at the pharmacy would be a reasonable response to a disaster.

§ 2600.141. Resident health exam and medical care.

(7) Medication regimen, contraindicated medications and medication side effects. Comment: The Department provided health form (MA 51) should be revised to clearly indicate whether a resident is capable of self-medicating, self medicating under staff supervision, or with assistance. Many residents simply need someone to check they have taken their medications, but that should not count as "with assistance"

§ 2600.142. Physical and behavioral health.

(a) Each home shall address in the resident's support plan the dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if deemed necessary by the health exam. Comment: If a resident has a case manager, the referrals for services may be made by that agency instead of the personal care home. This will be documented in the support plan. In order to work within the confines of the mental health services provided by the county, etc., we need to allow the decisions and referrals to be made by the responsible authorities. Sometimes that would not be the personal care home. This requirement does not mandate a home to pay for the cost of these medical and behavioral care services.

(b) If a resident refuses routine medical, Add: "psychiatric" or dental examination or treatment, the refusal and the continued attempts to train the resident about the need for health care shall be documented in the resident's record.

(d) Add: "If a resident refuses medical or behavioral treatment recommended by a physician, the resident may be asked to leave the personal care home." Comment: On occasions where an individual refuses to take prescribed medication or have other prescribed treatment, the individual may become aggressive, disruptive and destructive to the facility and a danger to the other residents.

§ 2600.143. Emergency medical plan.

(3) An emergency-staffing plan.

(e) If the resident's medical condition, as determined by a physician, indicates the need for a transfer to a hospital or long term care facility, the administrator shall notify the resident's designated emergency contact person or family member, or both, as appropriate, and shall provide whatever assistance is necessary in making arrangements for the resident's transfer to an appropriate facility. Add: "If a resident is admitted to the hospital for a psychiatric condition, the current regulations regarding privacy in this matter shall apply." Comment: There are legal limitations regarding contacts made when an individual is hospitalized for psychiatric reasons. Please refer to federal HIPAA regulations. Providers are required to follow HIPAA laws.

§ 2600.144. Use of tobacco and tobacco-related products.

(e) Smoking in resident bedrooms is prohibited Comment: This should be included in the reasons for eviction or giving a 30 day notice. Without a consequence, this important rule can not be enforced.

§ 2600.161. Nutritional adequacy.

(e) Dietary alternatives shall be available.... **Comment:** Delete this regulation. This becomes cost prohibitive for a non-medical facility. In large facilities working with SSI incomes, the necessary kitchen personnel and expertise, number of special diets, etc. is prohibitive. Where residents have the choice to eat or not eat the special diet, what would the facility responsibility be if the resident chooses to eat the main diet instead? In a nursing setting a special diet is the only option that a resident has for his meal. In that situation the regulation makes sense. This regulation seems to be in contradiction to point c above.

(f) Therapeutic diets as prescribed... **Comment:** Delete this regulation.. Personal Care Homes cannot be forced to provide therapeutic diets. Small homes and those caring for SSI clients cannot afford the dietetic staff this regulation would require.

(g) Drinking water shall be available to the residents at all times. **Delete the next sentence.** **Comment:** With the addition of other beverages, the possibility of adding too many calories to an already diet rich in calories is a possibility. If water is available, medically it is the best choice for a beverage between meals.

§ 2600.162. Meal preparation.

(a) Foods shall be prepared in a consistency designed to meet the needs of the resident. Same comment as 2600.161 (e) above.

(e) When a resident misses a meal **Add:** "due to an appointment or unavoidable conflict in schedule..." , , **Comment:** In a large facility, it is impossible to serve food on demand because someone did not come to the dining room at the appropriate time.

§ 2600.164. Withholding or forcing of food prohibited.

(a) A home may not withhold meals, beverages, snacks or desserts as punishment. **Add:** "However, meals may be withheld when scheduled medical or dental procedures necessitate it."

(c) If a resident refuses to eat consecutively during a 24-hour period, the resident's primary care physician and the resident's designee or a family member shall be immediately notified. **Comment:** In an independent living setting this rule does not apply. In a large independent living facility without assigned seats, it is not possible to verify all persons are eating. Residents are free to eat out. To monitor this so closely would limit resident rights and place unnecessary burdens on staff. If it is discovered that a resident is purposefully not attending meals, then the above suggestion is appropriate. Generally this behavior would be noted in addition to other symptoms of psychiatric deterioration.

§ 2600.171. Transportation.

(5) At least one staff member transporting residents has completed the initial new hire direct care staff training. **Comment:** This appears to assume existing staff are somehow unqualified and incompetent.

(6) The vehicle shall have nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, tape, and scissors, **Delete:** "and syrup of ipecac". **Comment:** Unnecessary and not even recommended by the American Red Cross. Used most frequently for children in home settings, not in vehicles. Deteriorates in vehicles where it is impossible to maintain ideal temperatures for storage. that are stored together.



§ 2600.181. Self-administration

**Comment:** Since the designations relate to the medical form, MA-51, residents should be designated by the health care provider as being able to SELF-administer his/her medications; or self administer his/her Medications UNDER SUPERVISION; or as NOT able to self-administer his/her own medications.

A resident is capable of SELF administering medications if the resident can use the medication as prescribed in the manner prescribed (Examples include being capable of placing medication in the resident's own mouth and swallowing completely, applying topical medications and not disturbing the application site, properly placing drops in eyes, correctly inhaling inhalants and properly snorting nasal therapies), and is able to remember and follow the schedule for taking or using the medication.

A resident is capable of self administering medications UNDER SUPERVISION if he/she can do the preceding things only with supervision or assistance that can be provided by a lay staff person.

A resident is NOT able to administer his/her own medication, even under supervision, if skills of a licensed health professional would ordinarily be required to administer one or more of the medications.

Clearly defined definitions should be provided to the medical providers making these distinctions and validated by the medical community. Currently words and definitions used in this document and the MA-51 are different. Understandings differ with each practitioner making these determinations and do not necessarily agree with the definition interpreted by the inspectors which appear in these regulations. Physicians providing care do not have access to nor are they familiar with Personal Care Home regulations. They are familiar with MA-51 forms, although the choices within it are not defined or clearly differentiated for them.

(a) **Suggested wording:** A home shall provide residents with assistance, as needed, with medication prescribed for the residents designated "under supervision" on the MA-51. This assistance includes helping the resident to remember the schedule for taking the medication, storing the medication in a secure place and offering the resident the medication at the prescribed times. (Refer to above).

(b) **Suggested wording:** Medication not prescribed for the resident's self-administration or under supervision shall be administered by a licensed physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse or licensed paramedic, as appropriate. **Comment:** Medication administered under supervision should be able to be given by a lay staff-person if the staff person has demonstrated capability to administer the particular type of medication... i.e. eye drops, inhalers, nasal sprays, etc. It would be reasonable to have the personal care facility be responsible to have a licensed health care provider or the Department of Welfare train and certify the staff people that would be helping w/ meds. Single certification for duration of employment of staff person seems reasonable.

(c) **Suggested wording:** The resident's support plan shall identify if the resident is able to self-administer medications or have assistance with medication "under supervision". **Comment:** This would be redundant, however, because it would already be documented in the MA-51.

(d) **Suggested wording:** If the resident does not need assistance under supervision in the MA-51 with medication, medication may be stored in a resident's room for self-administration. The administrator shall take precautions to assure that medications, which are stored in the resident's room, are maintained in a safe and secure manner. **Comment:** It is not possible for the administrator to guarantee protection against contamination, etc.

(e) A resident is capable of self-administering medications if the resident can use the medication as prescribed in the manner prescribed. **Delete the remainder of the section:** '(See note at head of section).

**2600.182 Storage and disposal of medications and medical supplies**

(a) Prescription, OTC and CAMs shall be kept in their original labeled containers and may not be removed more than 2 hours in advance of the scheduled administration **Add:** "except as necessary for packaging for easier self administration by residents with such designation on the MA-51" **Comment:** Just as in a private home setting, some individuals for physical or cognitive reasons may not be able to open containers sent from the pharmacy but may be able to take their medication from a mediset if packaged by a trained staff member. This is also true for a resident leaving the facility for a weekend, vacation or several hours including a meds time. In these situations, it seems that a trained staff member would be doing all in their power to insure correct medication compliance by using every means possible to assist the resident. Such a blanket rule about 2 hours is unrealistic in a non-medical setting. Residents are not homebound. Trained staff members know best how to assist each individual resident. Assistance with injections and sterile liquids shall be provided immediately upon removal of the medication from its container. **Comment:** Injectibles should not be administered in a non-medical facility by anyone other than a resident who is self medicating such as giving himself/herself insulin. If unable to give his/her own injectible medication, the resident should either be moved to a medical facility or have a physician prescribe home health care support from a visiting nurse, etc.

(c) **Suggested wording:** Prescription, OTC and CAM stored in a refrigerator shall be kept in a separate locked container or in a refrigerator in a locked area .

(d) Prescription, OTC and CAM shall be stored separately. **Comment:** Unclear and unnecessary regulation with the proper labeling of each medication. Safe organization and storage may look different in different institutions. This regulation is not helpful. There may be systems that are useful which have all categories of one resident's medication stored in one location, separate from another. There are multiple safe systems of organization available in the pharmaceutical community and should not be mandated by regulations from a non-medical state department.

(e) **Suggested wording:** Prescription, OTC and CAM shall be stored under proper conditions as directed by a pharmacy. **Comment:** For a non medical facility, it is prohibitive to contact all pharmaceutical companies involved to obtain separate information on all medications for storage. We do not even have access to the pharmaceutical companies that produce the medications that we assist residents in taking. They are prepared and packaged in bubble packs by the pharmacy. Under the direction of the pharmacy or physician, proper storage instructions are communicated. We do not have access to a pharmacy on site).

(f) **Suggested wording:** Prescription, OTC and CAM, discontinued and expired medications, and prescription medications for residents who are no longer served at home shall be returned to the pharmacy for destruction or destroyed as directed by the pharmacy." **Comment:** Again we do not work with or have access to such information. It is the pharmacy's responsibility in working with us. When a resident permanently leaves the home, the resident's medications shall be given to the resident, the designated person, if any, or the person or entity taking responsibility for the new placement on the day of departure from the home.

(g) Antiseptics and medicines for external use shall be stored separately from oral and injectable medicines. **Comment:** Same comments as above regarding systems of storage available. These should not be regulated by Personal Care Regulations.

(h) **Suggested wording:** Prescription, OTC, CAM and syringes shall be stored as directed by a pharmacy". **Comment:** All pharmacies are regulated by Federal regulations and will be in compliance when giving direction for storage to a personal care home.

§ 2600.183. Labeling of medications.

**Comment:** Our facility and many like us are served by pharmacies that package medications in single dose bubble packs to which the following regulations seem not to relate adequately.

(a) The original container for prescription medications shall be labeled with a pharmacy label. **Comment:** Bubble packs are labeled with pharmacy labels.

(d) Sample medications shall be identified to the particular resident's use **Comment:** Meaning what? Why the resident is using the medication or which resident is to be using the medication? Physicians do not necessarily communicate with the personal care home of independent living residents who transport themselves to the office about the reasons for every medication prescribed. It is hard to imagine that they would be likely to begin this process for sample medications. Why should it be different from regular prescribed medications? The accompanying order or a previous order should be sufficient. and accompanied by a physician's order **Add:** "unless previously prescribed as a regular medication" **Comment:** Sample medications are often given for regularly prescribed medications due to insurance problems and the reason for the medications is documented with the MA-51 or other medical records or prescriptions. The physician is attempting to assist a patient with inadequate prescription coverage. In these situations, the continuing routine would indicate the usage.

§ 2600.185. Use of medications.

(b) If the home helps with self-administration, then the only prescription, OTC and CAM medications that are allowed to be given are those prescribed, approved or ordered by a licensed physician, certified registered nurse practitioner, licensed dentist or physician's assistant within its scope of practice. **Comment:** In a personal care facility, residents are able to buy and bring to the facility OTC's which they desire. Would it not be reasonable to allow them to bring those medications to the medication storage area with their other medications? Staff would then be able to help monitor what they are taking, consult with a physician regarding the advisability, side effects, etc. and to have these medications listed on the Emergency Transfer Sheet. This would appear to be safer than refusing storage of such medication with individuals whose physician has designated that they need to take medication "under supervision". No one can prevent a resident from buying such medication, but we can be available if they desire assistance in their management of it, if this regulation is changed not to include OTC's and CAM's.

(c) **Delete entire section:** **Comment:** Verbal changes should be able to be made by any practitioner licensed to prescribe, who is caring for the patient. Clearly it's preferable when that person is the prescriber or the person on-call for the prescriber. There are situations where an available prescriber needs to change orders due to negative side effects, over medication, etc. of a medication prescribed by a physician who is unavailable. This can be ascertained by history, lab results, etc. and can be most speedily accomplished verbally. This regulation appears to go beyond common medical practice.

§ 2600.186. Medication records.

(b) If the home helps the resident with self-administration **Add:** "under supervision", a medication record shall be kept to include the following for each resident's prescription, OTC and CAM:

(2) **Delete entire section:** **Comment:** Doing this would mean having package-insert information for each patient's medication in his/her own medication record, making a huge amount of paperwork. It might be reasonable to require that the personal care facility have access on site to information on side effects, such as might be found in a patient information leaflet. However, even this information may not be available for some CAM's. A current PDR, or similar printed or on-line resource should be enough. It is possible to obtain from the pharmacy a collection of Patient Information leaflets that would include all the prescription meds that residents are on. If a pharmacy is willing to send a

print-out with each new prescription not previously prescribed for that facility, it could be kept on file as an additional resource for the facility. This should not be regulated by a non-medical department with no access to the pharmacy from which it would be required. A current PDR within 2 years should be adequate. Poison control is an accurate up to date resource available to all facilities and individuals for questions regarding medications when the pharmacy is not available.

(3) **Delete entire section.** **Comment:** Too vague. Contraindicated based on what? On patient allergies? On interactions with other medications? On past medical history? This is the job of physicians and pharmacists, not of personal care home personnel!

(6) **Delete entire section:** **Comment:** This information is already available in the patient file and on the emergency transfer sheet. It would be redundant and unnecessary paperwork.

(7) **Suggested wording:** Dosage, date, time and the name or initials of the person who supervised or assisted with the self-administration of the medication. (See note below.)

(c) The information in subsection (b)(7) shall be recorded at the same time each dosage of medication is self-administered. **Add:** "under supervision. When using bubble packaging or medisets, the person who helped with the self administration of medication under supervision shall sign for each card or mediset given." **Comment:** When using bubble packaging as is common from the pharmacies for this industry, the prescribed medications and dosage are listed on the card containing the bubbles. One bubble may contain many different medications, depending on the size of the tablets or capsules. When the individual supervising the process signs a medication log, they are indicating that the medications in the bubble have been observed being taken. It is impossible to differentiate each medication since it is the pharmacy who takes responsibility for the packaging and preparation of the medications. It would seem reasonable to have the staff person sign for each individual card which is prepared by the pharmacy and given to the individual resident by the staff person. Otherwise, we have no way of knowing if there are any mistakes within the cards. We are not a medical or pharmaceutical facility. The pharmacy is responsible for that part of the process.

(d) **Suggested wording:** If a resident refuses to take a medication, the refusal shall be documented in the resident's record and reported to the physician as soon as the physician or practice is available. Subsequent refusals to take a prescribed medication shall be reported as required by the physician. **Comment:** In the case of psychiatric medications, most psychiatrists are unavailable outside of weekdays and regular business hours. Many are only available certain days of the week. Discretion must be used if the medication is a life sustaining medication versus a mood altering or symptomatic relief medication. With training, all staff persons involved with medications can make decisions about when it is necessary to take a person to the ER if a physician is not available. At the very least the facility should have 24 hours in which to contact a physician. Missing one or two doses of most meds given outside of the hospital will not make a huge difference.

§ 2600.187. Medication errors.

(a) **Suggested wording:** Documentation of medication errors shall be kept in the medication record. Medication errors include the failure to self-administer medication, self-administering the incorrect medication, self-administering the correct medication in an incorrect dosage self-administering the correct medication at the incorrect time or medication taken by the wrong resident. A medication error shall be reported to the physician as soon as possible. **Comment:** See note above about availability of physicians. This regulation is unclear in reference to whom it applies. If it applies to a resident designated by the MA-51 as "Self medicating" how would the personal care home have any way of knowing about all the above stipulations? It seems unreasonable if an individual is responsible for their own medications. However, if the regulation is in regard to residents being assisted "under supervision", the following should apply. Poison control should be contacted for direction regarding the immediate treatment needed for the resident in situations other than failure to document when the prescribing physician is not available. Documentation of their direction shall be maintained in the meds log. It is also unreasonable to call a physician for a "failure to document" if the medication

can be shown to have been given. With the use of dated bubble packs and medisets, that is easy to prove. No physician wants to be called for this type of error nor does it appear to have a rational reason. It is an in-facility error to be corrected there.

§ 2600.188. Adverse reaction.

**Suggested wording:** If a resident has a suspected adverse reaction to a medication, the home shall immediately consult a physician or poison control. The resident's family shall be notified, if applicable. The home shall document adverse reactions, the physician's response or poison control's direction.

**Comment:** Poison Control is specialized in understanding the immediate need for treatment and is available much more quickly than most physicians. and any action taken in the resident's record.

§ 2600.221. Activities program.

The administrator shall develop a program of activities designed to promote each resident's active involvement with other residents, the resident's family and the community. The program shall provide social, **Add:** "Spiritual", physical, intellectual and recreational activities in a planned, coordinated and structured manner. A current weekly activity calendar shall be posted in a conspicuous place in the home. **(Comment:** Residents are spiritual beings and homes should be required to offer religiously oriented activities at least weekly.)

§ 2600.224. Preadmission screening tool.

(a) A determination shall be made, prior to admission, and documented on the standardized preadmission screening tool in conjunction with the resident-home contract that the needs of the resident can be met by the services provided by the home. **Comment:** Good idea, but homes cannot be forced into a cookie-cutter approach where all homes are forced to admit all residents who meet screening criteria. Personal Care homes must be allowed to specialize in one or more types of care.

§ 2600.225. Initial assessment and the annual assessment.

(g) If a resident is determined to be immobile as part of the initial intake or annual assessment, specific requirements relating to the care, health and safety of an immobile resident shall be met immediately. The resident shall be continually assessed for mobility as part of the resident's support plan. **Comment:** A Provider cannot be forced to keep a resident who becomes immobile. They must be allowed to assist a resident in finding an appropriate other placement. This is critical to maintaining program integrity and continuity. Some programs and facilities are simply not designed to provide adequate care for immobile residents and forcing such could endanger the resident and place undue liability upon the Provider.

§ 2600.226. Development of the support plan.

(a) **Suggested wording:** A support plan shall be developed and implemented for each resident within one month of admission to the home. **Comment:** It is often difficult to contact the multiple service agencies involved with MH and MR related residents. It would be helpful to have one month in which to set up a support plan meeting in order to have the best chance for including all caregivers and support persons who may wish to be involved. This also gives the staff at a facility the time to get to know a resident, their immediate and long term needs and potential solutions available through referral. This plan shall also be revised within one month upon completion of the annual assessment **Comment:** This seems unnecessarily frequent for long term care when the needs have been documented to have remained the same by the physician on the annual physical exam (MA-51) by the physician. We are not a treatment facility. If the needs change according to the level of care indicated by the physician on the MA-51 it would seem reasonable to review the support plan. To do this review annually on a stable population is unnecessary administrative and unwise use of staff time when they should be caring for residents. Or it could increase the costs of care due to the administrative problems of organizing these meetings frequently. This could limit the ability of homes to exist for those least able to afford the care. **Add:** if more than 3 changes in the level of

functioning of the resident are indicated on the assessment. It shall address all of the needs of the resident's current assessment including the resident's personal care needs. **Comment:** Unless several changes are noted, it seems unreasonable to bring together an entire team to suggest that the personal care home now may need to assist with bathing or some other individual ADL need. The facility would always have the prerogative to bring together the team, but it may only be necessary when multiple changes are noted indicating a potential deterioration in the individual which may need to be addressed by several agencies. This seems like an inflexible rule which could make a good idea unworkable. It could serve to detract from resident care if those involved in meeting together now have less time to address resident issues. Each meeting could potentially represent 6-10 man hours of care not available to the resident depending on how many individuals are participating with care and treatment of an individual resident. Many of our residents do have that many caregivers and support staff combined in various parts of their lives. For this reason, it should be mandated with great care and only when absolutely necessary.

§ 2600.228. Notification of termination.

(b) If the home initiates a discharge or transfer of a resident, or if the legal entity chooses to close the home, the home shall provide a 30-day advance written notice to the resident, the resident's legal representative, and the referral agent citing the reasons for the discharge or transfer. This shall be stipulated in the resident-home contract signed prior to admission to the home. A 30-day advance written notice may not be given if a delay in discharge or transfer would jeopardize the health or safety of the resident or others in the home **Suggested wording:** as documented by the facility. **Comment:** When working with large numbers of residents who have chronic mental illness, it is important that the home have the ability to prevent issues from becoming a danger, even when outside agencies are unavailable to support the home. There are times when the resident is appropriate in other settings where there are not current triggers (the ER, etc.), but upon return to the home environment is unable to maintain appropriate or even adequate behavior. At these times, the facility needs the ability to protect the rest of the residents from unnecessary disruption and danger to their lives. A physician is unwilling to document or certify for behavior they have not observed nor do they carry the responsibility for the protection of others within the facility. They have not usually been to the facility nor do they know the other individuals who reside there unless they are a house doctor as in a nursing facility. Personal care homes do not have a house doctor. It is unreasonable for a physician to be the final decision maker about appropriateness in these situations. No other agency maintains that perspective but all are focused on the identified individual's needs at times to the detriment of other individuals. A Personal Care Home needs to have the ability to immediate eviction if a resident is not able to demonstrate appropriate behavior for any reason that jeopardizes the rest of the population. Clearly, efforts to effect change in behavior should be tried and documented.

This shall occur when the resident needs psychiatric or long-term care or is abused **Add:** "or becomes abusive or threatening to others" in the home, or the Department initiates a closure of the home.

(h) The only grounds for discharge or transfer of a resident from a home are for the following conditions: **Comment:** As a private entity, a Provider must retain the right to discharge a resident for any reason. These are not state run facilities. Without this control, it will be impossible for a provider to maintain a quality facility. Staff and resident morale will be detrimentally affected.

(6) **Add:** If the resident fails to comply with his/her medical or psychiatric treatment plan.

§ 2600.251. Resident records.

(b) The entries in a resident's record shall be permanent legible, dated and signed by the person making the entry **Comment:** What about the use of electronic record keeping within the HIPAA guidelines? Legibility would be greatly improved if allowed by regulations..

§ 2600.252. Content of records.

Paxton Street Home, 14

Much of this information is available in the assessment and screening forms required by the Department. These records are kept in the resident file. Why is it necessary to ask for this information again if the Department is supplying the Assessment and Screening documents to be used and they are already available in the resident file?

(5) **Suggested wording:** Dietary suggestions if known.

(8) **Suggested wording:** The documentation of physician visits and orders when known". **Comment:** Independent living individuals in a large facility often take care of their own medical appointments and have no need for assistance with setting up transportation. They do not think to let staff know when they have routine physician visits other than those prompted by the home such as MA-51 annual visits.

§ 2600.261. Classification of violations.

(b) The Department's criteria for determining the classification of violations are available from the appropriate personal care home regional field licensing office. **Comment:** The Department's criteria is outdated (last revised in 1992), punitive and unreasonable. Class 1 violations must be reserved to fit the above definition. Current criteria, if enforced, will cause confusion, frustration and economic hardship within the provider community.

**MEDICAL EVALUATION**

New  Updated

1. MA RECIPIENT NUMBER	2. NAME OF APPLICANT (Last, first, middle initial)	3. SOCIAL SECURITY NO.	4. BIRTH DATE	5. AGE	6. SEX
7. ATTENDING PHYSICIAN			8. PHYSICIAN LICENSE NUMBER		
9. EVALUATION AT (Description and code) <input style="width:50px;" type="text"/>		10. For the purpose of determining my need for TITLE XIX INPATIENT CARE, and if applicable, my need for a shelter deduction, I authorize the release of any medical information by the physician to the County Assistance Office, State Department of Public Welfare or its agents.			
01 Hospital 02 NF 03 Personal Care/Dom Care 04 Own House/Apartment 05 Other (Specify) _____		Signature - Applicant or Person Acting for Applicant		Date	

11. HEIGHT	WEIGHT	BLOOD PRESSURE	TEMPERATURE	PULSE RATE	CARDIAC RHYTHM
------------	--------	----------------	-------------	------------	----------------

12. MEDICAL SUMMARY

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13. In event of an emergency the patient can vacate the building <input type="checkbox"/> 1. Independently <input type="checkbox"/> 2. With Minimal Assistance <input type="checkbox"/> 3. With Total Assistance	14. Patient is capable of administering his/her own medications <input type="checkbox"/> 1. Self <input type="checkbox"/> 2. Under Supervision <input type="checkbox"/> 3. No
---	--

15. ICD-9-CM DIAGNOSTIC CODES

				Primary (Principal)
				Secondary
				Tertiary

16. Professional and Technical Care Needed - Check  each category that is applicable

Physical Therapy  
  Speech Therapy  
  Occupational Therapy  
  Inhalation Therapy  
  Special Dressings  
  Irrigations  
 Special Skin Care  
  Parenteral Fluids  
  Suctioning  
  Other (Specify) \_\_\_\_\_

17. PHYSICIAN ORDERS

Medications \_\_\_\_\_

Treatment \_\_\_\_\_

Rehabilitative and Restorative Services \_\_\_\_\_

Therapies \_\_\_\_\_

Diet \_\_\_\_\_

Activities \_\_\_\_\_

Social Services \_\_\_\_\_

Special Procedures for Health and Safety or to Meet Objectives \_\_\_\_\_

18. PROGNOSIS - Check <input checked="" type="checkbox"/> only one <input type="checkbox"/> 1. Stable <input type="checkbox"/> 2. Improving <input type="checkbox"/> 3. Deteriorating	19. REHABILITATION POTENTIAL - Check <input checked="" type="checkbox"/> only one <input type="checkbox"/> 1. Good <input type="checkbox"/> 2. Limited <input type="checkbox"/> 3. Poor
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**PHYSICIANS RECOMMENDATION**      To the best of my knowledge, the patient's medical condition and related needs are essentially as indicated as above.

20A. On the basis of the present medical findings the patient will eventually be able to return home or be discharged.       Yes       No      If yes, check  only one  
 1. Within 180 days       2. Over 180 days

20B. I recommend that the services and care to meet these needs can be provided at the level of care indicated - check  only one  
 NF Services       In Home/Community Services       Personal Care/Residential       ICF/MR Care       Inpatient Psychiatric Care  
 Other (Specify) \_\_\_\_\_

Physician (Printed Name) \_\_\_\_\_ Phone \_\_\_\_\_ Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

**FOR DEPARTMENT USE**

Medical and other professional personnel of the Medicaid agency or its designee MUST evaluate each applicant's or recipient's need for admission by reviewing and assessing the evaluations required by regulations.

21A. Medically Eligible <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Medically Appropriate for Waiver Services	21B. Length of Stay <input type="checkbox"/> Within 180 Days <input type="checkbox"/> Over 180 Days
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22. Comments

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Original: 2294

14-475 (461)

**Pennsylvania Community Providers Association**

2400 Park Drive  
Harrisburg, PA 17110  
717-657-7078  
717-657-3552 FAX



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To: Teleta Nevius

Fax Number: 705-6955

From: Lynn Keltz

Date: 11/4/02

Re:

---

The original will be mailed today.

NOV 14 2002  
14-475 (461)

**PCPA**

Pennsylvania  
Community  
Providers  
Association

*PCPA promotes a community-based, responsive and viable system of agencies providing quality services for individuals receiving mental health, mental retardation, addictive disease and other related human services.*

November 4, 2002

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

Dear Ms. Nevius:

On behalf of the Pennsylvania Community Providers Association, a trade association representing nearly 200 providers of mental health, mental retardation and substance abuse services, I am taking this opportunity to provide comments on the draft Personal Care Boarding Home regulations, published in the Pennsylvania Bulletin on October 5, 2002.

The definition of Personal Care Home in statute describes individuals who are able to live more independently than those persons in a licensed long-term care facility but who do need some personal assistance in their daily lives. Many residents are persons with mental retardation or mental illness. These persons, also, are obviously able to live fairly independent lives since they are living outside of state funded systems of care established through the MH/MR Act of 1966. People who have this degree of independence do not require the depth of regulation of their daily lives that is required for more vulnerable populations. The proposed regulations are needed in order to address the less professional personal care homes but it is important to note that too much regulation may reduce the number of homes available to consumers.

Consistent enforcement of the current PCH regulations would largely have prevented the need for this wholesale change of regulations. It was known in many communities that the Office of Social Programs (OSP) did not visit personal care homes and would announce visits when complaints were made. Owners and managers of personal care homes who lacked management experience and expertise in related human services fields and operated in less than a fully professional manner were able to quickly and temporarily "fix" the conditions described in complaints. The Department of Public Welfare must provide funds to hire a sufficient number of quality OSP licensing and program staff. If that were done now, the current regulations could be

enhanced, thus avoiding the upheaval to smaller PCH providers who have been providing quality, family-like services to consumers.

The comments that follow are primarily directed to training and staffing requirements and the need to adjust the training curriculums to better address consumer needs.

#### 2600.56 Staffing

(c) The requirement that the Administrator be present in the home for 20 hours per week is more stringent than is necessary. Other persons with a lesser degree of training can manage the home in the absence of the Administrator. If the designee must meet all of the qualifications and training for an administrator, their salary and benefits should be equal or very close to that of the administrator. This cost will be prohibitive for many personal care homes and was not factored into the Department of Public Welfare's mandatory cost factors.

#### 2600.57 Administrator training and orientation

(a) The requirement that a PCH Administrator's competency based training must be a department-approved training is micro management of administrator training. The PCPA members who are personal care home providers also provide services and supports licensed by the Department of Public Welfare and/or the Department of Health. They adhere to the regulations of those departments and are well aware of the education and training required by personal care home administrators and similar managers. We suggest that the regulations be changed to allow personal care home providers who are multi-service providers licensed by entities of the Departments of Public Welfare and/or Health to use other training programs that incorporate the requirements of 2600.57.

(c) (6) Mental illness and gerontology should not be combined as a training topic; they are two very specific and different areas of training. In addition, item (ii) should also be separated, as dementia and cognitive impairments are not necessarily similar and therefore should be identified separately. Mental illness and mental retardation are not the same, and should also be listed separately. The number of individuals with substance abuse problems is high in the general population; therefore education on substance abuse – basic recognition and referral information – should be listed as well.

#### .142 Physical and behavioral health

(a) Add substance abuse problems to the items included in the support plan.  
(b) Attempts should also be made to train residents about the need for mental health and drug & alcohol services in the same way that medical or dental services training is required.

(c) If a resident has a serious mental health or substance abuse problem, efforts should also be made to obtain consent for treatment.

.143 Emergency medical plan

An emergency plan should also include mental health care. Additionally, It is important that staff of personal care homes are aware of mental health commitment laws and the local contact persons for such mental health emergencies.

.225 Initial assessment and the annual assessment

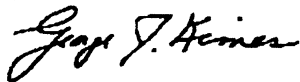
The initial and annual assessments need to include a mental health and substance abuse assessment.

.236 Administrator training

The administrator training should also include training on basic identification of substance abuse disorders and referral sources for these services.

PCPA appreciates the opportunity to provide comments on these draft regulations. We look forward to providing additional input throughout the remaining regulatory process. Please feel free to contact me if you have any questions or concerns about these comments.

Sincerely,



George J. Kimes  
Executive Director

Original: 2294

14-475  
492

**PENNSYLVANIA CATHOLIC HEALTH ASSOCIATION**

**facsimile**  
TRANSMITTAL

**to:** Teleta Nevius, Director  
 Department of Public Welfare  
 Office of Licensing and Regulatory Management

**fax #:** 717-705-6955

**re:** Proposed Rulemaking  
 55 Pa Code Chapters 2600 and 2620  
 Personal Care Homes  
 32 Pa. B. 4939 et seq. (10/5/02)

**date:** November 4, 2002

**pages:** 3, including this cover sheet.

RECEIVED  
 NOV 11 2002  
 11:17 AM  
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From the desk of...

**Sister Clare Christi Schiefer, OSF**  
 President  
 Pennsylvania Catholic Health Association  
 223 North Street  
 P. O. Box 2835  
 Harrisburg, PA17105

717/238-9613  
 Fax: 717-238-1473

Original: 2294

14-475 (497)

November 4, 2002

Teletta Nevius, Director  
Office of Licensing & Regulatory Management

Department of Public Welfare

316 Health &amp; Welfare Bldg.

PO Box 2675

Harrisburg PA 17101-2675

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, someone 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 1/2 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 25<sup>th</sup> 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**

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!

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...

(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, high 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.

**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 1/2 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

**Pennsylvania Protection and Advocacy, Inc.'s Comments  
to the Proposed Rulemaking for Personal Care Homes  
Published in the Pennsylvania Bulletin on October 5, 2002**

RECEIVED  
COMMUNITY RELATIONS  
DIVISION  
OCT 10 2002  
REVIEW COMMISSION

The comments that we offer here pertain solely to areas for which we suggest further revision to the proposed regulations. For all areas of the regulations upon which we are not herein providing comments, we offer our strongest support for their retention as is, and without diminution in response to comments from others.

First, we provide broad comments on general areas that require improvement. Then, we provide specific language suggestions for specific provisions of the regulations.

**Licensure and Enforcement**

We are appalled that these proposed regulations include NO improvements to the existing licensure and enforcement system. The proposal to switch to inspections from every year to every three years is even more frustrating. This is not the way to improve licensure and enforcement in the Commonwealth. DPW needs to improve its performance in the licensure and enforcement areas. Since it seems that half the problem with personal care homes is inadequate regulatory standards and the other half is inadequate licensure and enforcement, then the Department has missed a lot by failing to propose needed improvements in licensure and enforcement.

**Abuse and Reportable Incident Reporting**

We are horrified that the reporting of abuse or neglect or of other reportable incidents does not prompt any department investigation into the circumstances surrounding the reported conduct. In most cases, the PCH is being called on to self-identify problems and then to self-evaluate the cause with no outside input or scrutiny of potentially serious risks to resident health and safety. While it is possible that many PCHs in good conscience perform this task honestly, the public records indicate otherwise. DPW regularly finds that PCHs fail to report suspicious deaths, the arrest of an administrator, the serious bodily injury of a resident, etc. For this reason, these incidents must be reported and the report must prompt an investigation by the department and failure to report something must warrant a citation and a fine. We also believe that the list of "reportable incidents" must be expanded.

**Training, Qualifications and Staffing**

Existing staff must not simply be grandfathered and deemed to meet the new requirements. While they should not have to undergo new training programs unless they cannot demonstrate competency through the Department approved method required of new staff members, they must not be exempt from demonstrating competency, within 1 year of the effective date of the regulations.

We agree strongly that there must be a specially trained medication technician to administer medication with proven competency. Presently, direct care staff with no education requirements



and questionable literacy skills are causing untold medication errors. The onus must be placed on responsible, trained staff to insure that resident medications are taken as prescribed and that all refusals or adverse reactions are noted and reported to doctors.

### **Comments on Specific Provisions of the Regulations**

#### **2600.3 Inspections and licenses or certificates of compliance**

When, in the last draft, we pointed out the conflict between the provision of 2600.11 that allowed for inspections every 3 years and the provision of 2600.3 calling for inspection every year, we urged annual unannounced inspections. We are shocked and disturbed to see that the Department responded to this comment by eliminating the requirement of 2600.3 that inspections take place annually. This is woefully inadequate. An annual inspection requirement must be reinserted here and for 2600.11.

Thus, we suggest that 2600.3 and 2600.11 be consolidated. Additionally, the Department must add some valuable enforcement language here to improve the poor enforcement process and to be responsive to the enforcement recommendations unanimously supported by the entire Personal Care Home Advisory Committee. The new 2600.3 should read:

- (a) "An authorized agent of the Department shall conduct an unannounced on-site inspection of a personal care home at least annually"
- (b) "A certificate of compliance shall be issued to the legal entity by the Department if, after an inspection by an authorized agent of the Department, it is determined that the personal care home is in full compliance with all requirements and that the requirements for a certificate of compliance are met.
- (c) In addition to the annual inspection, the department shall inspect as often as required by 62 P.S. 211(I) and more often as necessary.
- (d) Where a violation is found, submission and compliance with an acceptable plan of correction followed by actual verified correction of violations shall be required to achieve full compliance for licensure purposes. Only a plan of correction that clearly articulates the facility's understanding of the reason for the violation, the impact or consequences of the violation and which specifically corrects the present violation and provides a process to ensure that there will not be future violations shall be accepted by the department.
- (e) An applicant for a license for a new facility shall, if in full compliance with all regulatory requirements that can be met prior to admitting residents, receive a "New Facility Full License". An applicant that is found to have violations shall not be issued a new facility license until the facility is in full compliance.
- (f) All homes shall have adequate fiscal resources to pay utilities, staff, insurance, taxes, etc. prior to licensure.
- (g) All homes shall have an adequate amount of liability insurance or bond to cover negligence and theft.

#### **2600.4 Definitions**

Abuse – Add another item (vii) Sexual contact between staff and residents.

Ancillary Staff - “Ancillary Staff are employees whose tasks do not include the provision of personal care services or direct care but can include cooking, cleaning, and other non-direct care services required in the personal care home. Ancillary staff who have completed direct care training may provide direct care services, as provided herein.”

Instrumental Activities of Daily Living – the definition has omitted several of the IADLS that exist in the current regulations at 2620.33. These should be included. (iii) should be changed to “Securing and using transportation”. And, the following should be added:

- (vi) Making and keeping appointments
- (vii) Securing health care
- (viii) Correspondence
- (ix) Care of personal possessions

Long Term Care Ombudsman – the definition is erroneous. Although charged by the Department of Aging, the LTC Ombudsman serves all residents regardless of age. Thus, the language must be changed as follows “complaints made by or on behalf of ~~elder individuals~~ residents ....”

Neglect – The Neglect definition needs to be revised to fit the PCH context. The “caretaker” in this context is the PCH, which is responsible for providing adequate housing, furnishings, and access to medical care to its residents and should absolutely not be excused from a finding of neglect based on its inability to properly provide services. Thus, the second sentence of the definition should be deleted.

Personal Care Services - Need to define personal care services as all services listed in the section of the regulations that covers, including all activities of daily living and all instrumental activities of daily living (which are referenced in the sections on personal hygiene, tasks of daily living, financial management, etc.).

Restraint – Add that mechanical restraints include, “lap trays when not being used for meal service.”

SP—Support plan – Change the “or”s to “and”s. These items must be inclusive and not an option to pick one.

Other definitions need to be added:

Designated Person – This term, from the current regulations, seems to have been collapsed in with “designee”, which formerly just referred to the administrator’s designee. Using the same term for both is confusing. “Designated person” should be retained as the term for an emergency or other family/friend, etc. contact person for a resident and “designee” should be used for the Administrator’s designee.

Home – all throughout the regulations the term “home” is used without any clarity that “home” means “licensed personal care home”

Licensee  
PCH Operator  
Personal Care Staff

**2600.5 Access requirements**

Add (d), "The personal effects of residents shall not be searched without the resident's consent."

Additionally, it is not clear why the regulations need to spell out purposes for the visit. But, if it must, then it must include the purpose of assisting residents in exercising their rights under the law.

**2600.11 Procedural requirements for Licensure or Approval of personal care homes.**

(b) is absolutely unacceptable. This provision would require inspections to take place only once every 3 years entirely contravenes the goal of the regulations, to insure health, safety, and welfare, and the goal of inspection, to insure compliance with regulations.

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

The requirement of an annual inspection must be maintained and improved upon. We have suggested consolidation of this section with 2600.3 and provided suggested language above.

**2600.13 – Maximum Capacity**

This section says that the maximum capacity set for the "personal care section" of the home. In no place is the "personal care section" of the home defined. A provider could easily view this as being distinct and separate from a "personal care + memory care section" of the home, etc. This must be defined.

**2600.14 – Fire Safety Approval**

Fire safety approval needs to be updated if the home begins to serve a resident population with different needs in addition to structural changes. Thus, if a PCH has never served persons who are blind and suddenly admits 2, unless their fire safety approval originally took into account the possibility of serving that population, they must get a new fire safety approval. Additionally, the timeframe in (c) - 30 days – is too long. 2600.14(c) must be revised as follows:

"If the building is structurally renovated or altered after the initial fire safety approval is issued or if the home begins to serve a resident population with different needs or abilities than the residents served at the time of the last fire safety approval, the home shall submit the new

first safety approval, or written certification that a new fire safety approval is not required, for the appropriate fire safety authority. This documentation needs to be submitted to the department no more than 2 weeks after completion of the structural alteration or renovation or the admission of a member of a new or different resident population ~~within 30 days of the completion of the renovation or alteration.~~”

Because buildings can deteriorate over time and fire safety standards are improved upon over time, fire safety approvals need to be renewed on a regular basis. Thus, we suggest that you add as (f): “Fire safety approvals must be renewed at least once every 3 years.”

### **2600.15 - Abuse reporting**

It is essential that any Abuse or Neglect (or complaints about abuse or neglect) be immediately brought to the attention of the Department and all others, as required by law. It is also essential that any of these items prompt immediate onsite investigations by the Department. Neither of these two essential components have been included in the proposed regulations.

Additionally, family members or legal representatives must be notified of reports of Abuse or Neglect and the personal care home must be required to immediately provide family members or legal representatives with this notice. Finally, the regulations should provide for penalties for failure to report abuse or neglect.

### **2600.16 Reportable incidents**

Abuse reporting and reportable incidents must be promptly brought to the Department’s attention and they must prompt immediate onsite complaint investigations and, where appropriate, a referral to the Ombudsman. Family members or legal representatives must also be notified of both and the personal care home must be required to swiftly provide family members or legal representatives with this notice. Additionally, the initial unusual incident reporting must be completed by using technology tools (such as phone, fax, or e-mail) that ensure an immediately notice is given.

Because it should not be up to the home to determine whether deaths are suspicious, and there is a glaring conflict of interest in asking them to report the deaths that are due to abuse, neglect, malnutrition, etc., it is essential that the department require the home to report ALL deaths. They can be reported on a one page standard fax or e-mail-able form so that the department can review the death and cause of death for anything suspicious. The same is true for hospitalizations.

(a) (1) The key issue here should be that all deaths are reported not just the ones due to the circumstances listed. This could be more clearly written by the following statement: “Any death of a resident including those due to accident, abuse, neglect, homicide, suicide, malnutrition, dehydration, or other unusual circumstances.”

(a) (3) The key issue here seems to be that any treatment at a hospital or medical facility should be reported in addition to any serious physical injury or trauma. The way it is worded, it could mean that serious physical injury, trauma or medication error only need to be reported if they

required treatment at a hospital or medical facility. Any serious physical injury or trauma needs to be reported as well as any medication error. Take out all of what was there at (3) and insert: "Any healthcare situation requiring treatment at a hospital or medical facility, not to include routine healthcare visits."

(a) (13): The sentence should begin, "An observed situation or a complaint of...."

(a) (15): After "no staff" add "or inadequate staff".

(a) General comment: 1) Any refusal to eat/drink for 48 hours, and

(c) After "designee" replace the words with, "by telephone, fax, or e-mail."

General comment: We suggest adding another item – (g) that states: The home shall inform the family members or legal representatives of residents of the occurrence of an unusual incident affecting their resident or of an unusual incident affecting all residents. This shall be done within five days of the occurrence.

Subsections (b) and (e) contemplate that the facility must investigate the reportable incident, but the regulation does not specifically state this and should be edited to do so.

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

### **2600.17 – Confidentiality**

Resident records must be made available to Pennsylvania Protection and Advocacy as well as others with legal authority to review them. The regulation must state this.

### **2600.18 Applicable health and safety laws**

At the end, add the phrase, "prior to and throughout licensure."

### **2600.19 Waivers**

The existing waiver section is problematic in that it lacks any: 1) disclosure to potential residents of any approved or pending waivers for their facility, 2) consumer right to appeal a waiver, 3) insuring that waivers are time limited and not indefinite, and 4) stating who at DPW has the authority to grant a waiver. These all must be inserted.

Additionally, the waiver section fails to capture that waivers are to be granted in exceptional circumstances only and that the burden falls on the PCH to demonstrate and reasonable and appropriate basis for being granted an exception to the regulations.

(a) (2): Replace with: "There is an alternative method for meeting the intent of the regulation."

(f) Since waivers should be the exception, they must be given an expiration date at the time of approval to ensure their periodic review.

### **2600.20 Resident funds and 2600.29 Refunds**

2600.20(a) is applicable where "the home assumes the responsibility for maintaining a resident's financial resources." Is this the same as providing financial management? If so, the term financial management should be used for clarity's sake.

2600.20(a)(1): This needs to include a requirement that the home keep receipts for any purchases made on the consumer's behalf. We have now seen too many incidents where the home's records show that purchases were made but, there are no receipts and no goods to go with the records. The first sentence should be edited as follows: "(1) A separate record of each resident's financial resources, include the dates of transactions, ..."

The first sentence of 2600.20(a)(2) should be edited as follows: "Deposits, withdrawals, and expenditures shall be documented with dated written receipts."

2600.20(a)(4): The words "if available" should be deleted. Any funds which the facility is holding for the resident must be available to be given to the resident, upon request, within 24 hours.

2600.20(a)(5) should be edited to require the home to obtain a dated written receipt from the resident for cash disbursements.

2600.20 (b)(10)-(12): There are some crossovers and inconsistencies between this section and 2600.29. Our comments relate to the timeframes in which funds and refunds must be returned to residents.

The language in these sections is unclear and, thus, hugely problematic. The primary cause of the problem is the use of "discharge or termination" as a trigger for certain actions. This is problematic because "discharge and termination" are processes and not dates certain. Thus, if the language in (11) means that within 30 days of written notice of discharge or termination, the resident shall receive an itemized written account of funds, etc... this is less objectionable than if the Department means that within 30 days of the actual date of departure resulting from a discharge or termination process.

Instead of the confusing usage of "discharge or termination" as triggers, the required actions should be triggered by the residents actual date of departure. How soon after the date of departure the PCH should be required to provide the residents funds and accounting will differ

based on whether the departure was unexpected or planned with 30 days written notice. The regulation have not accounted for circumstances we have too often seen this summer, where there is a voluntary closure, Department closure or emergency evacuation of a PCH.

In all circumstances, funds and accountings must be provided to residents far sooner than 30 days from date of departure. In most circumstances the money is needed to bury the former resident or pay a new provider, etc. Requiring the facility to return a resident's own money swiftly doesn't prevent the facility from collecting or billing for unpaid services. Additionally, a provision must be added to require any funds held by a facility to be returned to a resident upon the facility's being shut down by the Department.

Thus, in 2600.20(b)(12) The resident's funds that are being held by the home must be returned to the resident with a full accounting of funds "on or before the day of departure" not "immediately [which is not defined] upon discharge or termination". This needs to apply when the resident has given notice of moving out, when the home is being closed by the owner, and when the Department is relocating the all residents due to a licensure action. Only when there is an emergency or unanticipated departure or relocation should the home be allowed a little more time to return the clients funds. Thus, the language should be revised as follows:

(12) "Upon discharge or transfer of the resident, whether due to the termination of services by the home, the voluntary closure of the home, the decision of the resident to leave the home where the resident has provided appropriate advance notice, or licensure action of the Department to relocate the resident, the administrator shall **immediately** return the resident's funds being managed or being stored by the home to the resident on or before the day of departure."

Thus, in 2600.20(b)(10), where the resident dies, the residence should have 10 business days.

2600.20(b)(13) should be added and it should state that where the resident's departure is unanticipated or emergency departure due to change in condition or emergency relocation by a state agency, the home has 48 hours to return the residents funds.

There is a conflict between Sec 2600.20(b)(8) prohibiting an Administrator or employee from being a resident's rep payee and the definition of "financial mgt" on p. 8 which allows the administrator to be a rep payee. Because there may be circumstances in which no one else is available to be representative payee, there may be reasons where this should be allowed. However, the administrator serving as rep payee should be allowed by only if the resident, family, and legal representative are given a standardized disclosure form provided by the department that explains what Rep Payee means, that others are available to do it for free (MHA's do it, ARCs do it), that it is voluntary, that they can terminate the rep payee relationship at any time, and how to terminate the relationship. If being a rep payee is permitted by the department, this section must then include a provision that having the administrator be rep payee cannot be a condition for admission.

There needs to be a provision included that requires "the return of funds to be by cash or a good a valid check, failure to issue a valid check will be a violation of this chapter and will start the

clock on interest accrual which will accrue in the amount of 1% per day until funds are available at the bank from which the resident can obtain her monies and a valid check has been reissued.”

Lastly, 2600.20(6) has an error. It prohibits commingling of the residents “personal need allowance” and the PCH funds. This should prohibit commingling of the residents “personal funds” and the PCH funds.

#### **2600.23 – Personnel Management**

(1): The PCH should not only be required to keep records of who is/was scheduled to work but who actually showed up to work so that what staff members and what amount of staffing was really available is recorded.

#### **2600.25 Personal Hygiene**

Need to add that consumers who require assistance with clipping nails on fingers and toes shall be provided with that assistance.

#### **2600.26 – Resident/home Contract**

The Resident/home contract needs to have more clarity. The contract should be a standard contract used for all residents (thus, each home can have its own contract but, the contract should not differ in form from resident to resident). This language is in the current regs but has not been included in the proposed regulations. The section should be revised as follows:

2600.26 (a): “Prior to... The administrator or his designee is responsible for completing this contract with resident or the resident’s designee... The contract shall be signed by the administrator or his designee with authority to act on behalf of the home ... At a minimum, the contract shall specify and include the following in accordance with all requirements of this chapter:”

(a)(1)(viii): Remove the phrase, “including whether the home is designated as a smoking or nonsmoking home.” If smoking areas are properly vented, the rest of the house should be smoke-free.

(a) (1) (xi): Replace this item with the following language, “A list of personal care services that will be provided to meet the resident’s needs as identified in the assessment in the manner articulated in the support plan and the costs. A copy of the current support plan must be attached.”

#### **2600.29 – Refunds**

Similar to our comments to 2600.20, our comments relate to the timeframes in which funds and refunds must be returned to residents. The language in these sections needs to be clearer as to exactly when a resident gets his refund. The timeframes allowed in this section are too long.

#### **2600.41 Notification of rights and complaint procedures**



(c) Move the “upon admission” phrase to just behind the “resident”. This will make the phrase more meaningful.

(g) Many complaint procedures have responses within days. Two weeks is entirely unacceptable. Additionally, complaints usually occur just before or on weekends, holidays, and evening shifts. In many situations, it is important that immediate action be taken to address the problem effectively. This time should be put in hours to make that point. We suggest 48 or 72 hours, and would be very concerned if this timeline were longer.

(h) At the end of the paragraph, add the words, “near a telephone.”

#### **2600.42 Specific rights**

(b) This needs to include a right to be free from intimidation.

(e) The telephone must be accessible and available on each floor of the home. “A resident shall have private access to an accessible telephone on each floor in the home.” Also include 24-hour access with no limit on the use of the phone.

(g) That’s not 365 days but 365 days/year.

(i) Resident shall receive assistance from the home as required by the resident’s assessment ....

(m) A resident must be able to leave and return to the home at reasonable times without home rules limiting the resident’s ability to do this. Thus, the section should be revised to say “A resident shall have the right to leave and return to the home at reasonable times.”

(q) The last sentence seems to prohibit the personal care home from hiring a resident to perform work. Clarify the last sentence.

(q) Keep the first sentence and replace the rest with the following, “This does not include personal housekeeping tasks related directly to the resident’s personal space unless the personal care home provides that service.” It should be understood that staff persons would be performing their duties. The provider should have the freedom to hire a resident to perform staff tasks.

(u) For consistency, this item must be replaced with “A resident shall have a right to remain in the home, so long as it is operating with a license, except as set forth in 2600.228”.

(w) The resident must have the right to reside in the facility with continued supports pending the outcome of a complaint investigation. The resident needs to have the right to appeal discharge and termination decisions to the Department. This has many times been discussed and recommended to the Department. What good is the right to complain without retaliation if the resident cannot appeal and have the Department look into a retaliatory eviction?

Need to add:

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

(bb) A resident has the right to reasonable accommodations of his disabilities.

(cc) A resident has the right to receive assistance in applying for public funding if private funding is exhausted.

#### **2600.53 Staff titles and qualifications for administrators.**

(2) Add the phrase, “with an emphasis in human services, administration, or nursing.”

(k) should be added to state: “An administrator shall meet all the requirements of this section prior to serving as an administrator for any home.”

#### **2600.54 – Staff titles and qualifications for direct care staff**

(5) and (6) should be added, which read:

(5) “Have completed the department approved training.”

(6) “A direct care staff person shall meet all the requirements of this section prior to serving as direct care staff for any home.”

#### **2600.55 Exceptions for staff qualifications.**

(a): This is inadequate to insure the health and safety of consumers. As stated above, administrators and staff must be allowed 1 year in which to test out or be trained anew. We cannot allow under qualified required to remain under qualified just because they were under qualified at a fortuitous time. Thus, (a) must be revised to state: “The staff qualification requirements for administrator and direct care staff shall be met by all staff persons hired or promoted to the specified positions prior to the effective date of this chapter within 1 year of the effective date of these regulations. Passing the competency test devised by the department under 2600.58 will constitute satisfaction of the staff training requirements.”

(b): A direct care staff person who meets all the requirements of the regulations can have a break in service of up to a year. That is based on the fact that they met the requirements prior to the break in service. The language here allows for a break in service and return to work after 1 year even if the person never met the regulatory requirements. This is not what was agreed to and is not acceptable. If the staff person tests out, they can go back to work within 1 year and without having to sit through a training class, etc. But, this can happen if and only if the person passes the competency test.

(c) A person age 16-17 can serve as a direct care staff person (the words “direct care” have been left out of the proposed regulations) with the included limits on job function BUT only if they have satisfactorily completed the training and competency testing.

### **2600.57 Administrator training and orientation.**

(c) (2): Administrators need to be trained in how to access and assist residents in accessing healthcare through their insurance plans, especially where the resident has medical assistance. Thus, this should be added to (c)(2).

Add a (c)(9) "The Department or Department approved trainer shall measure the performance of the applicant and provide the successful applicant with a written verification of her successful completion of the training."

Add a (d)(7) "The Department trained administrator who provides the 80 hours of competency based training to the applicant shall measure the applicant-administrator's performance in a manner approved by the Department and shall provide the applicant-administrator with a written verification of her successful completion of the training."

(g) The proposed regulations mistakenly put the administrator time at 40 hours. This needs to say 140.

### **2600.58 Staff training and orientation**

Again, having "competency-based" training but no mechanism for measure competency is useless. So, language needs to be added here as well that:

For the in class portion of the training: "The Department or Department approved trainer shall measure the performance of the applicant and provide the successful applicant with a written verification of her successful completion of the training."

And, for the on-site portion of the training: "The Department trained direct care staff or administrator who provides the 12 hours of competency based training to the applicant shall measure the applicant-direct care staff's performance in a manner approved by the Department and shall provide the applicant-direct care staff person with a written verification of her successful completion of the training."

### **2600.59 Staff training plan**

In the last sentence of the first paragraph say, remove the phrase, "for developing and conducting the staff training plan".

### **2600.83 Temperature**

(b) Replace with "The indoor temperature must be a maximum of 80 degrees Fahrenheit when residents are present in the home." Air conditioning must be mandatory. Some medications do not have proper effects if the body is too warm. Additionally, moving hot air has a greater heat-effect just as moving cold air has a greater chill-factor. Further, bedrooms must be included as persons may not be able to leave their bedroom because of medical conditions.

### **2600.87 Lighting**

The lighting needs to be not only operable but in an adequate amount for safely performing the activities that are likely to be performed in the area. Thus, the sentence should be revised to add to the very end “in an amount adequate for safely performing activities in that area.”

### **2600.88 Surfaces**

Add a (c) that speaks to lead paint and asbestos that currently exists in the home. “If lead paint and/or asbestos is found in a building or contained in any part of the structure, the building must have a certification respectively from a lead paint remediation company and/or an asbestos remediation company that the building is safe for residents and the lead paint/asbestos does not pose a risk.”

### **2600.89 Water**

(a): Again, having hot and cold water under pressure for the residents is not the same as having enough to accommodate the needs of the actual residents. Thus, the sentence of (a) should be revised to read: “The home shall have hot and cold water under pressure in all bathrooms, kitchen, and laundry areas in an amount adequate to accommodate all of the needs of the residents in the home.”

### **2600.90 Communication system**

(a) Replace with, “The home shall have a working, non-coin operated, telephone system with an outside line that is accessible in emergencies. At least one phone shall be located on each floor of occupancy and shall be accessible to persons with disabilities who live on that floor.”

### **2600.95 Furniture and equipment**

Furniture must be appropriate to a home setting and comfortable. We suggest: “Furniture and equipment shall be in good repair, comfortable, clean, free of hazards, and appropriate for a home-like environment.”

### **2600.97 Elevators and stair glides.**

A valid certificate of operation does not ensure that the equipment is operational. As with smoke detectors, 1) if this equipment becomes inoperative, repair shall be completed within 48 hours of the time the equipment was found to be inoperative and 2) the home shall develop emergency procedures that will be immediately implemented until the equipment is operable. These items are important, as there may be persons who rely on that equipment daily to get around the facility.

### **2600.99 Recreation space**

The title of this section should include “equipment”.

“Recreational items” seems to indicate equipment that would encourage physical exercise. Some examples of this kind of recreational equipment must be included in this list.

### **2600.101 Resident bedrooms**

(a), (b) and (c): It has long been noted that the space afforded a resident is less than that afforded in a prison cell. (a), (b), and (c) should all be consolidated to simply state that “Each resident shall have 100 square feet of floor space measured wall to wall, including space occupied by furniture.”

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

(e) Change the 7 feet to 8 feet. The children’s regulations require at least 7½ feet. The standard for ceiling height ought to be set at 8 feet for fire safety purposes. Perhaps existing homes could be grand fathered in at 7½ and waived for less than 7½ feet.

(k) (2) If a plastic cover is used on the mattress, then there must also be a durable mattress pad for comfort.

(k) (4) Add, an operable lamp.

(n) Remove the “unless in an emergency situation” phrase. Bedrooms should be private and each resident should be encouraged not to enter another bedroom without an invitation. We would be giving a mixed message to some residents if we say it is okay to enter a room in an emergency. Further, exits must be more clearly identified than to go through someone’s bedroom.

(q) “Each bedroom must have walls and doors that extend from floor to ceiling.”

(s) Revise this to read, “In each bedroom, there should be a wall switch that is connected to at least one operable ceiling light or lamp for general lighting when entering a dark room.”

### **2600.102 Bathrooms**

(a), (b), and (c): What does the phrase, “including residents, family and personnel” mean? At the last comment period, we indicated that the ratios of fixtures were too low. This becomes more of a problem if staff persons utilize them or if a sink, toilet, and shower/tub are in one bathroom so that a person using one fixture would prohibit the use of the others.

- (a) In addition to the ratios of fixtures, there must be a minimum of two toilets.
- (b) In addition to the ratios of fixtures, there must be a minimum of two sinks.
- (c) Clearly there must have been a mistake to change this number from 8 to 15. There must be at least one bathtub or shower for every six (6) residents, similar to the children's regulations (55§3800). Additionally, each resident must be given the opportunity to bathe/shower at least once a day.

General comment: Given the current ratios in the draft regulations, there are potential problems if six residents use one bathroom (one sink, one toilet, one shower). If all fixtures are in one bathroom, then someone using one fixture would prohibit the use of the other fixtures.

Additionally, these regulations fail to require that bathrooms be accessible for residents with disabilities.

#### **2600.105 Laundry**

- (d) It must be clear that PCH staff persons are responsible for changing bedding and towels.
- (f) As the laundry service is defined in this section, the administrator should do more than just take reasonable measures, which are undefined. "The administrator must ensure that residents' clothing is not lost or misplaced in the process of laundering."
- (g) Clarify this. Was it meant to mean, "Lint is removed from all dryers at least daily"?

#### **2600.106 Swimming areas AND OTHER BODIES OF WATER**

(1) Not all applicable laws and regulations require fencing and self-closing latched gates. These two items have been shown to prevent significant numbers of accidental deaths by drowning and must be required by any personal care home that has a pool, regardless of the local regulations.

Add another item (3), "For personal care homes with more than 20 residents, there shall be a person who is certified in Red Cross Life Saving present when the pool is in use."

General comment: Although fountains and small ornamental fish ponds may not be of concern, regular ponds and lakes may be of concern. Is anything being done to address these?

#### **2600.109 Firearms and weapons.**

As a standard, "Firearms, ammunition, and weapons should be prohibited on the premises and during transportation of residents." However, if a waiver is desired, then it should meet the requirements drafted here, but these requirements should not be in regulation!

#### **2600.121 Unobstructed egress**

(a) Place a period after “unobstructed” and remove the “unless” phrase.

Why is locking a door permitted? A door has the appearance of permitting egress in an emergency. People will go toward the door to exit. If exiting to a safe area is not an option, then the door needs to be replaced with a wall or window.

There must be alarms placed on all doors of homes that house wanderers (who are not in secured units) to prompt notice of egress.

#### **2600.129 Fireplaces**

(b) These requirements should only apply to working fireplaces and must include periodic cleaning. Use the following, “The chimney and flue of a working fireplace shall be inspected and cleaned at least once a year.”

#### **2600.130 Smoke detectors and fire alarms.**

Add an item before (a): Most if not all smoke detector companies recommend a minimum of one detector on each floor, including the basement and attic, with specific directions on where to locate the detector. This general requirement should be the first item on this list.

#### **2600.133 Exit Signs**

(b): remove the phrase “if the exit or way to reach the exit is not immediately visible”. Access to all exits should be marked with readily visible signs, regardless of whether the exits or way to reach them is not immediately visible.

#### **2600.141 Resident health exam and medical care**

The health examination must be completed within 7 days of admission unless admission was sudden/unscheduled and the home needs 30 days to get the resident in to a doctor. Additionally, it is imperative that the resident’s annual health examination be completed by her own primary care physician and not by a “home” doctor.

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

(b) is a major step backwards. The requirement from 2620.34 to obtain health services for a resident has been completely eliminated. Now, the home has no obligation to insure that the resident gets needed healthcare, and this is very problematic. Saying, as is said in proposed (b) that a resident shall have access to medical care and that the home shall help arrange this if the resident needs this is not the same as requiring the home to know and recognize when a resident needs medical care and to insure that the medical care is obtained. This must be inserted in the final regulations.

#### **2600.142 Physical and behavioral health**

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

**2600.143 Emergency medical plan**

Subsection (d)(3) should be amended to require that all diagnoses be listed, as follows:

“Resident’s medical **diagnoses.**”

Subsection (d)(9) should include a resident’s health care proxy, as well as power of attorney.

**2600.144 Use of tobacco and tobacco related products**

General comment: If smoking tobacco is permitted inside, then there must be a separate room designated for smoking that is properly ventilated to prevent smoke from entering the rest of the house.

**2600.161 Nutritional adequacy.**

(b) After “well balanced meals” add, “and a minimum of two snacks, one of which shall be at bedtime”.

**2600.162 Meal preparation**

(c) These times are okay if a snack is offered at bedtime.

**2600.163 Personal hygiene for food service workers**

(a) In order to convey what is intended, replace the last “or” with “and”.

**2600.164 Withholding or forcing of food prohibited**

(b) should say, “A resident shall not be forced to eat food. All appropriate cueing shall be used to encourage and remind residents to eat and drink. Repeated or continuous (lasting 24 hours) refusal to eat or drink shall be reported to appropriate treating professional and family or legal representative.”

Add a (d) which states, “A home shall provide nutrition and hydration. If a home has a resident with cognitive impairments that affect his/her ability to eat and drink adequate amounts of food and water, then staff must be trained in proper cueing and feeding techniques.”

**2600.171 Transportation**

(a) (3) Teenage drivers are high risk for a reason. The driver of a vehicle in the children’s regulations (55§3800) is required to be 21 years of age and the driver here must meet that same standard. Additionally, at least one staff person during the transportation of residents must have direct care staff training.



Add a (d) that states, "For SSI recipients, the home shall not charge an SSI recipient for transportation to/from a medical provider. The home shall utilize the Medical Assistance Transportation Program through which the SSI recipient is entitled to reimbursement or a Para transit ride to their medical provider at no cost to the SSI recipient." This statement will prevent the Department from assisting a provider in balance billing an MA recipient, which is in contravention of the state and federal laws.

#### **2600.181 Self-Administration**

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

Subsection (e) takes a step in the right direction by attempting to define when a resident is capable of self-administration. It is unclear, however, whether this subsection is describing a resident who is capable of self-administering medications without assistance (and who could therefore store their medications in their own room) or one who needs assistance from staff. In addition, it is not clear what the "examples" given in the last sentence are meant to be examples of. The "examples" all address whether the resident is physically capable of ingesting or applying a medication, not whether he or she can understand the purpose and dosage, etc. of the medication, which the previous section addresses. This provision must make clear that a resident who is capable of placing a pill in his mouth and swallowing, but has no idea what the purpose of the medication is, is not "capable of self-administering medication".

#### **2600.184 Accountability of medication and controlled substances**

At 2600.184 the home should be required "to obtain medications for residents and keep an adequate supply of resident medication on hand at all times".

#### **2600.185 Use of medications**

An additional provision should be added stating that medications may only be administered to the resident for whom they were prescribed. There have been instances of facility staff purposely giving a resident another resident's medication.

#### **2600.186 – Medication records**

Subsection (b) should include the condition, which each medication is intended to treat.

#### **2600.224 Pre-Admission Screening Tool**

The Pre-Admission Screening tool should still be a department approved/provided form. The pre-admission screening must include a mobility assessment, as has always been required. Add, "The pre-admission screening instrument will be provided by the Department and provide basic information about the person and the suitability of the home to provide care for that person. Copies of this instrument are available from the appropriate PCH licensing field office."

#### **2600.225 Initial Assessment and Annual Assessment**

The assessments should be done within 72 hours of a discharge from hospital or of notice of change of condition. Thus, (d)(2) and (4) should be revised to reflect this.

#### **2600.226 Development of the support plan**

Until the support plan is complete, services must be provided as articulated in the assessment. It makes tremendous sense so that all staff know what the resident's needs are from the beginning and can sufficiently meet them.

(a) For some residents, having a support plan immediately in place is key to their survival. Change this item to the following statement: "This plan shall also be revised within 72 hours of completion of the annual assessment or upon any changes in the level of functioning of the resident as indicated on the assessment. It shall articulate how all of the needs identified in the resident's current assessment including their personal care needs will be met. The support plan shall be attached to or incorporated into and serve as a part of the resident/home contract."

(b) All three entities (resident, resident's family, and advocate) shall be informed. The use of the word "or" permits a choice of who is informed.

(c) If the resident's family declines to participate or cannot attend meetings to develop the support plan, then the reason shall be documented. We need to further delineate "reasonable efforts", as interested family members may work when meetings are typically scheduled. The meetings must be scheduled jointly with those who plan to attend.

#### **2600.227 Copies of the support plan**

Copies of support plan must also be attached to the contract so that something that is binding articulates what services the resident needs and is supposed to be receiving as well as how and when they are supposed to be receiving them.

The home shall make a copy of the support plan for the resident and for the participants in the development of the support plan. A copy of the current plan will be maintained in the resident's records and available to the resident on request.

#### **2600.228 Notification of Termination**

Subsection (a) should be amended to provide that “A resident shall have the right to request and receive assistance from the facility in relocating...”.

This section needs to be clearer that a home cannot charge a resident for more than the 30 day notice period and should have a provision that exempts the resident from paying the full 30 days where the resident is intimidated, threatened, or coerced to leave early. Thus, the language from 2620.26(c) should be reinserted and improved upon as follows:

” The administrator may require a 30-day prior written notice from a resident who chooses to leave the home. The resident may be charged for up to 30 days of rent and personal care services after the date of the notice whether or not the resident remains in the home for the entire period. However, no rent shall be charged after the date of departure if the resident complains of and the Department finds that the resident’s departure has been the result of coercion or intimidation to leave early or the result of a reduction in or a denial of personal care services.”

(a) should be revised to read “A resident/their designated person shall ...”

(b) should be revised to read “... a 30 day advance written notice to the resident and the resident’s designated person”.

We need to protect the resident against being relocated to an inappropriate setting. Thus, the regulations must include the language of 2620.27(2) that has been omitted. This language, in cases where the resident is a danger to self or others, calls for the administrator to take appropriate steps to protect the other residents while insuring that the dangerous resident is served until appropriately relocated. This language needs to be reinserted.

Section (f) needs to be revised to make it clear that a Department closure gives rise to the same relocation assistance as does a voluntary closure. Additionally, it needs to be revised to make clear that the administrator shall not interfere with the relocation process. Thus, the language should be revised as follows:

“If the legal entity chooses to voluntarily close the home or the Department has prevailed in legal action to close the home....Each resident shall .... These procedures shall .... Neither the legal entity, administrator, nor staff shall be involved in or interfere in the relocation efforts.”

Section (h)(3) needs to be revised to be clear that the change to a resident’s needs must be confirmed by the resident’s physician or the area agency on aging and cannot be solely left to the determination of the home. This was in 2620.27 and has been omitted here. Additionally, it is unclear how the resident’s functional level could have “advanced” such that the home cannot meet his needs. “Advanced” implies an improvement. The use of this word is not clear and not necessary. Thus, this should be revised as follows:

“If a resident’s functional level has declined such that the resident’s physician or a local appropriate assessment agency has confirmed that the resident’s needs cannot be met in the facility ....”

Section (h)(5) needs to be amended to track with the resident's right to remain in the home unless she has "failed to pay after reasonable documented efforts by the home to obtain payment." This is language to protect against a resident who is being evicted for failure to pay but was never made aware of monies that were owed. This language was added to the resident's rights section but needs to be included here as well.

## **SECURED UNIT REQUIREMENTS**

### **2600.229 Secured unit requirements**

General comment: It is not clear that these requirements are "in addition" to the other requirements. Additionally, none of these provisions must be waived. Statements must be added to reflect these two items.

Somewhere in this section it is important to state, "In secured units, substances which could be dangerous to a resident if ingested shall be locked up."

The section should begin with a paragraph saying that: "Secured Units to serve residents with confirmed cognitive impairments and a need for restrictions on their mobility are permissible for homes that meet all licensure requirements of this chapter and this section. Prior to opening or operating a secured unit, the Department shall confirm that all requirements are met and certify in writing that the home has met the requirements and is authorized to operate a secured unit."

### **2600.231 Doors, locks and alarms**

(1) needs to expressly state that there must be adequate wandering space. "Exercise" space implies a designated exercise or gym area. The reality is that persons with cognitive impairments are prone to wandering and need adequate open space in which to safely do this.

### **2600.232 Environmental standards.**

(4) This need to be further delineated or clarified. One option is to say – "The home shall provide a full description of the adaptive devices and equipment to be utilized for the resident population to enhance environmental awareness, such as but not limited to: Braille on railings, audio aides, shaker beds, large numbered or pictured telephone buttons, etc."

### **2600.237 Staff training on dementia**

This section should specify how many additional hours of orientation and training must be completed.

### **2600.240 Notification to Department**

There are many problems in this section. Of primary objection is the implication that these units can be opened and operated simply by submitting a "notice" to the department that the home is opening and operating such a unit. This must be seriously rewritten to make clear that the home

must submit a “request for approval of secured unit” and that the department must come out and inspect and find that the home meets all the requirements of this chapter and section and affirmatively grants approval for the home to open and operate a secured unit.

(1) should read, “60 day prior to desired date of the secured unit becoming operational for the first time, the legal entity shall submit to the appropriate Department Regional Office in writing a request for approval of secured unit indicating the home’s need or desire to implement a secured unit within the home.”

(2) should read, “If the home makes any later changes to an approved secured unit...”

(3) should read, “The following document shall be included in the written request for approval of secured unit”

General comment: The home that operates a secured unit must be required to disclose to potential residents and their families or legal representatives what requirements the department imposes, proof/verification that the home meets these requirements, a description of what services the home provides and of what safety mechanisms are in place for the secured unit to protect the health and safety of the cognitively impaired residents.

#### **2600.241 Mobility Standards**

(c): There is no reasonable explanation for why the home could need or should be provided 30 days to notify the licensing office that a resident who is immobile has moved in. The home should have 72 hours to fax a standardized notice form and the department can then decide whether it wants to come out and check that all the different and additional requirements for serving residents who are immobile have been met.

#### **2600.251 Resident records**

(1) This timeframe for maintaining records is inadequate in light of legal rights of residents. While, generally, a resident has 2 years to sue for a tort, he/she has 7 years to sue over breach of contract. Thus, for a facility to be able to demolish all records before 7 years has passed would be to allow facilities to obviate legal duties they otherwise have to retain those documents. This section needs to be revised to make the minimum 7 years and the maximum 8 years.

#### **2600.252 Content of records**

(a)(3) The photograph must be no more than a year old. People’s looks change

(b) Add a number (9): This section must include information on the resident’s dentist and other specialty doctors that the resident uses (e.g., cardiologist, neurologist, pulmonary specialist, ophthalmologist, allergist, audiologist, oncologist, dermatologist, surgeons, etc.)

#### **2600.253 Record retention and disposal**

(b) and (c) One item should speak to how long records must be kept and the other item should speak to when and under what conditions the records must be destroyed. There is a potential conflict between these two items. Clarification is needed. What happens if an audit or litigation is finished after two years? We suggest:

(b) The resident's record shall be maintained for a minimum of 7 years following the resident's discharge from the home.

(c) The resident's record will be destroyed 8 years after their discharge from the home. If at the end of 8 years, there is any unresolved audit or litigation; then the record will be destroyed 6 months after any audit or litigation is resolved.

#### **2600.262 Penalties**

(b) through (g): These items need to be written more clearly. There should be a separate item for each class that describes the penalties.

(c) Remove the sentence, "This time period may be extended for good cause."

(g) Remove the word "may" and replace it with "will".

## IRRC

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**From:** Larree Beilharz [LBEILHARZ@ppainc.org]  
**Sent:** Monday, November 04, 2002 3:35 PM  
**To:** IRRC  
**Subject:** Comments to the Proposed Rulemaking for Personal Care Homes



Comments to  
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Attached are PP&A, Inc.'s comments on the proposed rulemaking for personal care home regulations.

<<Comments to Proposed Rulemaking PCH.doc>>

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Original: 2294

14-475 (496)

PO Box 689  
Duncansville PA 16635  
814-695-1665

# Blair County Area Providers Association

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 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 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.

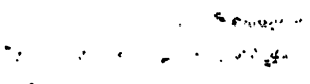
Our provider organization represents more than 100 personal care homes. Some of our homes represent the small basic personal care home (Mom & Pop) and other are much larger and provide a wide range of services. What is needed is to recognize each home for their potential and to



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?

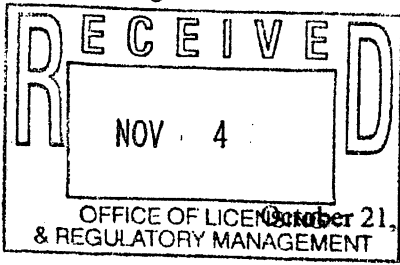
Sincerely,



Neil A Robertson  
President, BCAP

Original: 2294

14-475 (383)



NOV 7 2002  
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REGISTRY  
COMMISSION

Teleta Nevious, Director  
Dept. Of Public Welfare  
Room 316  
Health and Welfare Building  
P.O. Box 2675  
Harrisburg, PA 17120

IRRC  
333 Market Street  
14<sup>th</sup> Floor  
Harrisburg, PA 17101

Senator Harold Mowery, Chairman  
PA Senate Public Health and Welfare  
Committee  
Senate District 31  
Senate Box 203031  
Harrisburg, PA 17120-3031

George Kinney, Chairman  
PA House of Representatives  
Health and Human Services  
Committee  
Room 108  
Ryan Office Building  
Harrisburg, PA 17120-2020

Dear Ms. Nevious, IRRC, Senator Mowery and Mr. Kinney,

I am writing because someone I care about resides in a personal care home. My loved one is unable to live independently, but is not in need of nursing home care. The personal care home provides my loved one with the support and assistance they need while still encourages them to be as independent as possible.

I have been advised about the proposed changes in the regulations and this has caused me great concern. We have been happy with the care that is being provided and as you know, care is expensive. I am concerned that many of these proposed changes are excessive and undoubtedly will result in even more expense to the residents residing in personal care homes because of the cost to the facility of implementing these changes. Many residents residing in this home are not in a position to bear any more expense.

I am requesting that the proposed regulations be stopped and that the Department of Public Welfare work with personal care home operators, employees, residents and families and they be given an opportunity to make suggestions and come to a reasonable and agreeable set of regulations.

Sincerely,

Address:

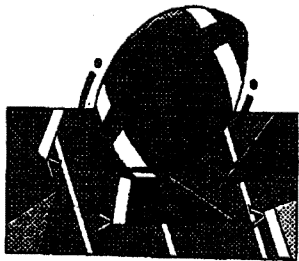


Patricia Weitz  
2165 Leach Rd.  
Linesville, PA 16424-3317

Original: 2294

14-475 (467)  
'Same Commenter  
as # 1''

**WINDSOR PLACE**  
**A FOSNIGHT HARVEY ASSISTED**  
**LIVING FACILITY**  
**ONE WINDSOR WAY**  
**PITTSBURGH, PA 15237**  
**(412) 364-6411**  
**(412)318-2077 FAX**



Go North Hills and Pine Ridge



TO: Teleta Nevins / OLRM

FAX #: 717-705 6955

FROM: Synn Fosnight

# PAGES INCLUDING COVER SHEET: 9

DATE: 11/4/02

MESSAGE: Please find enclosed my suggestions  
to 2600. Hard copy is in the mail but I  
wasn't sure if you would get it today  
& I know this needs in today

TY



*Lynn H. Fosnight R.N.  
Administrator*

**WINDSOR PLACE**  
**A FOSNIGHT HARVEY ASSISTED LIVING FACILITY**

Ms. Teleta Nevius, Director  
Office of Licensing and Regulatory Management  
Health and Welfare Building, Room 623  
Commonwealth and Forster Streets  
Harrisburg, PA 17105

November 1, 2002

Dear Ms. Nevius,

I am writing to you again today concerning the proposed regulations for Personal Care Homes, (PCH's), in Pennsylvania, 55 PA Code, Chapter 2600. As you know you or Ellen and I have met multiple times over the past year to discuss these regulations. We had you to our two PCH's in Western Pennsylvania to meet the residents and employees. I spoke to you, along with many others, about the problems with the drafts done before this draft and offered solutions of how to make these regulations ones that ensured the health, safety and welfare for all residents in Pennsylvania. In fact, I heard you say over and over, "That is a good idea we will change that in the draft we are submitting to the Governor. Ellen write that down." Unfortunately, Ellen's notes got lost or you forgot what it was you thought were good ideas because NOT ONE of the suggestions made can be found in the current published draft!!! I feel as if I have wasted 1 1/2 years of my life and very valuable time talking with you, it is appalling how you have ignored the suggestions of so many people.

Again I will try to put my comments and suggestions into writing.

1. The Personal Care Home industry is a private pay industry. We do not receive money from the government to carry through any of the mandates in these regulations. Our cost analysis to enact these regulations for our homes would be a monthly increase to each resident of approximately \$680.00 to our home of 32 beds and \$217.60 for our home with 100 beds! Where are they to come up with this money? Where would you come up with it?
2. 2600.14 - How does one write a written fire safety approval and who issues it? This

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is very ambiguous and needs a lot more definition for anyone to be able to do successfully. This also was not in any previous draft – where did it come from?

3. 2600.20 – Resident funds. Subsection (b), point 4 – The protection of resident's funds is extremely important. If a home were to allow access to \$10.00 for each resident on a daily basis, this means Saturday and Sunday too, you are creating an environment that is ripe for theft. If you want the money protected in a manner that would ensure that theft does not occur, and allow the administrator time off, Monday through Friday is sensible. For instance if we managed money in our home that has 100 beds we would need to have \$2000.00 available every Saturday and Sunday to be given to the resident. Where could this be done safely? The more people who know the combination to a safe or who have keys to a locked office, the greater the chance of theft. This should be taken out and allow access to monies only M-F.
4. 2600.29 – Refunds. Subsection (d) – Our current contract does not give refunds upon death, this is clearly spelled out and explained to the resident and family. This is a private pay business and we should have the right to make our contract as we want. This allows the consumer to decide whether he wants to go to my home with this clause or go to another home that might not have this clause. I do not feel it is up to regulations to decide how refunds occur upon death. Apartments do not refund upon death, why should PCH's?
5. 2600.32 – Specific Rights. Subsection (i) and (j) – who is to do this? Is the PCH responsible and if so how is it to be paid for? Is the family/POA? Like many of these subsections they are unclear and will require a set of interpretive guidelines to enact. This is something that providers and inspectors feel must be avoided at all costs.
6. 2600.53 – Staff titles and qualifications for administrators. Subsection (a) must include subsection (d) as its first point. The cost of only having an RN, LPN, NHA or someone with an Associate Degree or 60 hours of college credit as the only means for being an administrator is phenomenal. First there are not enough RN's or LPN's available to work in hospitals and nursing homes – how are they to be found and compensated to work in PCH's? Second you are excluding individuals who are bright from climbing the ladder in a company. By going to the training and passing the competency test they will demonstrate their ability to perform the duties necessary to be an administrator. Please revisit your thinking in this area.
7. 2600.54 – Staff titles and qualifications for direct care staff. Point (1) does not allow for 16 and 17 year olds to be direct care staff. They are currently allowed to be in the 2620 regulations. Ms Nevius you sat and talked with several of our 16 and 17 year old staff and they expressed over and over to you how much they loved their job and to please not take the opportunity away from them or future 16 and 17 year olds. Several of them told you how because of this job they are now going to be nurses. If they had not be given this opportunity they would not be thinking of nursing for a career. They bathe and toilet our residents of both sexes and expressed to you they do not have a problem with this. Our residents have expressed how important it is to them to have these "young ones" around as they are a connection to the outside world in a unique way that our other employees do not provide. Our residents love to see the tattoos and piercings they have gotten. They enjoy their loving and giving

attitude. Please do not take these kids away from the elderly. I know you allow the 16 and 17 year olds to work in other areas of the home, however, it is during the one on one contact between the resident and the caretaker that relationships are established that allow for the free flow of conversation and showing of the tattoos and piercings! Point (2) does not take into consideration that there are many people who dropped out of school for many varied reasons who are capable to care for residents in PCH's. The competency based training should determine if a person is capable to work in a PCH, not their age or diploma or GED. We do however agree strongly that 16 and 17 year olds should not be performing tasks relating to medication administration.

8. 2600.57 – Administrator training and orientation. Bravo for adding competency based training and for increasing the hours in class. However I would like to point out that you had agreed that subsection (e), the 24 hours of annual training was excessive and would be changed to 12 hours. NHA need 48 hours in two years, they deal with an elderly population that is frailer, sicker and in need of skilled care. PCH's do not. The hours of training should not correspond to NHA. 12 hours is sufficient.
9. 2600.58 – Staff training and orientation. Subsection (c) states that prior to direct contact with residents they must complete and pass competency based training. I wholeheartedly support competency based training however, there MUST be time for supervised direct care and in class training at the same time. I say this because there are many people that I have hired who have stated unequivocally that they are able to change adult briefs, clean up vomit and bathe elderly residents. Unfortunately when it came time to actually do this they could not do it – the heart was willing but the stomach was not. Time is valuable and wasting hours in class before it is determined the ability to tolerate all aspects of the job is useless. Training must be combined – supervised on hands with in class is vital. The resident pays the employees salaries. If they only stay long enough for in class training and find out that on hands they cannot do the job, the resident has paid for nothing.
10. 2600.60 – Individual staff training plan. This section is overkill. If a staff training plan is in place why would one have to be written for each individual employee? This is wasteful of time and money – again who is to pay for this but the resident.
11. Physical Site – is a section with subsections. However there is not grandfathering of existing homes present. Grandfathering of existing structures must be written in these regulations or you will be putting several homes out of business. Please add this.
12. 2600.85 – Sanitation. Subsection (d) does not make sense for bathrooms. PCH's are residential homes. Our bathrooms are like yours at home. We do not have covered trash receptacles under the sinks, and I am sure you do not have them in your home. The cost for this in our 2 homes alone would be approximately \$2,000.00. This is unnecessary and wasteful of the residents money.
13. 2600.94 – Landings and stairs. Subsection (a), a landing of 3 feet by 3 feet must allow for grandfathering of existing landings. Otherwise current homes would be out of compliance and will not be able to operate displacing residents from their home all across Pennsylvania.
14. 2600.101 – Resident bedrooms. Subsection (c) must allow for grandfathering of existing homes. If this is what you would like for new construction I see no problem.

- 2600.101 continued. Subsection (k), point 1 and 2. These two points contradict each other. Is the mattress to be fire retardant and plastic covered? Again I stress that PCH's are homes and if smoking is not allowed in the bedrooms a fire retardant mattress is expensive and unnecessary. Plastic covered mattresses do make sense though to prevent infection and to protect the mattress if it would become soiled. Subsection (r) leaves the door wide open for interpretative guidelines again. What constitutes a "comfortable chair"? Who is to supply the chair if the PCH supplies one that the resident decides is not comfortable? I feel this line should be taken out.
15. 2600.102 - Bathrooms. Subsection (a) Supplying toilets at a ratio of 1/6 for visitors and for staff is not reasonable for regulations. Our purpose is to provide for the residents. Again this is an area that must be grandfathered as there are considerable PCH's that would not meet this ratio. This is also something brand new that never appeared in any of the other drafts - where did this come from and what purpose does it serve? Current 2620 ratio is 1/6 for the residents and this is more than sufficient. Subsection (c) states that the ratio for bathtubs should be 1/15 and again include family and personnel - WHY would we be supplying a bathtub for staff and family - surely this was a joke?!? Please refer to Chapter 2620 for the ratio there as it only applies to residents and is sufficient. Subsection (c) states that toiletry items are to be made available. By whom? If the PCH is responsible for these items that would increase the monthly cost to the resident. Chapter 2620 does not require the PCH to supply these items and neither should 2600.
16. 2600.107 - Internal and external disasters. Subsection (a) states that emergency procedures shall be developed and approved by qualified fire, safety and local emergency management offices. This is not written very clearly. Who is to develop these procedures? Who is a qualified fire, safety and local emergency management office and where are they? This could be costly if we are paying someone to write these and approve them. Subsection (b) asks for this plan to be reviewed and approved by these same offices, what is the cost for this? Again I remind you that the only place for money to come from is the resident as there is no funding from the government for these mandates. Subsection (c), point 4 seems to be space prohibitive. For our 100 bed home the amount of just water to be on hand would need a tremendous amount of space. Many PCH's are residential homes and would never have the space available. May be it is more reasonable to have a one day supply of water and non-perishables on hand. And point 5 although in practice sounds nice is not always able to be done. For one thing many of us have medications supplied in special packaging for each resident. When you are getting close to the end of the cycle they have been prepackaged for you would not have 3 days on hand. Insurance would not pay for 3 days of medications just to be on hand and with medication changes this would be extremely costly to the resident, we are not nursing homes or hospitals where insurance covers the cost of the medication. This point needs to be dropped, the intention was good but it is not practical.
17. 2600.132 - Fire Drills. Subsection (d). PCH's provide care for mostly elderly residents many of whom use a walker to aide ambulation. This subsection requires the home to be evacuated in 2 1/2 minutes! Current 2620 requires the home to be evacuated in 5 minutes.

Five minutes is a reasonable time for elderly residents to accomplish an evacuation. 2 ½ minutes is not. Residents will be rushed and falls are more likely to occur. It seems to me that fire drills are most important for the staff to be knowledgeable about. They are the ones who must react quickly and calmly to direct the residents. Nursing homes and hospitals do mock drills that the staff participates in not the patients. This makes the most sense to me also. I would like to see you change this section to mock drills performed by staff. Subsection (h) needs to be dropped. You have written that residents must go outside the building each fire drill. We are dealing with mainly elderly residents who cannot endure the cold, would fall easily on the ice, would get soaking wet if it is raining, would not be able to endure the heat from the sun unprotected, etc. I am sure you did not think this sentence through. Schools do not evacuate outside in inclement weather and neither should residents of PCH's. This again shows a lack of understanding on your part of who you are dealing with and a provision that does not provide for the safety, health and welfare of the residents. Again I would suggest that the current 2620 regulations are adequate for PCH's.

18. 2600.141 Resident health exam and medical care. Subsection (a), point 7. The doctor will not write, as I have told you before, contraindicated medication and possible side effects for each medication. The pharmacy will supply this if needed. The doctor does need to write the medication regime, remove the rest. Point 8 - I don't know what you mean and when I asked our house physicians they did not either. Please remove.
19. 2600.161 - Nutritional adequacy. Subsection (c) You might want to add to the end of the sentence if permitted by the physician. If a resident is obese it is not in their best interest necessarily to give added portions. Subsection (g) You require beverages to be offered every 2 hours. There are a couple of problems with this. First, some residents are on fluid restrictions and this would not be healthy for them. Second, you do not specify during waking hours this is to be done - please tell me you do not want them to be woken every 2 hours and offered something to drink?!? Third, in order for a beverage to be offered every 2 hours to each resident I would have to hire another staff person just to do this each shift. This means an additional \$180.00/day or \$5,400.00/month. Residents of PCH's are for the most part able to speak and ask for a drink. This regulation needs dropped.
20. 2600.162 - Meal preparation. Subsection (f). During the summer we do serve cold plates for a meal. This might be a fruit plate with cottage cheese, a plate of tuna/chicken/egg salad with crackers, or sandwiches, chips and cold beets or baked beans. These are healthy meals. On hot days the residents enjoy this. This subsection although good intentioned misses the mark. Perhaps on a daily basis one of the three meals should have hot and cold foods. I would add another Subsection and this would (n) that states: "In the event a menu must be changed, effort to convey the change must be made to the residents one hour before the meal time." This would allow for the resident to ask for something else and have it prepared in time for the meal and also it allows for the fact that there are things that could happen with the food that is unavoidable - for instance something could be burned by accident, or something might have spoiled before it was to be used (such as



- vegetables or fruits) or a recipe might just be a flop. It is more important for the food to be nutritious and prepared appetizingly than for the menu to be correct at all times.
21. 2600.171 - Transportation. Subsection (a), point 4 states the driver of the vehicle cannot be a resident, First of all we are not to violate resident rights. A resident has the right to leave and return to the home (see section 2600.32 subsection (m)). We cannot stop them from riding in the car with another resident if that is what they want to do. We are not the police. This needs dropped form the regulations.
  22. 2600.181 - Medications. First I think it is a necessity to add to this section a medication tech provision. It is a fact that most homes are administering medications not assisting with medications and to pretend otherwise is foolish. A subcommittee of the PCH Advisory Committee is working on a program now. Subsection (e) is confusing. Are you saying if a resident cannot recognize and distinguish medication, know why they are taking it, know the dose and when it is to be taken and be able to do the examples outlined in the subsection would require an RN, LPN, CRNP, MD, DMD, EMT, or a PA must be present to give the medications? If so the cost of this regulation will put all small PCH's out of business as they cannot afford to have one of these people on 24 hours a day. There are a lot of medications that are given on each shift so 24 hour coverage is not an inflammatory statement. The cost to have an LPN on 24 hours would be \$336.00/day or \$10,080/month at a conservative \$14.00/hour. This mandate again can only be paid for by the resident as PCH's do not receive funding from the government. Could you afford to pay this increase Ms. Nevius? Also where do you propose PCH's would find nurses to work? There is a nursing shortage all across Pennsylvania and all across the USA. This section needs rewritten.
  23. 2600.182 - Storage and disposal of medications and medical supplies. Again I bring to your attention Subsection (d) that reads "Prescription, OTC, and CAM shall be stored separately." I have shown this to our pharmacist, to friends who are pharmacists, to doctors, to other nurses and to physician assistants and they agree that this regulation makes absolutely no sense at all. These things do not need to be stored separately and if they are will probably cause medication errors if someone has to look three or more places for medications. I know I have explained this to you before and you verbalized understanding of my explanation - but you left this in. Again I question why you asked for comments if you did not take the time to understand and include them in this draft. This must be changed for the safety, health and welfare of the resident. Subsection (g) again separates things that do not need to be separated - antiseptics and external use medications should not be stored separately. A lot of homes have medications carts that are supplied by the pharmacy and these are set up to keep all medications for each resident in a drawer/bin for that person. It is not practical to separate. Hospitals and nursing homes do not separate these things out.
  24. 2600.186 - Medication Record. Subsection (b), points 2 and 3. It was suggested to you several times that it would be unnecessary to have with each residents medication record the possible side effects and contraindicated medications. It would be most efficient to require that each medication area have a drug reference book present that describes the

- different dosages the medication comes in, route, side effects and contraindications in it. This allows for ease of use and is a sensible solution. Subsection (d) sounds like a good idea but as we told you before is not practical. The physician does not want called or faxed at the end of each shift concerning refused medications. They do not have the time or the staff available to take the messages daily. I ran this by both our house physicians and they felt that a list could be kept of refusals and given to them when they make rounds. This would seem to be a sensible suggestion and would provide for the health safety and welfare of the resident.
25. 2600.201 - Safe Management Techniques. Subsection (a) and (b) are not really necessary for PCH's in general. They could be used in homes maybe that have special populations - like head injuries. I don't really see the need for this section with the elderly population. Also on costing out having someone trained in safe management techniques teaching a course I found that for teachers in VA this course involves 16 hours of training. The instructor teaches 15 in a class and her cost to give the seminar is \$800.00 for the 16 hours. We have 98 direct care staff in our two homes. This would mean 7 classes at \$5,600.00 for the instructor and at \$7.50/hour for each employee's wages to attend the seminar a cost of \$60/day or \$120/2 days for the course times 98 employees = \$11,760.00 just for this section. Unless you know of someone who does this for free the resident cannot absorb this \$17,360.00 course.
  26. 2600.223 - Description of services. I am not sure I understand this section at all. This section needs clarified and defined before it can truly be commented on.
  27. 2600.225 - Initial assessment and the annual assessment. Subsection (b) does not specify who is to do this assessment. Is this just a questionnaire that the administrator asks the resident? Most administrators are not trained to do a medical, social, medication and psychological assessment. This section needs clarified as to what is involved or required.
  28. 2600.226 - Development of the support plan. PCH's are not nursing homes or hospitals. This document does not belong in a PCH. PCH's do not have case managers, social workers, or doctors on staff. This section needs deleted.
  29. 2600.228 - Notification of termination. Subsection (h), an additional grounds for discharge needs to be added. I suggest a point 7 be added - If a resident causes another resident to have a loss of control over their own environment. For instance if a resident screams all night or day and causes another resident to lose sleep a 30 day notice can be given to the resident who screams.
  30. 2600.229 - Secured unit requirements. There does not appear to be a grandfather clause to this section and that needs to be added. The entire section seems to be way over done in its requirements - the admission standards and care standards for example. The administrator training added to this section seems to me should be part of the initial training for all administrators not just for secured units. The staff training also should be for all staff as dementia residents do live in PCH's that do not have a secured unit.
  31. 2600.241 - Resident records. Subsection (c) should add at the end of the sentence or forms developed by the PCH which include all the information necessary.
  32. Enforcement - The PCH Advisory Committee submitted a lengthy paper on enforcement

Page 8

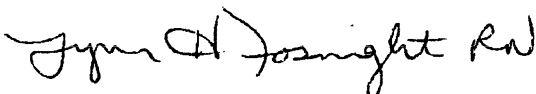
to Secretary Houstoun early in 2002, (we have never heard from her whether she liked/disliked, approved/disapproved, or in any way wanted to initiate any of the suggestions made. This document was given to her at least 8 months ago. It strengthened and enlarged the current 2620 regulations. I would like to suggest that this document be added to enforcement as written in 2600.

33. 2600.254 - Policies, plans, and procedures of the home. I believe there are approximately 30 policies and procedures to be written for the PCH in this draft of 2600. Although this may look great on paper it is not great. First it will take people away from caring for residents if they must be writing, updating and reviewing them. Second, although you can purchase some of these things from companies such as Briggs, they are not inexpensive and do not come personalized to each PCH. Time and purchasing cost money. Where is it to come from?

I know you spent a lot of time and energy writing and working with these draft regulation. I know your heart was in the right place, but like the direct care staff who wants to work the job but cannot do it because their stomach won't allow it, you had not done hands on care for a resident so how could you write regulations for it? Unfortunately the system was flawed from the beginning by not having any PCH providers or any residents at the table when they were being written. Instead they were written by people who do not do the care or live in the PCH's so therefore do not have a working knowledge of the ins and outs of PCH's. I respectfully ask you to stop the process of getting these regulations initiated and ask you to start over. I would be most interested in sitting in on writing a new draft and I know there are other providers who would be also. Residents/or their families would also like to participate in the writing of a new draft.

Thank you for your consideration of my comments, hopefully this time some of them will be initiated.

Sincerely,



Lynn H. Fosnight RN  
Administrator

cc: IRRC, Governor Mark Schweiker, The Honorable Hal Mowery, The Honorable George Kinney, The Honorable Tim Murphy, The Honorable Jane Clare Orie, The Honorable David Mayernik, The Honorable Mike Turzai, Secretary Feather Houstoun, and Deputy Secretary William Gannon



Original: 2294

14-475 (500)

# VINCENTIAN HOME

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[REDACTED]	
<b>TO:</b>	Dept. of Public Welfare
<b>ATTENTION:</b>	Teleta Nevius
<b>FROM:</b>	Sr. Anne Kuhl, V.S.C., N.H.A.
<b>DATE:</b>	11-4-02
<b>FAX NUMBER:</b>	1-717-705-6955
<b>NO. OF PAGES: (INCL. COVER)</b>	3

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