

# Regulatory Analysis Form

(Completed by Promulgating Agency)



# IRRC

Independent Regulatory Review Commission

## SECTION I: PROFILE

(1) Agency:

Department of Public Welfare

(2) Agency Number: 14-514

Identification Number:

IRRC Number: 2712

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3:10 pm

INDEPENDENT REGULATORY  
REVIEW COMMISSION

(3) Short Title:

Assisted Living Residences

(4) PA Code Cite:

55 Pa. Code Chapter 2800

(5) Agency Contacts (List Telephone Number, Address, Fax Number and Email Address):

Primary Contact: Jennifer Burnett (717) 783-1550 Fax (717) 772-2527 jenburnett@state.pa.us  
Deputy Secretary, Office of Long-Term Living, Forum Place, 555 Walnut St., Harrisburg, PA 17101

Secondary Contact: Elaine Smith (717) 346-9168 Fax (717) 772-2527 elasmith@state.pa.us  
Bureau of Policy and Strategic Planning, Forum Place, 555 Walnut St., Harrisburg, PA 17101

(6) Primary Contact for Public Comments (List Telephone Number, Address, Fax Number and Email Address) – Complete if different from #5:

(All Comments will appear on IRRC'S website)

(7) Type of Rulemaking (check applicable box):

- Proposed Regulation
- Final Regulation
- Final Omitted Regulation
- Emergency Certification Regulation;
- Certification by the Governor
- Certification by the Attorney General

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(8) Briefly explain the regulation in clear and nontechnical language. (100 words or less)

The regulation establishes the minimum standards for building, equipment, operation, care, program and services, training, staffing and for the issuance of licenses for assisted living residences operated in Pennsylvania.

(9) Include a schedule for review of the regulation including:

- A. The date by which the agency must receive public comments: September 15, 2008
- B. The date or dates on which public meetings or hearings will be held: \_\_\_\_\_
- C. The expected date of promulgation of the proposed regulation as a final-form regulation: July 31, 2010
- D. The expected effective date of the final-form regulation: 6 months after publication
- E. The date by which compliance with the final-form regulation will be required: 6 months after publication
- F. The date by which required permits, licenses or other approvals must be obtained: 6 months after publication

(10) Provide the schedule for continual review of the regulation.

The Department will continue to meet with industry stakeholders, consumers, and other interested parties on an ongoing basis to discuss the implementation, application and effectiveness of the regulation.

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### SECTION II: STATEMENT OF NEED

(11) State the statutory authority for the regulation. Include specific statutory citation.

Public Welfare Code, Act of June 13, 1967, P.L. 31 No. 21 (62 P.S. §§ 211, 213 and 1001-1087).

(12) Is the regulation mandated by any federal or state law or court order, or federal regulation? Are there any relevant state or federal court decisions? If yes, cite the specific law, case or regulation as well as, any deadlines for action.

Yes. This regulation is mandated by Act 2007-56 which was enacted in Pennsylvania on July 25, 2007.

(13) State why the regulation is needed. Explain the compelling public interest that justifies the regulation. Describe who will benefit from the regulation. Quantify the benefits as completely as possible and approximate the number of people who will benefit.

Currently, there is no regulation of assisted living residences in Pennsylvania. Assisted living residences are, however, a significant long-term care alternative which combines housing and supportive services. They are designed to allow people to age in place, maintain their independence and exercise decision-making and personal choice. This regulation establishes the minimum standards for licensure of assisted living residences to allow individuals to age in place. The regulation protects consumers' health and safety, privacy and autonomy while at the same time balancing providers' concerns related to liability and individual choice. The first year of licensure inspections (FY 10/11) is projected to benefit 3,750 residents in 50 facilities.

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(14) If scientific data, studies, references are used to justify this regulation, please submit material with the regulatory package. Please provide full citation and/or links to internet source.

A survey of existing personal care homes is attached to this regulatory analysis form.

(15) Describe who and how many will be adversely affected by the regulation. How are they affected?

No adverse effects are anticipated from the promulgation of this regulation.

(16) List the persons, groups or entities that will be required to comply with the regulation. Approximate the number of people who will be required to comply.

Facilities that seek to operate as assisted living residences or as dually licensed personal care homes and assisted living residences will be affected by the regulation. It is anticipated that 50 assisted living residences will be licensed in FY 2010-2011; 150 assisted living residences in FY 2011-2012; 200 assisted living residences in FY 2012-2013; and 250 assisted living residences in FY 2013-2014.

**SECTION III: COST AND IMPACT ANALYSIS**

(17) Provide a specific estimate of the costs and/or savings to the **regulated community** associated with compliance, including any legal, accounting or consulting procedures which may be required. Explain how the dollar estimates were derived.

Costs are expected to be incurred by the regulated community beginning in Fiscal Year 2010-2011 and in out years consisting of a flat application or renewal fee of \$300 per home, an additional fee of \$75 per bed, and for those facilities granted a special care designation, a third fee of \$150. It is assumed these fees will remain constant in the out years. Additional costs may be incurred for those facilities choosing to meet licensure requirements depending upon each facility's current status in relation to potential new costs imposed by the regulation. It is assumed that those facilities that choose to apply for Assisted Living Residence licensure will already comply with the facility structural requirements of the proposed regulations, so no costs are assumed for structural modifications. It is assumed that 50 assisted living residences will incur these costs in FY 2010-2011; 150 assisted living residences in FY 2011-2012; 200 assisted living residences in FY 2012-2013; 250 assisted living residences in FY 2013-2014, and 300 assisted living residences in FY 2014-2015.

(18) Provide a specific estimate of the costs and/or savings to **local governments** associated with compliance, including any legal, accounting or consulting procedures which may be required. Explain how the dollar estimates were derived.

Not applicable.

(19) Provide a specific estimate of the costs and/or savings to **state government** associated with the implementation of the regulation, including any legal, accounting, or consulting procedures which may be required. Explain how the dollar estimates were derived.

The Department estimates administrative costs to implement this change at \$0.437 million state funds in Fiscal Year 2010-2011. No additional costs to state government are anticipated in out years that will not be covered by fees collected from licensees.

The administrative costs for personnel have been estimated based on hiring sufficient staff in order to obtain licensure of an assisted living residence. Staffing is expected to include Department of Public Welfare inspectors, supervisors, clerical and an attorney. Administrative operational expenses are expected to be incurred for general operating and systems support work. It is estimated that 50 assisted living residences will need to be inspected/licensed during Fiscal Year 2010-2011. Staff will need to be

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hired six months prior to licensure activity in Fiscal Year 2010-2011 in order to ensure they are trained and ready to begin licensure work on January 1, 2011. In Fiscal Year 2010-2011 it is anticipated that 8 staff will be required for a full year at a cost of \$0.734 million. The Fiscal Year 2010-2011 costs are anticipated to be offset by \$0.297 million of licensure fees assessed the regulated community resulting in net anticipated cost to the State of \$0.437 million. It is assumed more assisted living residences will need to be inspected and licensed in out years so that both staff/operating costs and revenue from licensing fees will increase in out years.

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(20) In the table below, provide an estimate of the fiscal savings and costs associated with implementation and compliance for the regulated community, local government, and state government for the current year and five subsequent years.

	Current FY Year	FY + 1 Year	FY + 2 Year	FY + 3 Year	FY + 4 Year	FY + 5 Year
<b>SAVINGS:</b>	\$	\$	\$	\$	\$	\$
Regulated Community						
Local Government						
State Government	\$0	\$0	\$0	\$0	\$0	\$0
<b>Total Savings</b>						
<b>COSTS:</b>						
Regulated Community (Additional costs may be accrued by those choosing to meet ALR licensing requirements)	\$0	\$0.297M	\$0.892M	\$1.190M	\$1.487 M	\$1.784M
Local Government						
State Government	\$0	\$0.437 M	0	0	0	0
<b>Total Costs</b>	\$0	\$0.734 M	\$0.86 M	\$1.32 M	\$1.55 M	\$1.798
<b>REVENUE LOSSES:</b>						
Regulated Community						
Local Government						
State Government	\$0	\$0	\$0	\$0	\$0	\$0
<b>Total Revenue Losses</b>						

(20a) Provide the past three year expenditure history for programs affected by the regulation.

Program	FY -3	FY -2	FY -1	Current FY
Co. Adm. Statewide	\$33.780 M	\$30.968 M	\$34.843 M	\$38.115 M

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(21) Explain how the benefits of the regulation outweigh any cost and adverse effects.

This regulation establishes the minimum standards for licensure of assisted living residences to allow individuals to age in place. The regulation protects consumers' health and safety, privacy and autonomy while at the same time balancing providers' concerns related to liability and individual choice.

The establishment of Assisted Living Residence licensure will provide Pennsylvania's citizens with another choice when they consider their long-term care service needs. An individual that chooses to reside in an assisted living residence will have the opportunity to age in place and could delay or prevent the need for placement in a nursing facility.

(22) Describe the communications with and input from the public and any advisory council/group in the development and drafting of the regulation. List the specific persons and/or groups who were involved.

The Department developed the proposed regulations in consultation with the Assisted Living Residence Regulation Workgroup that was comprised of industry stakeholders, consumers and other interested parties. The Department held meetings with the workgroup on October 17, 2007, November 6, 2007, November 27, 2007, December 11, 2007, January 8, 2008, January 29, 2008, February 11, 2008, February 26, 2008 and April 1, 2008. Over thirty-five stakeholders were invited to participate in the workgroup, which included disability advocates, advocates for older adults, consumers, union representatives, an elder law attorney, public housing agencies, trade associations for profit and non-profit long-term care nursing facilities and many other interested parties. Over the course of the meetings, the Department provided the workgroup with several draft versions of the proposed regulations and solicited their comments and recommendations. The proposed regulation was also discussed at the Long-Term Care Subcommittee of the Medical Assistance Advisory Committee (MAAC) on June 13, 2007, August 8, 2007 and April 9, 2008. The Assisted Living Residence proposed regulation were also discussed at the Medical Assistance Advisory Committee (MAAC) on June 28, 2007 and at the Consumer Subcommittee of the MAAC on March 23, 2007. The Assisted Living Residence regulation was also discussed at the Stakeholder Planning Team on April 9, 2007.

After the close of the comment period on September 15, 2008 and at the direction of IRRC, the Department provided seventeen additional opportunities for industry stakeholders, consumers and other interested parties to dialogue on the regulation. These opportunities were provided on September 18, 2008 (House Aging & Older Adult Services Committee Public Hearing), January 6, 2009 (industry stakeholders), January 6, 2009 (industry stakeholders), January 20, 2009 (industry stakeholders), February 19, 2009 (consumers and industry stakeholders), February 19, 2009 (consumers and industry stakeholders), March 16, 2009 (consumers), March 20, 2009 (industry stakeholders), April 14, 2009 (industry stakeholders), April 28, 2009 (consumers), April 28, 2009 (consumers and industry stakeholders), May 21, 2009 (industry stakeholders, consumers and other interested parties), May 27, 2009 (industry stakeholders), June 8, 2009 (consumers and industry stakeholders), June 19, 2009 (conference call industry stakeholders), June 19, 2009 (consumers), June 26, 2009 (industry stakeholders).

The Department also issued a "draft" final-form regulation on June 24, 2009. The purpose of the release of the "draft" final-form regulation was to solicit additional input as recommended by IRRC and

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commentators.

(23) Include a description of any alternative regulatory provisions which have been considered and rejected and a statement that the least burdensome acceptable alternative has been selected.

No regulatory alternatives were considered since this regulation was mandated by Act 2007-56.

(24) Are there any provisions that are more stringent than federal standards? If yes, identify the specific provisions and the compelling Pennsylvania interest that demands stronger regulations.

Since there are no Federal assisted living residence licensure standards, there are no provisions that are more stringent than Federal law.

(25) How does this regulation compare with those of other states? How will this affect Pennsylvania's ability to compete with other states?

Research of other states have shown a variety of standards for building, equipment, operation, care, program and services, training, staffing and for the issuance of licenses for assisted living residences. Based on the review of that research, the Department has determined that the regulations will not put the Commonwealth at a competitive disadvantage with other states.

(26) Will the regulation affect any other regulations of the promulgating agency or other state agencies? If yes, explain and provide specific citations.

The regulation does not affect existing or proposed regulations of the Department or other state agencies.

(27) Submit a statement of legal, accounting or consulting procedures and additional reporting, recordkeeping or other paperwork, including copies of forms or reports, which will be required for implementation of the regulation and an explanation of measures which have been taken to minimize these requirements.

The rulemaking requires some additional paperwork by the Commonwealth and ALRs. However, there is no reasonable alternative to the increased paperwork.

Required forms will be developed by the Department in cooperation with the stakeholders and will be shared in draft form for review and comment prior to implementation. With respect to the initial and additional assessment forms (§§ 2800.224 and 2800.225) and the preliminary and final support plans

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(§§ 2800.224 and 2800.227), the ALR may use its own forms as long as all the required information in the Department's standard forms is included. The Department will also work with stakeholders to develop sample policies and procedures to assist ALRs to comply with the final-form regulation. ALRs will also be required to develop a residence handbook which is to be approved by the Department.

(28) Please list any special provisions which have been developed to meet the particular needs of affected groups or persons including, but not limited to, minorities, elderly, small businesses, and farmers.

This regulation applies to older individuals and adults with disabilities who choose to live in an assisted living residence, which will allow them to age in place.

There are special provisions relating to special care units that serve individuals with Alzheimer's and dementia and that also serve individuals with acquired brain injury.

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### Assisted Living Survey Summary

New regulations have been proposed for Assisted Living facilities in Pennsylvania. The draft regulations were published in August 2008 with a comment deadline of 30 days from the date of publication.

In October 2008 the Independent Regulatory Review Commission (IRRC) submitted comments to the Department of Public Welfare on the proposed Assisted Living Regulations. In its letter, the IRRC stated: "Before submitting the final-form version of this regulation, the Department should survey existing facilities and the industry across the state to ascertain exactly the number of rooms that will be qualified to be licensed to provide ALR services under the Department's regulation." Accordingly, the Office of Long-Term Living (OLTL) did a mail survey of 1,437 Personal Care Homes (PCHs) in the Commonwealth. Personal Care Homes had the option of submitting their responses by way of email, by fax or by mail. The majority of responses were received by fax. A copy of the survey from is attached. Presented below is a summary of the survey responses.

The survey asked for some information about the person completing it and the PCH they were from. It then asked how many total rooms the facility had and proceeded to more detailed information regarding the number of rooms by size for rooms in general, rooms with a bathroom and rooms with a kitchen.

The Department received 723 responses to the survey. The 723 responses represented a total of 27,233 rooms. Of those rooms 20,648 were indicated to have a bathroom and 5,409 with a kitchen or kitchen facilities. It should be noted that there are inconsistencies in some of the data in this report because a small number of the individual survey responses did not provide correct totals.

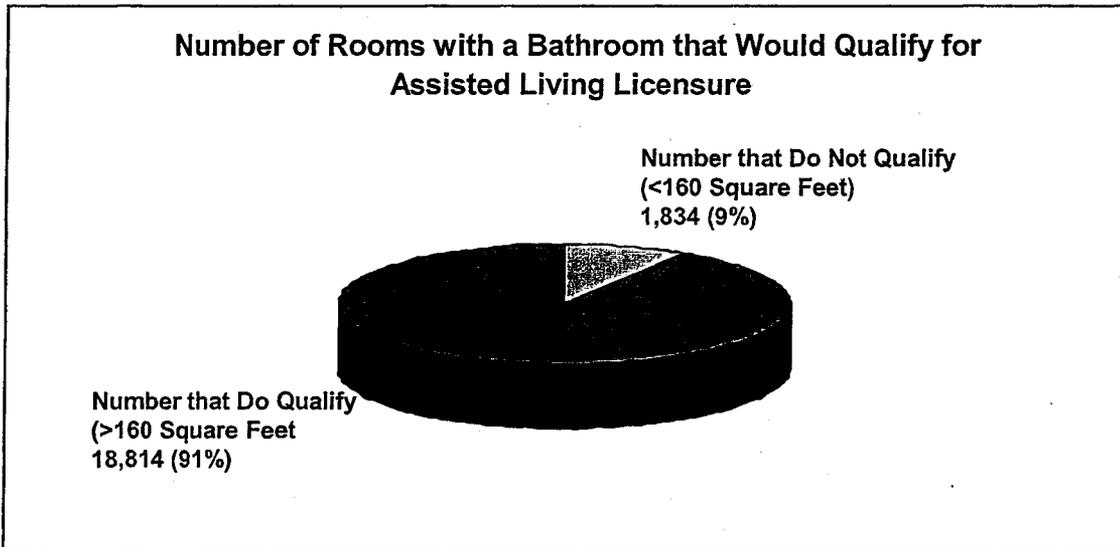
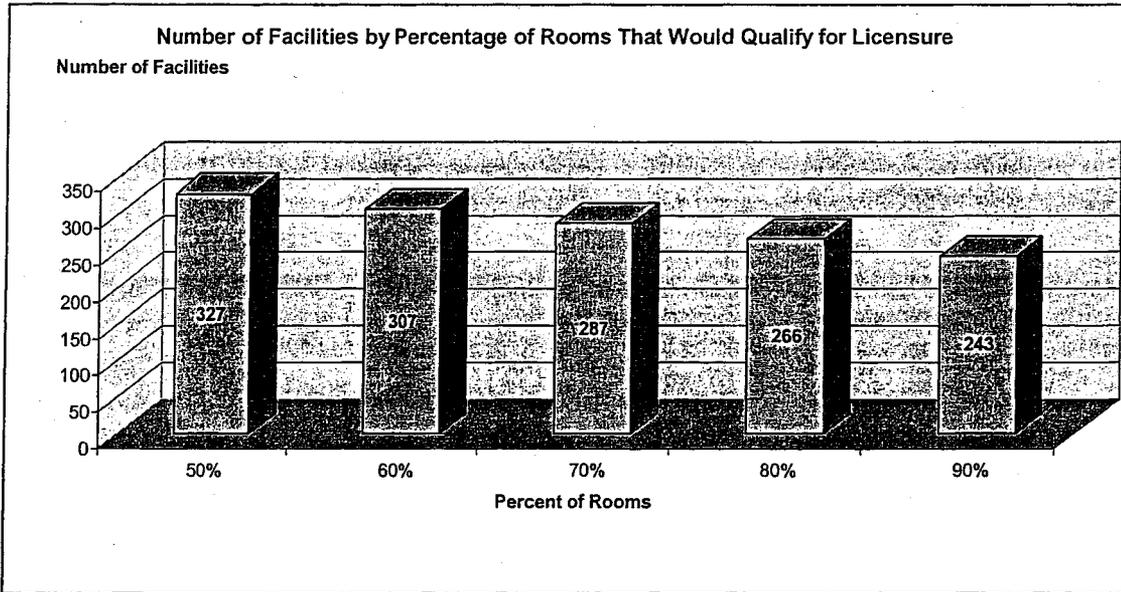
For facilities in existence prior to the effective date of the regulation, the final-form regulations require a minimum of 160 square feet of space for a room, with 210 square feet total if two residents share a room. The final-form regulations would prohibit more than two residents occupying a single room for both new and existing facilities. Existing facilities must also provide access to a kitchen with a refrigerator and microwave and a common for hot food preparation. A bathroom is required in all living units in both new and existing facilities.

For new facilities (those facilities constructed after the effective date of the regulation), each living unit for a single resident must have at least 225 square feet of floor space, with 300 square feet total if two residents share a living unit. New facilities must also have kitchen capacity to include a small refrigerator, cabinet for food storage, a small sink and space for small cooking appliances.

The number of rooms meeting the minimum requirements was calculated for all living unit categories (general rooms, rooms with bathroom and rooms with kitchen). The table below shows the breakout of those that meet the requirements and for those that do not.

<b>Room Type</b>	<b>Meet Minimum Size</b>	<b>Do Not Meet Minimum Size</b>	<b>Total</b>
<b>General Rooms</b>	24,450	2,783	27,233
<b>Rooms With Bathroom</b>	18,814	1,834	20,648
<b>Rooms With Kitchen</b>	4,685	724	5,409

## Regulatory Analysis Form



When asked if the respondent would consider applying for licensure of their personal care facility as an assisted living residence, 262 individuals answered affirmatively. Over half of the respondents, 461 individuals, said they would not consider applying for licensure.

### Number of Responding Facilities by County

Adams	2
Allegheny .....	71
Armstrong .....	14
Beaver .....	10
Bedford .....	1
Berks .....	18
Blair .....	12

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Bradford.....	1
Bucks.....	19
Butler.....	24
Cambria.....	16
Cameron.....	1
Carbon.....	6
Centre.....	10
Chester.....	32
Clarion.....	3
Clearfield.....	6
Clinton.....	3
Columbia.....	2
Crawford.....	7
Cumberland.....	15
Dauphin.....	8
Delaware.....	17
Elk.....	2
Erie.....	15
Fayette.....	19
*Forest.....	0
Franklin.....	9
*Fulton.....	0
Greene.....	4
Huntingdon.....	2
Indiana.....	10
Jefferson.....	9
Juniata.....	7
Lackawanna.....	9
Lancaster.....	39
Lawrence.....	10
Lebanon.....	14
Lehigh.....	17
Luzerne.....	23
Lycoming.....	11
McKean.....	3
Mercer.....	10
Mifflin.....	2
Monroe.....	6
Montgomery.....	40
Montour.....	5
Northampton.....	19
Northumberland.....	5
Perry.....	2
Philadelphia.....	25
Pike.....	2
*Potter.....	0
Schuylkill.....	15
Snyder.....	1
Somerset.....	6
*Sullivan.....	0
Susquehanna.....	2
Tioga.....	2
Union.....	4
Venango.....	1
Warren.....	3

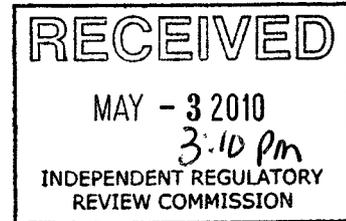
## Regulatory Analysis Form

Washington .....	15
Wayne .....	4
Westmoreland .....	32
Wyoming.....	4
York .....	17

\* No responses were received

CDL-1

FACE SHEET  
FOR FILING DOCUMENTS  
WITH THE LEGISLATIVE REFERENCE BUREAU  
(Pursuant to Commonwealth Documents Law)



DO NOT WRITE IN THIS SPACE

<p>Copy below is hereby approved as to form and legality. Attorney General</p> <p>By: _____ (Deputy Attorney General)</p> <p>_____ Date of Approval</p> <p><input type="checkbox"/> Check if applicable Copy not approved. Objections attached.</p>	<p>Copy below is hereby certified to be a true and correct copy of a document issued, prescribed or promulgated by:</p> <p><b>DEPARTMENT OF PUBLIC WELFARE</b> (Agency)</p> <p>LEGAL COUNSEL: <u>Yuth S. O'Brien</u></p> <p>DOCUMENT/FISCAL NOTE NO. <u>#14-514</u></p> <p>DATE OF ADOPTION: _____</p> <p>BY: <u>[Signature]</u></p> <p>TITLE: <u>SECRETARY OF PUBLIC WELFARE</u> (Executive Officer, Chairman or Secretary)</p>	<p>Copy below is hereby approved as to form and legality. Executive or Independent Agencies.</p> <p>BY: <u>[Signature]</u> <u>Andrew C. Clark</u></p> <p><b>APR 30 2010</b> Date of Approval</p> <p>(Deputy General Counsel) (Chief Counsel, Independent Agency) (Strike inapplicable title)</p> <p><input type="checkbox"/> Check if applicable. No Attorney General approval or objection within 30 days after submission.</p>
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NOTICE OF FINAL-FORM RULEMAKING

DEPARTMENT OF PUBLIC WELFARE

OFFICE OF LONG TERM LIVING

[55 Pa. Code Chapter 2800]

Assisted Living Residences

### *Statutory Authority*

The Department of Public Welfare (Department), by this order, adopts the regulation set forth in Annex A pursuant to the authority of sections 211, 213 and Article X of the Public Welfare Code (62 P.S. §§ 211 and 213 and 1001-1087). Notice of proposed rulemaking was published at 38 Pa.B. 4459 on August 9, 2008.

### *Purpose of Regulation*

The purpose of this regulation is to fulfill the statutory requirement in Act 2007-56 (Act 56) that requires the Department to adopt regulations establishing minimum standards for building, equipment, operation, care, program and services, staffing qualifications and training, and for the issuance of licenses for assisted living residences (ALRs) operated in this Commonwealth. 62 P.S. § 1021(a)(2)(i).

### *Background*

Act 56 was enacted in this Commonwealth on July 25, 2007. (Act of July 25, 2007, P.L. 402, No. 56.) Prior to that time, there was no legal definition of "assisted living residence" in this Commonwealth. Act 56 directed the Department to adopt regulations establishing the minimum licensing standards for ALRs which "meet or exceed" standards established for personal care homes (PCHs) under Chapter 2600 (relating to personal care homes). See 62 P.S. § 1021(a)(2)(i).

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Act 56 was intended to recognize that ALRs are a significant long-term care alternative nationwide. ALRs are a combination of housing and supportive services, as needed. They are widely accepted by the general public because they allow people to age in place, maintain their independence and exercise decision-making and personal choice. In enacting Act 56, the General Assembly found that it is in the best interests of all Pennsylvanians that a system of licensure and regulation be established for ALRs to ensure accountability and a balance of availability between institutional and home-based and community-based long-term care for adults who need such care. (Act 56, Legislative Findings and Declarations.)

Act 56 further directed the Department to develop regulations for ALRs in consultation with industry stakeholders, consumers and other interested parties. See 62 P.S. § 1021(d). As described more fully in the preamble to the proposed rulemaking, the Department convened a group of industry stakeholders, consumers and other interested parties and held numerous meetings over a period of many months to carefully consider the viewpoints of the groups and individuals that have a stake in this new licensure program. See 32 Pa.B. 4459. Following the notice of proposed rulemaking, the Department continued to consult with industry stakeholders, consumers and other interested parties which culminated in issuance of a “draft” final-form regulation on June 24, 2009. The purpose of the release of the “draft” final-form regulation was to solicit additional input as recommended by the Independent Regulatory Review Commission (IRRC) and commentators.

### *Affected Individuals and Organizations*

Individuals who choose to live in an ALR are affected by this final-form rulemaking. ALR providers are also affected.

### *Accomplishments and Benefits*

This regulation establishes the minimum standards for licensure of ALRs to allow individuals to age in place. This rulemaking protects consumers' health and safety, privacy and autonomy, while at the same time balancing industry stakeholders' concerns related to costs, liability and individual choice.

### *Fiscal Impact*

The Department estimates a net administrative cost to implement this change at \$0.437 million state funds in Fiscal Year 2010-2011. In the out years, costs will be covered by fee revenues.

Costs are expected to be incurred by the regulated community beginning in Fiscal Year 2010-2011 ranging from \$0.006 million to \$0.403 million per assisted living residence based on a 75-bed ALR. At a minimum, all ALRs would be required to pay a licensure fee amounting to the \$0.006 million on average. This cost assumes a flat application or renewal fee of \$300 per home, an additional fee of \$75 per bed and for those facilities granted a special care designation, a third fee of \$150. It is assumed these fees will remain constant in the subsequent years. Additional costs may be

incurred, which when added to the licensing fee brings the total potential cost up to the maximum estimated average cost of \$0.403 million in the first year. These costs may or may not be incurred depending upon each facility's current status in relation to potential new costs imposed by the regulation. The majority of the costs relate to additional personnel expense in administering medication, enhanced reporting and additional administrative costs for resident care. It is assumed that those facilities that choose to apply for ALR licensure will already comply with the facility structural requirements of the proposed regulations, so no costs are assumed for structural modifications. It is assumed that 50 ALRs will incur these costs in FY 2010-2011.

#### *Paperwork Requirements*

The final form rulemaking does require some additional paperwork by the Commonwealth and ALRs. However, there is no reasonable alternative to the increased paperwork.

Required forms will be developed by the Department in cooperation with the ALRs and will be shared in draft form with external stakeholders for review and comment prior to implementation. With respect to the initial assessment form and the preliminary and final support plans (§§ 2800.224, 2800.225 and 2800.227), the ALR may use its own forms as long as all the required information in the Department's standard forms is included. The Department will also work with stakeholders to develop sample policies and procedures to assist ALRs to comply with the final-form regulation. ALRs will also be required to develop a residence handbook which is to be approved by the Department.

*Public Comment*

Written comments, suggestions and objections regarding the proposed rulemaking were requested within a 30-day comment period following publication of the proposed rulemaking. The Department received 222 public comment letters as well as comments from legislators and IRRC. The Department also testified at a public hearing on September 18, 2008 convened by the House Aging and Older Adult Services Committee regarding the proposed rulemaking. In addition, the Department held individual meetings with industry stakeholders, consumers and other interested parties following the notice of proposed rulemaking. Finally, as mentioned above, in response to a recommendation of the IRRC, the Department issued a "draft" final-form regulation on June 24, 2009 to solicit further comment. IRRC posted this draft regulation on its website at <http://www.irrc.state.pa.us/Regulations/RegInfo.cfm?IRRCNo=2712>. The Department received 79 additional comment letters in response to this "draft" final-form regulation.

The Department received comments from every sector of the community that will be affected by the final-form rulemaking including industry stakeholders, consumers and other interested parties, IRRC and the majority and minority chairpersons and members of the House Aging and Older Adult Services Committee and the Senate Public Health and Welfare Committee.

The Department has continued to consult with and meet with industry stakeholders, consumers and interested parties to help ensure that this final-form rulemaking will achieve a balance between the competing interests of all parties in the regulatory review process. The Department has carefully considered all the comments it received in response to the notice of proposed rulemaking and the "draft" final-form

rulemaking. The Department would like to thank the many industry stakeholders, consumers and other interested parties for their expertise and consultation in the development of this regulation. The Department appreciates the many thoughtful comments submitted. Many of the suggestions and recommendations made by commentators have been incorporated into this final-form rulemaking.

### *Discussion of Comments and Major Changes*

The Department finds that IRRC summarized the major comments noted by commentators. As a result, the Department will use IRRC's comments as a "blueprint" for discussion of the major comments received. The Department has filed a separate "comment and response" document, which includes all of the comments received, with IRRC, the Legislative Committees, the Legislative Reference Bureau and commentators along with this final-form rulemaking. This preamble also includes responses to the major comments received as a result of the release of the "draft" final-form regulation on June 24, 2009.

### *IRRC Comments*

### *Legislative Comments*

IRRC recommended that the Department carefully consider the comments from legislators.

### *Response*

The Department agrees with this recommendation and appreciates the high level of interest that this rulemaking has generated from the General Assembly, IRRC and

the public. Many of the concerns expressed by members of the General Assembly were echoed in the public comment letters as well as in IRRC's comments and are included in this preamble and are reflected in the comment and response document which has been filed separately along with this final-form rulemaking.

*General – A. Distinction between Assisted Living Residences (ALR) and Personal Care Homes (PCH)*

IRRC posed several questions related to the implementation of Act 56 through the proposed regulation. IRRC stated that it would review the Department's response to its questions as part of its determination of whether the regulation is in the public interest. IRRC requested the Department explain the difference between an ALR and a PCH.

IRRC specifically asked for an explanation of the statutory language in Act 56 that allows PCHs to "assist residents in obtaining health care services" versus the requirement that ALRs be "required to provide supplemental health care services." It also asked, "If a PCH offers many of the same services as an ALR, what will stop consumers from contracting with PCHs when there is no statutory protection for 'supplemental health care services' or 'aging in place' at a PCH?" IRRC also inquired about the implications of the differences between an ALR and a PCH, including how these differences will affect residents and licensees in the future.

Finally, IRRC inquired about the fact that the current statutory provision for Act 56 related to "special care designation" does not reference the existing PCH regulations at 55 Pa.Code §§ 2600.231-2600.239 (related to secured dementia units). IRRC

commented that the definition of “special care designation” in Act 56 only refers to ALRs.

*Response*

The Department submits that this final-form regulation is in the public interest for a number of reasons. Implementation of Act 56 through this regulation provides another choice for consumers who are searching for a residential care option to meet the rising demand for the Commonwealth’s rapidly growing population of older adults as well as individuals with disabilities who wish to have another alternative to nursing facility care or a PCH. Assisted living is a new model of care for Pennsylvania in three basic ways: 1.) the concept of aging in place, 2.) the types of care offered to consumers and 3.) the design and construction of the facility. While there are similarities between ALRs and PCHs, there are also distinctions between the two types of licensure categories. As described more fully below, there are clear differences between PCHs and ALRs relating to the kinds of service offered to the residents, the physical site requirements for individual living units and the conditions for licensure. Not only that, but also, assisted living offers an opportunity for the Commonwealth to seek Medicaid waiver funding.

As the Department noted in the preamble to the final-form PCH rulemaking, “...the demand for residential care options is increasing.” 35 Pa.B. 2499. For consumers, an ALR is another choice in the array of long-term care alternatives in this Commonwealth. This regulation accords with the legislative intent behind Act 56 to “allow people to age in place, maintain their independence and exercise decision-making and personal choice.” (Act 56—Legislative Findings and Declarations.)

Implementing the final-form regulations will fulfill the legislative intent to provide a “significant long-term care alternative” to Pennsylvanians and to “ensure a balance of availability between institutional and home-based and community-based long-term care for adults who need such care.” (Act 56—Legislative Findings and Declarations (1) and (3).)

To address IRRC’s specific concerns regarding the provision of supplemental health care services in an ALR, Act 56 defines an “ALR” as:

“any premises in which food, shelter, personal care, assistance or supervision *and supplemental health care services are provided* for a period exceeding twenty-four hours for four or more adults who are not relatives of the operator and who require assistance or supervision in such matters as dressing, bathing, diet, financial management, evacuation from the residence in the event of an emergency or medication prescribed for self-administration.”

62 P.S. § 1001.(Emphasis added).

The definition of a PCH, while similar to the definition of an ALR, does not contain the key phrase “*supplemental health care services are provided.*” Hence, a distinction between an ALR and a PCH is that an ALR is *required* by law to *provide* “supplemental health care services,” whereas under Act 56 a PCH may not provide supplemental health care services, but, instead, may “assist” residents in obtaining “health care services” in the manner provided by § 2600.29 (relating to hospice care and services), 2600.142 (relating to assistance with health care) and 2600.181 (relating

to self-administration) through 2600.191 (relating to medications).” 62 P.S. § 1057.3(a)(13).

There is a major difference between requiring a facility to actually “provide” supplemental health care services and having a facility merely “assist” with “securing” health care. While one is mandatory, the other is permissive. A PCH can choose whether it wants to assist the resident to secure health care, but an ALR has no choice in the matter. An ALR must provide supplemental health care as defined in Act 56 or it will not meet the minimum licensure standard to operate as an ALR.

Requiring that an ALR provide supplemental health care services supports another core concept of an ALR, that is, an ALR allows individuals to “age in place.” Act 56 defines “age in place” or “aging in place” as “receiving care and services at a *licensed assisted living residence* to accommodate changing needs and preferences in order to remain in the assisted living residence.” 62 P.S. § 1001 (Emphasis added). Rather than having to move out of a PCH when a resident’s acuity needs become too great for the PCH to meet, an ALR is designed to allow a resident to age in place to accommodate changing needs as well as preferences of the resident. As stated in the preamble to the PCH final-form regulation, “Personal care homes are not licensed as medical facilities and are not required to hire licensed, certified or registered medical professionals. Although some personal care homes employ doctors, registered nurses, certified nursing assistants, certified registered nurse practitioners and licensed practical nurses to assist in service provision for the residents, this is not mandated.” 35 Pa.B. 2502.

This leads to a discussion of another significant difference between ALRs and PCHs. A PCH is restricted in the type of care that it can provide. A PCH, by statute, is

not permitted to serve individuals who “require the services in or of a licensed long-term care facility.” 62 P.S. § 1001. This was emphasized in the preamble to the PCH final-form regulation at 35 Pa.B. 2499: “Personal care homes are designed to provide safe, humane, comfortable and supportive residential settings for adults *who do not require the services in or of a licensed long-term care facility*, but who do require assistance or supervision with activities of daily living (ADL) or instrumental activities of daily living (IADL), or both.” (Emphasis added). Indeed, the PCH final-form preamble emphasized “Commonwealth law prohibits a personal care home from housing and serving residents whose care needs would qualify them for nursing facility care. This distinction is made in the statutory definition of ‘personal care home’ in section 1001 of the Public Welfare Code (62 P.S. § 1001), which provides that an individual who needs the level of care of a long-term care facility, or nursing home, cannot be served in a personal care home.” 35 Pa.B. at 2502.

To reinforce the distinction between an ALR and a PCH, Act 56 provides that prior to admission, an initial screening must be done to determine whether the potential resident requires the services provided by an ALR or a PCH. 62 P.S. § 1057.3(a)(1)(ii) and (iii). According to the statute, “a resident who currently does not require assistance in obtaining supplemental health care services, but who may require such services in the future or who wishes to obtain assistance in obtaining such services or reside in a facility in which such services are available, may be admitted to the ALR provided the resident is only provided service required or requested by the resident. Where services are required, the ALR shall develop a support plan as defined in 55 Pa.Code Chapter 2600 (relating to personal care homes) and any other regulations applicable to assisted living residences.” 62 P.S. § 1057.3(a)(1)(iii).

Thus, the level of care for an ALR resident can vary widely, ranging from an individual:

- who does not require supplemental health care services at the time of admission to the ALR, but who may require such services in the future, *or*
- who wishes to obtain assistance with obtaining such service, *or*
- who wants to live in a facility in which such services are available.

By contrast, the screening for a PCH provides that the screening will be done “to determine that the potential resident does not require the services in or of a long-term care facility and whether the resident requires the services of a personal care home, and if so, the nature of the services and supervision necessary.” (62 P.S. § 1057.3(a)(1)(ii)).

The screening requirements in this final-form rulemaking clearly exceed the preadmission screening currently in place for PCHs. See §§ 2800.224, 2800.225, and 2800.227 (relating to initial assessment and preliminary support plan; additional assessments; development of the final support plan). This should further allay concerns that there will be confusion in the minds of potential residents as to the appropriate place to live, whether it be a PCH or an ALR. The screening and assessment process for an ALR will allow an individual and his family, if applicable, to know “up front” whether or not the ALR can meet his care needs and preferences, and what those care needs are through the assessment process.

Furthermore, Act 56 provides that some services that would traditionally be offered in a skilled nursing facility may be offered by an ALR. For example, although Act 56 contains a prohibition against allowing a consumer with certain “excludable

conditions” to be admitted, retained or served in an ALR, the law permits an exception to be granted by the Department upon the request of the ALR. These “excludable conditions” defined in Act 56 include such skilled nursing care needs such as ventilator dependency, stage III and IV decubiti and vascular ulcers that are not in a healing stage, continuous intravenous fluids, reportable infectious diseases in a communicable state, nasogastric tubes, physical restraints and “continuous skilled nursing care twenty-four hours a day”. 62 P.S. § 1057.3(e). Nevertheless, if an exception is granted by the Department, an ALR may care for an individual whose health care needs fall within these excludable conditions, some of which would ordinarily be provided in a skilled nursing facility. 62 P.S. § 1057.3(f) and (g). Again, this accords with Act 56’s legislative intent that consumers who choose an ALR be allowed to “age in place” and receive care that is beyond the level that a PCH is authorized to provide.

The concept of allowing an ALR to provide for “aging in place” is also reinforced by the provisions of Act 56 that require the regulations for ALRs to create “standards for transfer and discharge that require the ALR to make reasonable accommodations for aging the place and that may include service from outside providers.” 62 P.S. §1026(a)(1)(viii). Finally, with respect to informed consent agreements, Act 56 provides that the Department’s regulations must create standards for informed consent agreements that promote aging in place. 62 P.S. § 1026(a)(1)(vii). Including the concept of “informed consent” in promoting the ability of an individual to age in place is yet another distinction between PCHs and ALRs.

In addition, in further response to IRRC’s request that the Department explain the difference between an ALR and a PCH, the Department would point out that a key distinction between PCHs and ALRs relates to “bricks and mortar.” As stated in the

preamble to Act 56, “[a]ssisted living residences are a combination of housing and supportive services, as needed.” (Act 56—Findings and Declarations.) While PCHs are required by the PCH regulations to have bedrooms for residents (see § 2600.101 (relating to bedrooms)), there is no requirement that the PCH resident have a private bathroom, living space or kitchen capacity in his own room. Furthermore, the regulations for PCHs permit up to 4 residents per bedroom. Bathrooms in a PCH may be shared and the PCH regulations provide specific ratios for residents for matters such as toilets, sinks and bathtubs or showers. 55 Pa.Code § 2600.102 (relating to bathrooms). On the other hand, Act 56 mandates that the regulations issued by the Department require that an ALR provide a resident with the resident’s own “living unit.” 62 P.S. §1026(a)(2)(ii). Act 56 further provides that a licensee shall not require residents to share a living unit, but two residents may voluntarily agree to share one unit, provided that the agreement is in writing and contained in each of the residency agreements of those individuals. Id.

A “living unit” in an ALR must contain a “...private bathroom, living and bedroom space, kitchen capacity, which may mean electrical outlets to have small appliances such as a microwave and refrigerator, closets and adequate space for storage and a door with a lock, except where a lock or appliances in a unit under special care designation would pose a risk or be unsafe.” 62 P.S. § 1021(a)(2)(iv). Under no circumstances may a resident be required to share a living unit in an ALR. 62 P.S. § 1021(a)(2)(ii). By law, the Department is required to establish the minimum square footage requirements for individual living units. 62 P.S. § 1021(a)(2)(v). Clearly, the characteristics of the accommodations that are provided in a PCH versus an ALR are distinguishable.

The physical site requirements for an ALR provide for greater privacy and freedom for the individual to exercise decision-making and personal choice. Residents in an ALR will have more options related to their personal preferences in their living units, such as meal planning and preparation, since kitchen capacity is required for the living units in an ALR.

Further, the minimum square footage for resident bedrooms versus living units is distinguishable between PCHs and ALRs. The minimum square footage for a single resident bedroom in a PCH is 80 square feet. Each PCH shared bedroom must have at least 60 square feet per resident with up to four residents sharing a bedroom. See § 2600.101 (relating to resident bedrooms). We also note that for individuals with mobility needs, the square footage requirement for PCHs is 100 square feet for the individual's bedroom. § 2600.101(c). These final-form regulations require for ALRs, however, at a minimum, 160 square feet for single person living units for existing facilities that wish to convert to ALR licensure, and 225 square feet for single person living units in an ALR which is built after the effective date of the adoption of these regulations. Since the requirement that the living unit must not only provide space for a resident's bedroom, but must also contain "living space" and "kitchen capacity" to allow for the individual to a private place to relax, entertain family and friends and possibly prepare meals (if the resident chooses to have appliances in his living unit), adequate square footage must be provided to accommodate all of these activities.

Additionally, as the legislature made clear in enacting Act 56, "No person, organization or program shall use the term 'assisted living' in any name or written material, except as a licensee in accordance with this chapter." 62 P.S. § 1057.3(i). Hence, only those ALRs licensed under this final-form regulation will be authorized to

advertise themselves as an ALR. When comparing potential long-term living options, prospective residents will have the assurance that the facility that they are considering is licensed as an ALR by the Department. This should further reduce the confusion that has been expressed by commentators as to explaining the difference between an ALR and a PCH.

In response to IRRC's inquiry about how residents and licensees will be affected by the statutory differences between ALRs and PCHs, an existing licensed PCH is neither required to seek licensure as an ALR, nor meet the new licensure requirements of Chapter 2800 (relating to assisted living residences). It is a business decision by a facility whether to seek licensure as an ALR or remain licensed as a PCH. This final-form regulation is designed to fulfill the statutory requirement that the Department establish minimum licensure requirements for an ALR. It does not dictate that an existing PCH convert to an ALR. The Department did, however, take into account that there are many existing PCHs that are interested in becoming licensed as an ALR. Therefore, the Department, with the advice and consultation of the stakeholders, made provision in the regulation to allow existing PCHs to convert to ALR by providing decreased square footage for living units and lower kitchen capacity requirements for "existing" facilities. In addition, the Department amended the language at § 2800.53 (relating to qualifications and responsibilities of administrators) to provide for a PCH administrator to be qualified as an ALR administrator if certain conditions are met. See § 2800.53(a)(6).

Finally, as to IRRC's inquiry about the fact that the statutory provision for Act 56 related to "special care designation" does not reference the existing PCH regulations at 55 Pa.Code 2600.231-2600.239 (related to secured dementia units), the Department

finds that there is no restriction in Act 56 that would preclude a PCH from continuing to provide secure dementia care in accordance with the PCH regulations cited by IRRC.

*General – B. Resident population*

IRRC inquired about what population will be served by an ALR. Specifically, IRRC asked how the care in an ALR differs from the care currently provided by long-term care facilities and PCHs. IRRC commented that this distinction is vital to potential residents and their families in their evaluation of which path best fits their current and future health care needs and the ability to pay and promotes happiness and wellness. IRRC further inquired what would be the advantages and disadvantages of choosing one over the other.

*Response*

Since ALRs provide for residents to age in place, the population of an ALR will vary widely. Prospective residents include adults who require assistance or supervision in such matters as dressing, bathing, diet, financial management, emergency evacuation, self-administration of medication. With respect to the provision by the ALR of supplemental health care services, some consumers may not require assistance in obtaining supplemental health care services currently, but may require such services in the future. Some may wish to obtain such services or reside in a facility in which supplemental health care services are available. It is apparent that the legislature wanted to provide flexibility to consumers by requiring that the ALR screening process would determine the individual's needs related to provision of supplemental health care services. The distinction between ALRs and PCHs is that ALRs are a long-term care

alternative that allow individuals to age in place, maintain independence and exercise decision-making and personal choice. Note that a PCH is not defined in Act 56 as a long-term care “alternative.” Instead, as discussed above, the definition of a PCH specifically excludes individuals who require the services in or of a licensed long-term care facility. ALRs are designed to provide a home-like environment where residents have an opportunity to have their own private living unit complete with a private bathroom and kitchen capacity which gives the residents an area to prepare their own meals if they choose to do so. As stated previously, as a long-term care alternative, an ALR is required to provide supplemental health care services; by contrast, a PCH is merely permitted to “assist” the resident in obtaining health care service as provided in the PCH regulations under §§ 2600.29 and 2600.181-191. A PCH may *not* provide supplemental health care services to residents. 62 P.S. § 1057.3(a)(13).

The distinction between an ALR and a long-term care facility is that a long-term care facility provides “nursing care and related medical or other health services” to individuals who need such care. 62 P.S. § 1001. Under the final-form rulemaking, the Department has clarified that an adult who requires the services of a licensed long-term care nursing facility *may* reside in the ALR, if certain conditions are met. These include: the needs of the potential resident can be met by the ALR; the appropriate supplemental health care services are provided to the resident; and the design, construction, staffing and operation of the ALR allow for a safe emergency evacuation of the resident. § 2800.22(b.1) and (d).

In choosing between a PCH, an ALR and a long-term care facility, an individual or the individual’s family will have to examine the individual’s current health care needs, potential future health care needs and preferences for living environments. As noted

above, an ALR offers another choice for consumers as the demand for residential options for older Pennsylvanians and people with disabilities is increasing.

*General – C. Affect on PCHs and their residents*

IRRC noted that commentators are concerned that the new ALR licensure will affect Departmental policy concerning PCHs in a manner that disrupts current PCH residents receiving higher levels of care. For example, under existing PCH regulations, the permissible spectrum of care extends through hospice care. The Department was asked to explain how implementation of ALR licensure will affect PCHs and their residents, whether the proposed regulations will in any manner diminish the ability of licensed PCHs to continue providing the same levels of care as they do now, and how Departmental enforcement actions related to PCHs and their current care will change as a result of this new category of licensure.

*Response*

PCHs are required in 55 Pa.Code § 2600.1 (relating to purpose) to provide safe, humane, comfortable and supportive residential settings for adults who do not require the services *in or of a licensed long-term care facility* (emphasis added), but who do require assistance or supervision with tasks of daily living, such as dressing, bathing, diet, and financial management. It is the Department's position that if a resident's needs are being safely met in a PCH, the resident should be permitted to remain in the PCH. However, It is the PCH's responsibility under the PCH regulations to assess, on an ongoing basis, whether the resident is in need of a higher level of care, and to

develop plan for placement as soon as possible. § 2600.225(d) (relating to initial and annual assessment).

*General—D. What specifically does “aging in place” mean for the resident and the ALR?*

Since “aging in place” allows a resident to remain in the assisted living residence, IRRC inquired how the Department defines “residence”. IRRC further inquired if a resident will remain in the same living unit or whether a resident will be moved to another area within an ALR as the resident’ needs changed.

*Response*

The Department’s interpretation of “residence” in the definition of “aging in place” refers to the ALR since aging in place is distinctly a new concept which applies to ALRs. As IRRC noted previously, a key distinction in Act 56 is the definition of aging in place. “Aging in place” is defined as “receiving care and services at a licensed assisted living residence to accommodate changing needs and preferences in order to remain in the assisted living residence.” 62 P.S. § 1001. Act 56 provides residences with the discretion to decide whether they designate portions or sections of the ALR for use only by residents not requiring supplemental health care services or whether they allow both those needing such services and those who do not need such services to reside within the same portions or sections of the ALR. 62 P.S. § 1057.3 (h) (ii). This will be a major determining factor in whether or not a person will move when needs change.

Additionally, special care units are residences or portions of residences that provide specialized care and services for residents with Alzheimer's disease, dementia, and brain injury. It is only in these special care units that specialized care can be provided to residences with these conditions. That is also another determinative factor in whether a resident will move from one portion of an ALR to another area within the facility.

In the case of a dually-licensed facility which is licensed as both a PCH and an ALR, when a resident who currently resides in a PCH later requires the services of an ALR, there are a number of factors to consider whether the resident would need to transfer to the ALR portion of the facility. A requirement of dual licensure for a PCH and ALR is that ALR areas must be collocated in the same building and be a distinct part of the building. A "distinct part" is defined as a portion of a building that is visually separated such as a wing or floor, or sections or parts of floors. § 2600.4 (relating to definitions). This provision is in the regulation because ALRs and PCHs have a number of significantly different physical site licensing requirements, such as room size, private bath and kitchen capacity. ALR living units must meet the square footage requirements of the ALR regulations; kitchen capacity must be provided in order to allow for resident meal choice; the living unit would have to be located in a distinct part of the facility and would have to meet all other ALR standards including the mandate to provide supplemental health care services. In other words, a PCH bedroom cannot automatically become an ALR living unit merely because the needs of its occupant change. If, however, a PCH bedroom qualifies as an ALR living unit by meeting the requirements of this chapter, and if the ALR chooses to designate it as such and

increase its ALR capacity accordingly, the resident would be able to remain in the same room he occupied as a PCH resident.

*General – E. Revision of existing PCH regulations*

IRRC questioned whether the Department has a strategy for revising the existing PCH regulations.

*Response*

The Department's policy is to continually review its regulations as circumstances change. Once this final-form regulation is promulgated, the Department will give careful consideration to whether the PCH regulations should be amended.

*General – F. Fiscal impact and the potential for Medicaid funding*

IRRC and legislators have questioned the fiscal impact of this regulation and also the potential for Federal financial assistance through a Medicaid waiver program. IRRC requested the Department explain how and when the Department intends to seek Medicaid waiver funding, including the anticipated Federal response. IRRC also inquired into how many rooms will be qualified to be licensed to provide ALR services. IRRC also requested an explanation on the availability of ALRs at a cost Pennsylvanians can afford.

*Response*

The Department intends to apply for a Medicaid waiver after this final-form regulation is published. The waiver application process consists of an application

submitted to the U.S. Department of Health and Human Services' Centers for Medicare and Medicaid (CMS). Thereafter, CMS reviews the application, provides comment and can request additional information. This process may be repeated until final approval is obtained. At least 38 states have CMS-approved Assisted Living waivers in place. If approval for the waiver is granted, the Department would implement it in the 2010-2011 fiscal year.

In October of 2008, the Department conducted a survey of the 1,437 PCHs licensed in the Commonwealth. We received 723 responses to the survey. The 723 responses represented a total of 28,774 rooms. Of those rooms, 20,648 were indicated to have a bathroom and 5,409 with a kitchen or kitchen facilities. Using the originally proposed square footage of 175 square feet, the Department estimated that there were approximately 220 PCHs that had at least 90% of their rooms that would meet the square footage requirements under the ALR regulations. Using the same survey results, approximately 243 PCHs had 90% of their rooms that would qualify as to room size under a square footage requirement of 160 square feet. While these PCHs would meet the square footage requirements, it is unknown how many of them plan to pursue licensure as an ALR.

In terms of the availability of ALRs at a cost that people can afford, it is important to recognize how costly long-term care services are and to view that cost in the context of services provided in other settings, such as in nursing facilities. Medical Assistance is the primary payer for approximately two-thirds of those using nursing facility-based care.

Today, our older population at highest risk of needing nursing facility level of care lacks the personal financial resources to pay for that care. Eighty percent of this

population has less than \$100,000 in liquid assets and only 27 % of those over 65 years of age have sufficient resources to cover 2.5 years of nursing facility care. The cost of nursing facility care is over \$70,000 a year for a private payer (Health Affairs, Volume 22, Number 3, May/June 2003 or [see www.http://content.healthaffairs.org](http://content.healthaffairs.org)). On the other hand, according to MetLife data, the average cost for assisted living nationally is \$3,000 a month, or \$36,000 a year

(<http://www.metlife.com/assets/cao/mmi/publications/studies/mmi-market-survey-nursing-home-assisted-living.pdf>).

By establishing a licensed ALR program in Pennsylvania, once a waiver is approved, persons with low income will have an opportunity to age in place and receive supplemental health care services at a much more affordable rate than they would in nursing facilities.

#### *General – G. Dual licensure*

IRRC, legislators and many other public commentators objected to the fact that the proposed rulemaking did not provide standards for dual licensure of PCHs and ALRs.

#### *Response*

The Department has provided for dual licensure for PCHs and ALRs in this final-form rulemaking. The dual licensure provisions are set forth at §§ 2800.4 (relating to definitions and 2800.11(g) (relating to procedural requirements for licensure or approval of assisted living residences; special care designation and dual licensure). If the ALR

and the PCH are collocated in the same building and are each located in a distinct part of the building, they may be dually licensed. See § 2800.11(g) (relating to procedural requirements for licensure or approval of assisted living residences; special care designation and dual licensure). As noted above, a “distinct part” is defined as “a portion of a building that is visually separated such as a wing or floor, or sections or parts of floors.” See § 2800.4 (relating to definitions).

Based on industry stakeholder input, the Department’s intent in this language is to provide some flexibility in the configuration of what constitutes a “distinct part” to allow for the establishment of smaller, visually separated clusters of ALR-licensed living units.

*General – H. Levels of care*

IRRC questioned whether the regulation provides a single level of care to residents. IRRC further commented that the Department should explain why the Department did not develop different ranges of requirements or levels of care to meet the unique needs of the different types of residents and also provide for choice and availability for consumers.

*Response*

The Department carefully weighed the competing concerns expressed by consumers versus industry stakeholders. Industry stakeholders suggested a “menu” approach whereby a few essential services such as personal care services, linen

service, meals, housekeeping and supervision be required so-called “core” assisted living services. They recommended that all other services be optional so that the resident could “pick and choose” from a menu containing a variety of services with different costs associated with each service option.

Consumers, however, were very concerned that it is difficult to compare and contrast one ALR from another if each offers an array of confusing “add-ons” to the basic “core” services. Further, there was concern that once an individual entered an ALR, the individual could be “nickel and dimed” for various add-ons that would rapidly deplete his financial resources and increase the cost of care dramatically from the consumer’s planned outlay for residing in an ALR. In the draft final-form regulation issued in June 2009, the Department attempted to reconcile these competing concerns by establishing two distinct levels of care: an “independent” core package and “enhanced” core package. See § 2800. 220 (relating to service provision). The Department has further modified these provisions of the final-form rulemaking to allow a consumer to “opt-out” of certain services in the two core service packages with a concomitant contract price adjustment. Further, to allay the concerns of consumers, the Department has added much more depth and detail to assessment of a potential ALR resident to ensure that the needs of the potential resident are carefully assessed so that the type and cost of care that will be provided by the ALR will be known “up-front.”

*General – I. Further consultation and advanced notice of rulemaking*

Although IRRC commended the Department for convening numerous meetings to consult with industry stakeholders, consumers and other interested parties in

preparing the proposed regulation, IRRC recommended that the Department organize additional meetings with stakeholders and that DPW publish an "advance notice of final rulemaking" to allow the opportunity to resolve and review any remaining issues prior to publication of the final-form rulemaking.

### *Response*

The Department recognizes that in any new licensure program, there will be many voices to consider and viewpoints to reconcile. To expect that consensus can be achieved in all areas is not realistic or feasible. Nevertheless, the Department has strived to be as inclusive and transparent in this rulemaking as possible. The Department, following notice of proposed rulemaking, continued to meet with stakeholders, both in group settings as well as individually. In addition, the Department facilitated several meetings with representatives from major industry groups and a coalition of consumers for both the elderly and persons with disabilities. In some cases, the parties were able to come to mutual agreement related to specific language changes and resolve several key issues in the regulation.

Finally, the Department worked closely and collaboratively with stakeholders, IRRC and the legislative committees by issuing a "draft" final-form regulation that was released for public comment and posted on IRRC's website on June 24, 2009. Following the 30-day comment period, the Department carefully considered the additional 79 comment letters it received and participated in further meetings with stakeholders and legislators. The Department finds that it has identified the major concerns expressed on all sides of the regulatory debate and has attempted either to

resolve the competing concerns by consensus or has struck a balance between what the industry stakeholders would like to see versus what consumers have advocated.

*§§ 2800.1 and 2800.2. Purpose and scope*

IRRC commented that it believes that these sections did not sufficiently explain the proposed regulation. IRRC also commented that these sections should distinguish ALRs from PCHs.

*Response*

The Department finds that the two cited provisions are designed to be very general overall statements related to the scope and purpose of the regulation. The language in these provisions is similar to the PCH regulations. See 55 Pa.Code §§ 2600.1 and 2600.2 (relating to purpose; and scope). Further, the distinctions between an ALR and a PCH are more fully set forth above in the discussion related to the statutory distinctions between an ALR and a PCH.

*§ 2800.3. Inspections and licenses*

IRRC questioned how the abbreviated inspection process would work and how it would differ from a routine inspection. Also, IRRC asked what portions of the inspection the Department would waive during an abbreviated inspection.

*Response*

Act 56 provides that “while developing regulations under this act, the department *may* provide for an abbreviated annual licensure visit when a residence has established a history of exemplary compliance.” 62 P.S. § 211(l) (Emphasis added). After careful consideration, the Department has decided to delete the provision in the notice of proposed rulemaking governing abbreviated annual inspections. See 38 Pa.B. 4459 at § 2800.3(c) (relating to inspections and licenses). This issue will be the subject of a future rulemaking after the Department has had an opportunity to study and review the matter further and gain greater experience in licensing ALRs.

*§ 2800.4. Definitions - Age in place or aging in place*

IRRC questioned why the definition did not mirror the statutory definition.

*Response*

The Department amended the definition to conform to the statutory definition.

*§ 2800.4. Definitions - Commercial boarding residence*

IRRC questioned the inclusion of this definition and noted that it was found in the exclusions in § 2800.2(b).

*Response*

The proposed definition contained an error. The Department’s intent was to conform to the definition and the exclusion in the PCH regulation since ALR regulations

must "meet or exceed" the PCH regulations under 62 P.S. § 1021(a)(2)(i). The definition has been corrected to be a "commercial boarding home" and the exclusion relates to a "commercial boarding home" to be consistent with the PCH regulations at § 2600.4 (relating to definitions).

*§ 2800.4. Definitions - Designated person and legal representative*

IRRC asked for an explanation of these terms. IRRC suggested that the terms are confusing. IRRC requested the Department explain why different terms are needed and appropriate. IRRC further questioned the intent of the phrase "or other person authorized to act for the resident" in the definition of "legal representative".

*Response*

A "designated person" is a broader term than "legal representative" and may be a family member, close friend or relative, who is to be notified in exigent circumstances, such as an emergency or closure of an ALR. See § 2800.4. Although in some situations a resident may choose a legal representative as a "designated person", it is not required for a resident to have a legal representative fulfill this role. In contrast, a "legal representative" has powers beyond those of a designated person and is "an individual who holds a power of attorney, a court-appointed guardian or other person legally authorized to act for the resident." § 2800.4.

Since not every type of legal representation can be identified, the definition left open the possibility of other types of authorization being included in the definition of

“legal representative”. The Department did, however, clarify the definition to include “other person *legally* authorized to act for the resident.”

*§ 2800.4. Definitions - Exemplary compliance*

IRRC questioned the use of this term and inquired how the 3-year history of exemplary compliance was established. IRRC further inquired into what would constitute a “deficiency”.

*Response*

As noted previously, the Department decided to withdraw this provision and will consider it for a future rulemaking.

*§ 2800.4. Definitions - Informed consent agreement*

IRRC questioned why the regulatory and statutory terms differed. The regulatory definition included additional language in subparagraph (iii) and IRRC recommended its deletion.

*Response*

The Department agreed and made the change so that the two definitions mirror each other in the definitions section.

*§ 2800.4. Definitions - Supplemental health care services*

IRRC questioned why the regulatory definition did not precisely mirror the statutory definition.

*Response*

The Department agreed and made the change so that the two definitions mirror each other.

*§ 2800.11. Procedural requirements for licensure or approval of assisted living residences; special care designation and dual licensure*

IRRC and legislators commented the licensure fees for an ALR were excessive. IRRC requested that the Department provide detailed information on how the fees were established, how the fees cover the Department's costs in implementing quality assurance and how much the fees will increase costs to residents. IRRC also requested an explanation of whether an application to change maximum capacity requires payment of a fee and if so, the amount of the fee. Finally, IRRC requested an explanation of how fees will be charged for dually licensed facilities.

*Response*

Based on the comments received, the Department reconsidered the fee structure for ALRs. The Department reduced the licensure application and renewal fee from \$500 to \$300 and reduced the per bed fee from \$105 to \$75. An application to change

the maximum capacity will require no additional licensure fee. It will, however, result in additional per bed fees to reflect the increased capacity. For dually-licensed facilities, the fee will be the same fee charged for a PCH license plus the licensing fee mentioned above for an ALR. Dually-licensed facilities would continue to pay the PCH per bed fee for those beds in the licensed PCH parts of the facility and the ALR per bed fee for those beds in the licensed ALR parts of the facility. The Department also will charge an application fee of \$150 for an ALR to request special care designation.

In terms of how the Department arrived at these fees, our initial intent was to make them reasonably related to the cost of regulating this care setting. We looked at the number of potential residences, approximated the number of beds per residence and calculated how much of our staff time it would take to license and oversee the program. We then looked at other states to make sure that our rates were not unduly higher or lower than others. When the proposed regulations were published, we received many comments from industry stakeholders stating that the fees that were proposed would be a disincentive for many of them to seek ALR licensure. Consequently, we decreased fees. Attachment B of the Regulatory Analysis Form contains a comparative analysis of licensure fees between Pennsylvania and a number of other states.

#### *§ 2800.19 Waivers*

IRRC questioned the timeframe for the Department to respond to waiver requests.

## *Response*

The Department did not specify a timeframe for responding to waiver requests. A review of the Department's other licensure chapters discloses that no other chapter provides for a timeframe for responding to waivers. See §§ 2600.19, 3130.4, 3140.5, 3270.13, 3280.13, 3680.5, 3700.5, 3800.22, 5310.5 and 6500.12. Indeed, at the request of commentators, the Department has provided greater transparency in the waiver process in this final-form rulemaking than that which exists in any other Department licensure regulation. Under the final-form rulemaking, waiver requests will be posted to the Department's website for a 30-day comment period prior to review and decision on the requested waiver. Given that the types of waivers requested may vary widely in scope and complexity, the Department is reluctant to bind itself to a specific timeframe for responding to waiver requests. Furthermore, since there is no other precedent in Department licensure regulations for a deadline for responding to waiver requests, the Department will not establish a deadline in this rulemaking.

## *§ 2800.22 Application and admission*

IRRC questioned the application and admission procedures and raised a concern as to whether these procedures are completed quickly enough to protect a resident's health and to protect a resident who may later be rejected. The Department was also asked to explain how it came up with the timeframes for the various admission procedures and why those timeframes are reasonable and protective of the public health, safety and welfare.

## *Response*

The Department made several significant changes to the admission and assessment procedures to respond to the concerns expressed by IRRC and other commentators. Based on these comments, this final-form rulemaking now provides for an initial assessment, a preliminary support plan, final support plan and certification that the needs of a potential resident can be met by the services provided by the residence. Specifically, the admission process includes the following: a medical evaluation completed within 60 days prior to or within 15 days after admission; an initial assessment completed within 30 days prior to admission or within 15 days after admission; a preliminary support plan developed within 30 days prior to admission or within 15 days after admission; a certification that the needs of a potential resident can be met prior to admission; and a final support plan within 30 days after admission.

These pre-admission and assessment procedures provide both the resident and the ALR with the information to determine whether a potential resident's needs can be met by the ALR prior to admission.

Further, to allow for flexibility, the rulemaking provides exceptions to the medical evaluation, initial assessment and preliminary support plan timelines under certain circumstances. The medical evaluation, initial assessment and the preliminary support plan can be completed 15 days after admission if one of the following conditions applies: the resident is being admitted directly to the ALR from an acute care hospital; the resident is being admitted to escape an abusive situation; or there is a situation where the resident has no alternative living arrangement. See §§ 2800.22 and 2800.224 (relating to application and admission; and initial assessment and preliminary support plan).

In addition to additional pre-admission requirements, the Department also added language to clarify both the certification process and the admission process. The regulation now defines who is authorized to make a certification. The Department added language that potential residents who do not need supplemental health care services and also potential residents who require the service of a licensed long-term care nursing facility may be admitted to an ALR. This added language was based on the statutory language of Act 56. 62 P.S. § 1057.3(b).

*§ 2800.25 Residence-resident contract*

IRRC questioned whether assisted living services must be listed separately or whether they can be bundled or unbundled to meet a resident's needs. IRRC also questioned the relationship between this section and 2800.220 (relating to service provision) which relates to assisted living services.

*Response*

The Department clarified the language in this section. This section now provides that a contract must specify the "fee schedule that lists the actual amount of charges for each of the assisted living services that are included in the resident's core service package in accordance with § 2800.220." As mentioned above, the Department further amended § 2800.220 to provide for two core service packages: an independent core package and an enhanced core package. These two packages provide different services based on a resident's needs. Since the services are clearly identified in the resident-residence contract, a potential resident will be able to accurately compare the

prices of assisted living services offered by different ALRs. In addition to the core service packages, an ALR must provide supplemental health care services and the supplemental health care services must be packaged, contracted and priced separately from the contract. 62 P.S. § 1026(b)(iii).

The Department also carefully considered the comments of industry stakeholders who argued that there were too many services listed in the two “core service” packages that consumers neither “want nor need” and expressed concern that the regulation would require individuals to accept and pay for services that consumers could do for themselves. The two examples cited most often were meals and personal laundry service as being a service that many consumers would prefer to do on their own or ask family or friends for assistance. The Department heeded these concerns and has made provision for the resident to “opt-out” of three services in the core service packages with an accompanying requirement that the contract price be adjusted accordingly. See §§ 2800.25(c)(2) and (l), 2800.220(d). The three services that a resident may opt out of are meals, housekeeping and laundry service. § 2600.220(c)(1)(ii-iv).

#### *§ 2800.30-- Informed consent process*

IRRC questioned whether the informed consent process will discourage providers from participating in the process, but also pointed out that other commentators believe that the informed consent provisions do not provide sufficient protection for consumers. IRRC requested that the Department explain how it developed the informed consent process and why it represents the best alternative to accomplish informed consent agreements.

## *Response*

While the informed consent process generated numerous comments, including suggestions that the process be omitted, the Department is, nevertheless, required by Act 56 to develop "standards" for an informed consent process. Act 56, however, was silent with respect to those standards. Thus, the Department, based upon recommendations by the American Association of Retired Persons (AARP) during the meetings that included industry stakeholders, adopted the procedures from HB 1351 (2007 Session) introduced by Representative Mundy.

In the proposed rulemaking, the Department was criticized for including a provision that would involve the local ombudsman in the informed consent process as an "investigator" or "mediator" rather than as an advocate for the resident. The Department has deleted those provisions in the final-form rulemaking. Instead, the notification provisions for the availability of the ombudsman are the only references remaining in the regulation. A rescission provision that allows either the resident or the ALR to cancel the agreement was also added in the final-form rulemaking, which further protects the rights of residents and providers. The Department also listened to the concerns of consumers by including in the notice of proposed rulemaking that informed consent agreements only be entered into by the residence and the resident when there was "imminent" risk of "substantial" harm to the resident. On reconsideration, however, and in response to objections made by other commentators, the Department has decided to delete those terms and adhere strictly to the provisions in the statute, which does not qualify the level or immediacy of the risk to the resident.

The Department has further limited the informed consent process to a resident who is competent unless a legal representative is involved in the process. Based upon all of these changes, the Department finds that it has struck a balance between the competing concerns of the parties while at the same time ensuring that the informed consent process meets the legislative intent and protects both the providers and consumers involved in the process.

*§ 2800.51. Criminal history checks*

IRRC questioned the requirements for criminal history checks of employees in light of Nixon v. Commonwealth, 789 A.2d 376 (Pa.CmwltH.Ct. 2001). IRRC specifically inquired how the Department will enforce this provision without violating the *Nixon* rule.

*Response*

The Department has clarified in the final-form rulemaking that it will follow the hiring policies set forth in the Department of Aging's Older Adults Protective Services Act (OAPSA) policy. This policy is available at [http://www.aging.state.pa.us/aging/lib/aging/COMMONWEALTH\\_OF\\_PENNSYLVANIA.pdf](http://www.aging.state.pa.us/aging/lib/aging/COMMONWEALTH_OF_PENNSYLVANIA.pdf). This represents the official administration policy and, until such time as there is legislative action to address the Nixon case, the Department is bound by the policy enunciated by the Department of Aging, which is responsible for OAPSA. This approach was suggested to the Department by Community Legal Services and we find that is a sound recommendation.

*§ 2800.56. Administrator staffing - administrator hours*

IRRC commented that the number of hours for an administrator to be present at the facility is excessive and that there is ambiguity in the proposed rulemaking related to the number of hours that an administrator or his designee must be physically present at the facility. IRRC asked for an explanation of why the Department is setting stricter standards for ALRs than for other long-term care facilities and noted that other types of long-term care facilities may share an administrator. IRRC also asked the Department to explain how many administrators would be needed for a typical facility to meet the requirements in a typical year and the associated costs. IRRC also requested the Department explain how the administrator requirements will accommodate the need for an administrator to attend offsite training sessions and meetings.

*Response*

The basis for the requirement that an administrator or designee be present 40 hours per week, with 30 of those hours during normal business hours was the Department's expectation that the acuity needs of the residents in ALRs will be substantially higher than for residents of PCHs. (Please note that there was an inadvertent error in the notice of proposed rulemaking that provided that the administrator had to be present at the facility an average of 30 hours per "month" during normal business hours. This has been corrected to require that the administrator be present at least 30 hours per week during normal business hours.)

The Department, however, never intended that an administrator or the administrator designee be present at the facility 24 hours a day, 365 days per year.

Instead, the administrator designee is to be available to fill the balance of the required hours per week that an administrator is absent. The Department has clarified the language in the final-form rulemaking to reflect that the administrator is able to go off-site for temporary absences, such as vacation and training. During those temporary absences, the administrator designee is required to be present to fill the required administrator hours in subsection (a). The Department also clarified in the final-form rulemaking that during the administrator's and administrator designee's absences, a direct care staff person must be in charge of the facility. During those times, the administrator or administrator designee must be on-call.

In addition to these clarifying amendments, the Department also amended the hourly requirement for administrators to 36 hours per week. The PCH regulations require that administrators be present in the PCH on average at least 20 hours per week. Because of the higher acuity levels we anticipate in ALR residents, the Department did not think this was adequate administrative coverage and instead initially set the ALR standard to be 40 hours a week. However, we received many comments from industry stakeholders who felt that meeting this requirement would be a challenge. They felt it would be difficult for them to conduct the functions of the position and to attend required training if they had to spend that amount of time at the residence. In response, we reduced the requirement to 36 hours and maintain that this change, coupled with the language we have added clarifying that administrator designees may provide some of the coverage, address the concerns raised.

Further, in § 2800.11 allowance has been made for administrator-sharing for dually licensed ALRs and PCHs. Finally, in response to the question related to costs of

administrators, the Department has provided this information in its analysis in the Regulatory Analysis Form.

*§ 2800.56. Administrator staffing - administrator designee*

IRRC commented on the provision requiring the same training for an administrator designee as for the administrator. Specifically, IRRC asked why the Department is setting this training requirement.

*Response*

Based on the comments received, the Department amended the language regarding the requirements for an administrator designee. The administrator designee is not required to meet the same training requirements as the administrator. Instead, in the final-form rulemaking, the administrator designee must meet the qualification and training requirements of a direct care staff person, have 3,000 hours of direct operational responsibility, and pass the Department-approved competency-based training test. A number of considerations went into development of this requirement. Industry stakeholders suggested that having 3,000 hours of direct operational experience, which is one criteria for being an ALR administrator in Ohio, would represent sufficient experience to be an ALR administrator designee. The Department accepted this recommendation but, in order to ensure resident health and safety, chose to add that administrator designees must also meet direct care staff requirements and must pass the Department-approved competency-based training test.

*§ 2800.60. Additional staffing based on the needs of the residents*

IRRC recommended that the level of nursing training for the on-call nurse be specified in the regulation.

*Response*

The Department agrees and made the change that the on-call nurse had to be "licensed". This would allow either a licensed practical nurse (LPN) or a licensed registered nurse (RN) to fulfill that requirement. The requirements for licensure of either are set forth in the regulations of the Department of State. 49 Pa.Code Chapter 21 (relating to state board of nursing).

*§ 2800.63. First aid, CPR and obstructed airway training*

IRRC commented that the requirement for "sufficient staff" is vague and does not provide a standard for protection that can be understood and implemented.

*Response*

The Department agrees with the comment and has specified a numeric ratio of 1 staff to 35 residents in the final-form rulemaking.

*Square Footage Requirements—§§ 2800.98, 2800.101 and 2800.104. Indoor activity space; resident living units; and dining room*

IRRC questioned why § 2800.101 does not allow for exceptions to the living unit size as specified in Act 56. IRRC further questioned why the Department has specified square footage size requirements for indoor activity spaces such as common areas and dining rooms and pointed out that parallel provisions in the PCH regulations do not have such specificity.

*Response*

Written request for a waiver of a specific requirement can be made under § 2800.19 (relating to waivers). Since there is already a section that provides for requesting a waiver of a requirement, the Department did not find it necessary to include a specific waiver subsection within § 2800.101 in the notice of proposed rulemaking. Nevertheless, in response to IRRC and stakeholder comment, the Department revisited this issue on final-form rulemaking and decided to amend this section to include the same language set forth in Act 56 relating to allowing exception to the size of the living unit to be made at the discretion of the Department. 62 P.S. § 1021(a)(2)(v).

The Department consulted with the Pennsylvania Housing and Finance Agency, which recommended specifying the square footage for the indoor activity and dining room space and the Department found that the recommendations were appropriate since they are clear, measurable and enforceable. Since the Department is directed to “meet or exceed” the standards in the PCH regulations, these square footage requirements build on the PCH regulations at 2600.98 (relating to indoor activity space) which require that the combined living room or lounge areas must “accommodate all residents at one time.”

*§ 2800.101. Resident living units – development of square footage requirements*

IRRC questioned how the Department developed the square footage requirements for resident living units. IRRC also asked what study or research was relied upon for determining the minimum square footage selected and how they best implement Act 56. IRRC also asked why these specific square footage requirements are necessary to protect public health, safety and welfare.

*Response*

If an individual resides in an ALR, that individual's living unit will be that person's home. The Department finds that the General Assembly, in enacting Act 56, intended that the minimum square footage for living units an ALR must be sufficient for a variety of types of consumers with a variety of needs. In order to accommodate a home-like atmosphere, including the required living space, bedroom space and kitchen capacity, the Department determined that adequate square footage would be required.

During the development of the notice of proposed rulemaking, the Department asked for feedback from industry stakeholders and consumers related to minimum square footage requirements for resident living units. Industry stakeholders argued that the minimum square footage for living units for new facility construction should be 150 square feet and for existing construction, 125 square feet. In contrast, consumers expressed concern that 250 square feet was inadequate, particularly for wheelchair users. Individuals in ALRs, as they age in place or if they have a disability and use a wheelchair, require sufficient room to move about comfortably and to have visitors come

to their living units. The Department also surveyed other states as to their square footage requirements for ALRs. A number of states that are at the forefront of the assisted living movement, including Vermont, Iowa, Louisiana, Oregon, Washington and Hawaii, have square footage requirements over 200 square feet for individual living units. The Department also finds that this level of square footage is the direction that the industry is moving towards.

Based on comments and further meetings with stakeholders, the Department has decided, however, to reduce the minimum square footage for new construction from the proposed 250 square feet to 225 square feet. The 225 square footage requirement should meet the needs of the residents for adequate space to accommodate both their living needs and mobility needs but also balance the concerns expressed by industry stakeholders related to costs. The Department notes that, according to the survey it conducted related to square footage, there are PCHS that are interested in pursuing licensure as PCHs that easily meet or exceed the minimum 225 square feet requirement. The Department has also specified that if two individuals share a room, the minimum square footage shall be 300 square feet in the living unit.

With respect to IRRC's other comment related to existing facilities and the square footage requirements, IRRC recommended that the Department identify how many licensed PCHs there are in the Commonwealth and how many meet the proposed minimum standard of 175 square feet in each living unit. Per IRRC's recommendation, as mentioned above, in October of 2008, the Department conducted a survey of the 1,437 PCHs licensed in the Commonwealth. It received 723 responses to the survey. Using the originally proposed square footage of 175, the Department estimated that

there were approximately 220 PCHs that had at least 90% of their rooms that would meet this requirement.

Although the survey results support the minimum square footage requirements set forth in the notice of proposed rulemaking for existing facilities, based on comments and additional meetings with stakeholders, the Department has decided, however, to reduce the square footage for existing facilities from the proposed 175 square feet to 160 square feet. Based on survey results, this change will increase the number of PCHs to approximately 243 that had at least 90% of their rooms that would meet this requirement.

This standard should balance the competing interests between existing facilities that want to convert to an ALR and the interests of the consumers and other interested parties who have requested adequate living space for residents of ALRs. The Department has also specified that if two individuals share a room, the minimum square footage shall for existing facilities be 210 square feet in the living unit. Finally, as noted above, the Department has clarified the language in this section to provide that exceptions to the size of the living unit may be made at the discretion of the Department. This mirrors the language in Act 56 at 62 P.S. § 1021(a)(2)(v).

*§ 2800.101. Resident living units – relationship between square footage, affordability and accessibility*

IRRC asked that the Department explain how it researched and assessed existing licensed PCHs in setting the square footage requirements in the regulations for ALRs. It asked DPW to consider the input from PCHA and PANPHA related to their

comment that the square footage proposed by the Department appears high when compared to other states and that some consumers may wish to have a smaller living unit to save money. Also, IRRRC requested that the Department explain how the method of specifying square footage will best provide for affordability and accessibility of ALRs for Pennsylvania's population.

*Response*

The Department assessed existing PCHs in the Commonwealth by conducting a survey, the results of which are found above. The Department also received numerous comments from long-term living trade associations and had numerous discussions with them on this topic. In addition to this input, in considering the minimum square footage requirements for ALRs in Pennsylvania, the Department looked at other states to assess their requirements and found that eleven states (Washington, Oregon, Iowa, Arizona, Wisconsin, West Virginia, Louisiana, Vermont, Kansas, Kentucky and Hawaii) all have single room occupancy requirements of 220 square feet or above. The Department finds that many of these states have vibrant assisted living programs and when Pennsylvania's program is underway, it will be in the top twelve states in terms of ALR room size.

*§ 2800.101—Square footage requirements for residences in existence prior to the effective date of regulation*

IRRC asked that the Department determine how many PCHs in existence at the time of the proposed regulation that the Department thinks would qualify for the 175 square foot minimum square footage requirement.

*Response*

As stated above, in October of 2008, the Department conducted a survey of the 1,437 Personal Care Homes (PCHs) licensed in the Commonwealth which revealed that approximately 220 PCHs had at least 90% of their rooms that would qualify under the 175 square footage requirement. Based on comments from industry stakeholders, the Department chose to decrease the square footage requirement to 160 square feet. Using the same survey results, the Department finds that approximately 243 PCHs had at least 90% of their rooms that would qualify based on the revised square footage requirements.

*§ 2800.101. Evaluation of the feasibility of existing licensed PCHs being able to change their licensure to assisted living*

IRRC commented that it is clear that many existing PCH licensees want to be licensed as ALRs. The Department acknowledged this interest by providing for different square footage for living units for existing facilities. The Department should explain how it researched and assessed existing licensed PCHs in setting the requirements in the ALR regulation. IRRC asked how many facilities in existence did the Department determine would qualify as ALRs and how many would not? Also, the IRRC asked how these limits would sufficiently meet the needs of ALR residents.

## *Response*

Act 56 requires that ALR regulations must meet or exceed the PCH regulations. In anticipation that many existing PCHs would be interested in either converting to ALRs or becoming dually licensed, the Department decided to use the PCH regulations as a framework in which to construct the ALR regulations. Doing that, however, meant balancing the ease with which PCHs could convert to ALRs against the significant differences between the two types of facilities. Much of our research was done by examining the PCH regulations closely and determining which were transferable to ALRs and which were not. We then set into place an extensive stakeholder input process to work out differences and, when that was not possible, to use that process to make informed decisions.

Based on the October 2008 survey described above and using the originally proposed square footage of 175 square feet for existing facilities, the Department estimated that there were approximately 220 PCHs that had at least 90% of their rooms that would meet the square footage requirements. Approximately 243 PCHs had 90% of their rooms that would qualify under a square footage requirement of 160.

In terms of how the number of potentially qualifying PCHs will meet the need in Pennsylvania for ALRs, we maintain that this is a good start. As new facilities come on line, the Commonwealth has the potential to grow a healthy home and community-based option for older residents and those persons with disabilities.

*§ 2800.101. Resident living units – kitchen capacity*

IRRC questioned how the Department came up with the requirements for kitchen capacity for the living units and asked a series of questions about kitchen capacity. First, IRRC questioned why the Department required refrigerators, microwave ovens and bar-type sinks for newly constructed living units when Act 56 only specified that the living units must have "kitchen capacity, which may mean electrical outlets to have small appliances such as a microwave and refrigerator". 62 P.S. § 1021(a)(2)(iv). IRRC further inquired why microwaves and refrigerators are required for new construction, but not for existing facilities; and also asked how much this requirement increases costs to a resident. If a resident does not wish to use these items, IRRC asked why should the resident pay for them?

IRRC also asked about a discrepancy in the regulations between existing facilities and new construction related to the removal of appliances based on safety considerations that are included in the new construction requirements but not for existing facilities. As to other required items for a living unit, IRRC questioned the list of required items and asks if residents may opt out of having such items.

### *Response*

The Department has made several significant changes to the final-form rulemaking with respect to kitchen capacity. In recognition of consumer choice, for both new construction and existing facilities, an ALR will be required to offer the resident the option to have a cooking appliance, a small refrigerator, or both. If the resident desires to have a cooking appliance, small refrigerator, or both, the ALR shall provide the appliances, unless the resident wishes to bring his own appliances. For both new construction and existing facilities, the final-form rulemaking now provides for the

removal of an appliance for resident safety or if the resident chooses to not have the appliance.

As to the costs for new construction, the Department submits that having a bar sink in the living unit is designed so that the resident can exercise maximum choice and have privacy and autonomy in his living arrangement. As mentioned above, the assisted living model of residential living emphasizes resident self-determination and choice. For an individual who chooses to cook his own meals, a small sink is necessary to allow the resident to wash dishes in a separate area. Otherwise, the resident would have to use his bathroom sink to wash dishes. At the same time, the Department is mindful that some residents may no longer wish to cook or have a cooking appliance in their living unit. The resulting language in the final-form rulemaking accomplishes an appropriate balance because it is directed at putting the consumer "in the driver's seat" as to the choice he makes about the accommodations in his living unit. As to existing facilities, the Department adopted the recommendation of industry stakeholders that many existing PCHs provide residents with access to a "country kitchen," which is separate from the facility's kitchen area but near enough to resident bedrooms to allow residents to prepare meals or wash dishes. To minimize costs to existing facilities, the Department adopted this recommendation and finds that it is reasonable to minimize costs to existing facilities that may wish to pursue licensure as an ALR.

As to whether a resident may opt out of having some of the other items listed in § 2800.101(j) and (q), the Department is required by Act 56 to "meet or exceed" the requirements set forth in the PCH regulations. These regulations at § 2600.100 (relating to resident bedrooms) require certain furnishings that are intended to protect the dignity, well-being and privacy of residents.

*§ 2800.102. Bathrooms*

IRRC recommended deletion of the phrase “applicable local, state and federal laws and guidelines”.

*Response*

The Department agrees and deleted this phrase. The requirement for compliance with applicable Federal, State and local laws, ordinances and regulations is already required at § 2800.18 (relating to applicable laws).

*§ 2800.108. Firearms and weapons*

IRRC questioned the threshold question of safety of firearms and weapons in an ALR. IRRC recommended allowing a facility to prohibit weapons and to require an ALR to disclose whether it allows firearms and weapons to prospective residents in its admissions procedures and documents. IRRC also recommended that the terms “living area” and “common living area” be reconciled. Finally, IRRC recommended use of consistent terminology to include “firearms, weapons and ammunition” throughout this section.

*Response*

The Office of Attorney General tolled the proposed regulation on the basis that the Department initially sought to ban all firearms and weapons from ALRs as

recommended by industry stakeholders, consumers and other interested parties who all advocated a ban on weapons and firearms. As a result of the Attorney General's comments, the Department modified the proposed rulemaking to require that ALRs, instead, must have a written policy regarding firearms. In the final-form rulemaking, the Department further clarified that an ALR have a written policy on firearms, weapons and ammunition and that an ALR is not required to permit these items. This policy will be included in the resident handbook so that the prospective resident is fully informed of the ALR's policy in this area.

The Department also made the technical changes recommended by IRRC related to use of consistent terminology related to "common living areas" and "firearms, weapons and ammunition" in the final-form rulemaking. The Department decided to continue to use the term "common living area" for conformity since the requirements for PCH use the same language. See § 2600.108 (relating to firearms and weapons)

#### *§ 2800.131. Fire extinguishers*

IRRC questioned why the regulation exceeded the PCH standard for fire extinguishers and reiterated concerns expressed by commentators as to costs and safety risks associated with having fire extinguishers in each living unit and in each kitchen.

#### *Response*

The Department has amended these provisions and will require a fire extinguisher for each floor, including walkways and common living areas every 3,000

square feet. This change was recommended jointly to the Department by industry stakeholders, consumers and other interested parties and is a reasonable standard that will protect health and safety of the residents.

*§ 2800.142. Assistance with medical care and supplemental health care services*

IRRC questioned the use of the phrase “such approval may not be unreasonably withheld.”

*Response*

The Department has deleted this language from the final-form regulation.

*§ 2800.162. Meals*

IRRC questioned what is meant by “appropriate cueing” as it relates to encouraging residents to eat and drink. IRRC commented that the requirement is vague. IRRC also questioned how this would apply to individuals who are cooking and eating in their own living units. IRRC recommended deletion of this provision or relocating it to § 2800.227 (relating to development of final support plan).

*Response*

The Department concurs with IRRC and other commentators that this issue is more appropriately dealt with based on the individual’s support plan in § 2800.227(d) so that it is tailored to individuals who eat their meals either in a congregate setting or

individually in their own rooms. As a result, the Department added the language “as indicated in the resident’s support plan” in subsection (g) of this section to clarify this requirement.

*§ 2800.171. Transportation*

IRRC questioned whether, when a residence provides its own vehicle, *all* vehicles must be wheelchair accessible and provide for any other assistive devices the resident may need.

*Response*

The Department has modified this provision after further consultation with stakeholders. The Department has clarified in the final-form rulemaking that if an ALR provides transportation, a minimum of one vehicle furnished by the ALR must be wheelchair accessible and provide room for any other assistive equipment the resident may need.

*§ 2800.225. Initial and annual assessment (now entitled additional assessments)*

IRRC questioned why the Department did not include language from § 2600.225(d) (relating to initial and annual assessment) from the PCH regulations in the ALR regulations relating to determinations of the resident’s need for a higher level of care and referral to an appropriate assessment agency.

*Response*

IRRC correctly points out that Act 56 may limit ALRs from accepting residents with certain conditions and health care needs. However, Act 56 also allows a facility to seek an exception from the Department to allow it to serve individuals with certain "excludable conditions". 62 P.S. § 1057.3(e) and (g). Since the ALR regulation is distinguishable from the PCH regulations in this regard, the Department did not adopt the language in 2600.225(d) from the PCH regulations. An individual who may need skilled long-term care services may be served in an ALR according to the individual's preferences and according to whether the ALR wishes to provide such care by seeking an exception from the Department to provide such care. Requiring a "higher level of care", therefore, is not a parallel concept for ALRs and PCHs since and ALR allow for aging in place may serve individuals whose acuity needs change over time, and may, if an exception is granted for an excludable condition, actually serve an individual who would otherwise have to be transferred to a nursing facility. A PCH, however, may not serve an individual who "requires the services in or of a long-term care facility." 62 P.S. § 1001.

*§§ 2800.224 and 2800.227. Initial assessment and preliminary support plan and development of the final support plan*

IRRC reflected the comments of many commentators who objected to the requirement that a licensed RN had to review and approve a support plan prepared by a LPN.

## Response

The Department declined to make this change. In both nursing facilities and in home and community-based long-term living programs, RNs must review and approve support plans. Since we expect that ALRs will have residents with higher acuity levels than those in PCHs, the Department determined that use of RN expertise was needed.

### *§ 2800.228. Transfer and discharge*

IRRC questioned how this section protects the rights of residents to be treated fairly and properly before a transfer or discharge occurs. IRRC also questioned the reliance on providing notice to an outside agency, in this case, an ombudsman. IRRC commented that it is not clear how the Department would be aware of whether the processes relating to notification of the ombudsman are being carried out in a timely manner. Also, as to the standards for admission or discharge, IRRC pointed out that the Department is required "by regulation" to establish the standards required for certification that a consumer may not be admitted or retained at an ALR. Finally, IRRC also asked how the Department can guarantee a timely and fair treatment of a consumer appeal.

## *Response*

To protect the resident, the grounds for transfer or discharge from an ALR are limited to those specified in subsection (h). In addition, to ensure a resident is being treated fairly and properly, the Department has specifically detailed the transfer and discharge process, including a 30-day advance written notice to the resident, the

resident's family or designated person. This notice must include the specific reason for transfer or discharge, the effective date of the transfer or discharge, the location that the resident will be transferred or discharged to, an explanation of the measures a resident or the resident's designated person can take if they disagree with the decision to transfer or discharge, and the name, mailing address, telephone number of the State and local long-term care ombudsman. In addition, the Department added a new provision that states that the notice shall also provide the resident's transfer or discharge rights, as applicable. To ensure an ALR is abiding by these notice provisions, the Department requires the resident record to include the notice and also the reason for termination of services or transfer of a resident. See § 2800.252 (relating to content of resident records).

The Department agreed with IRRC's comment regarding the certification language regarding transfer or discharge. Therefore, the Department added this language in subsection (i).

The Department, however, is not in the position or granted the authority for establishing "expedited" resident appeals regarding transfer or discharge. The Department does not have jurisdiction under Article X of the Public Welfare Code or Act 56 to adjudicate resident appeals. A resident's transfer or discharge is a contract matter between the resident and the ALR and, as such, the Court of Common Pleas has jurisdiction unless other provisions are made in the contract for dispute resolution, such as mediation or arbitration.

§ 2800.229. *Excludable conditions; exceptions*

IRRC asked why the certification language is limited to this section regarding excludable conditions. It stated that it is not clear that certification by a provider for a resident's admission or retention is limited to situations involving the excludable conditions listed at 62 P.S. § 1057.3(e).

*Response*

The Department agrees with IRRC's comment that the certification requirement is not merely limited to excludable conditions and has added language to §§ 2800.22 (relating to application and admission) and 2800.228 (relating to transfer and discharge) in accordance with Act 56.

*Miscellaneous clarity issues*

IRRC commented that various sections of the regulation provide for forms "as specified by the Department." IRRC further suggested that the Department take advantage of the stakeholder process in the development and content of these forms. IRRC also inquired how the Department will make these forms available.

*Response*

After publication of this final-form rulemaking, the Department intends to work closely with stakeholders during the 6-month interval between the publication date and the effective date of the rulemaking in the development and content of these forms.

*Additional Changes to the Regulation*

In addition to the comments submitted by IRRC and other commentators related to the notice of proposed rulemaking, as stated previously, the Department received 79 more comments from consumers, industry stakeholders and other interested parties after the issuance of the "draft" regulation on June 24, 2009. A number of those changes have been addressed above. Additional changes were made to the regulations based on these comments, including those described below.

### *Resident Rights*

Consumers commented that there are resident rights scattered throughout the regulations and requested that the residents rights be placed in one location.

### *Response*

In response to this concern the Department has prepared an Appendix containing all of the resident rights in the regulation. See Appendix A.

### *§ 2800.54. Qualifications of direct care staff*

Numerous commentators interpreted the regulation to mean that every direct care staff person must be able to communicate in all languages in order to meet the provision that states that they must "be able to communicate in a mode or manner understood by the resident."

### *Response*

The Department's intent was never to require that staff persons must be able to communicate in all languages. The Department has clarified in the provisions of the

final-form rulemaking that strategies that promote interactive communication be developed as part of a resident's support plan.

*§ 2800.60. Additional staffing based on the needs of the residents*

Numerous industry stakeholders questioned if they would be required to have a licensed nurse on call even if they already have one on staff.

*Response*

In order to address this concern raised by industry stakeholders, the Department has changed the regulation to allow that a licensed nurse must be on call or "in the building."

*§ 2800.171. Transportation*

Many industry stakeholders contended that transportation to medical appointments and social events should not be required unless they are scheduled by the residence. Many also objected that the regulation did not specify a limit on the distance they would be required to travel.

*Response*

The Department has changed the regulation to require that residences must provide or arrange transportation on "a regular weekly basis that permits residents to schedule medical and social appointments within a reasonable local area."

§ 2800.171(a). This will allow residences the ability to manage their work schedules while also meeting the needs of residents to get to medical and social appointments.

While the Department considered a specific radius of travel, given the differences in access to public transportation and geographical differences in the state, such specificity was not appropriate. The Department holds that a rule of reasonableness should apply.

*§§ 2800.64 and 2800.53. Administrator training and orientation and qualifications and responsibilities of administrators*

Many comments were received from industry stakeholders advocating for the grandfathering of PCH administrators and nursing home administrators as ALR administrators. Many comments were received from others advocating that no grandfathering be allowed.

*Response*

The Department took both of these views into consideration. While recognizing that both PCH administrators and nursing home administrators are in a unique position based on their experience to transition to ALR administrators, they should also be qualified to address the broad range of needs of the populations served by ALRs. Subsequently, §§ 2800.53 and 2800.64 have been amended, not to provide for grandfathering, but to allow each of these professionals to meet different sets of qualifications and training requirements while requiring passage of a competency test.

*Regulatory Review Act*

Under § 5.1(a) of the Regulatory Review Act (71 P.S. § 745.5a(a)), on **MAY 03 2010** the Department submitted a copy of this regulation to IRRC and to the Chairpersons of the House Committee on Aging and Older Adult Services and the Senate Committee on Public Health and Welfare. In compliance with the Regulatory Review Act, the Department also provided the Committees and the IRRC with copies of all public comments received, as well as other documentation.

In preparing the final-form regulation, the Department reviewed and considered comments received from the Committees, the IRRC and the public.

In accordance with § 5.1 (j.1) and (j.2) of the Regulatory Review Act, this regulation was [*deemed*] approved by the Committees on . The IRRC met on and approved the regulation.

In addition to submitting the final-form rulemaking, the Department has provided the IRRC and the Committees with a copy of a Regulatory Analysis Form prepared by the Department. A copy of this form is available to the public upon request.

*Order*

The Department finds:

- (a) The public notice of intention to adopt the administrative regulation by this Order has been given pursuant to §§ 201 and 202 of the Commonwealth

Documents Law (45 P.S. §§ 1201 and 1202) and the regulations at 1 Pa. Code §§ 7.1 and 7.2.

- (b) That the adoption of this regulation in the manner provided by this Order is necessary and appropriate for the administration and enforcement of the Public Welfare Code.

The Department acting pursuant to sections 211, 213 and Article X of the Public Welfare Code (62 P.S. §§ 211 and 213 and 1001-1087) orders:

- (a) The regulation of the Department is adopted to read as set forth in Annex A of this Order.
- (b) The Secretary of the Department shall submit this Order and Annex A to the Offices of General Counsel and Attorney General for approval as to legality and form as required by law.
- (c) The Secretary of the Department shall certify and deposit this Order and Annex A with the Legislative Reference Bureau as required by law.
- (d) This order shall take effect 6 months from the date of publication of the final-form regulation in the *Pennsylvania Bulletin*.

ANNEX A

TITLE 55. PUBLIC WELFARE

PART IV. ADULT SERVICES MANUAL

Subpart E. RESIDENTIAL AGENCIES/FACILITIES SERVICES

CHAPTER 2800. ASSISTED LIVING RESIDENCES

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## **GENERAL PROVISIONS**

### **§ 2800.1. Purpose.**

(a) The purpose of this chapter is to protect the health, safety and well-being of assisted living residents.

(b) Assisted living residences are a significant long-term care alternative to allow individuals to age in place. Residents who live in assisted living residences that meet the requirements in this chapter will receive the assistance they need to age in place and develop and maintain maximum independence, [self-determination] exercise decision-making and personal choice.

### **§ 2800.2. Scope.**

(a) This chapter applies to assisted living residences as defined in this chapter, and contains the minimum requirements that shall be met to obtain a license to operate an assisted living residence.

(b) This chapter does not apply to personal care homes, domiciliary care homes, independent living communities or commercial boarding [residences] homes.

### **§ 2800.3. Inspections and licenses.**

(a) The Department will annually conduct at least one onsite unannounced inspection of each assisted living residence.

(b) Additional announced or unannounced inspections may be conducted at the Department's discretion.

(c) [The Department may conduct an abbreviated annual licensure visit if the assisted living residence has established a history of exemplary compliance.]

(d)] A license will be issued to the legal entity by the Department if, after an investigation by an authorized agent of the Department, the requirements for a license are met.

[ (e) ] (d) The assisted living residence shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the assisted living residence.

### **§ 2800.4. Definitions.**

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

[*ADL--Activities of daily living*--The term includes eating, drinking, ambulating, transferring in and out of a bed or chair, toileting, bladder and bowel management, personal hygiene, securing health care, managing health care, self-administering medication and proper turning and positioning in a bed or chair.]

*Abuse*--The occurrence of one or more of the following acts:

(i) The infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish.

(ii) The willful deprivation by the assisted living residence or its staff persons of goods or services which are necessary to maintain physical or mental health.

(iii) Sexual harassment, rape or abuse, as defined in 23 Pa.C.S. Chapter 61 (relating to protection from abuse).

(iv) Exploitation by an act or a course of conduct, including misrepresentation or failure to obtain informed consent which results in monetary, personal or other benefit, gain or profit for the perpetrator, or monetary or personal loss to the resident.

(v) Neglect of the resident, which results in physical harm, pain or mental anguish.

(vi) Abandonment or desertion by the assisted living residence or its staff persons.

ADL--Activities of daily living--The term includes eating, drinking, ambulating, transferring in and out of a bed or chair, toileting, bladder and bowel management, personal hygiene, securing health care, managing health care, self-administering medication and proper turning and positioning in a bed or chair.

*Adult*--An individual who is 18 years of age or older.

[*Ancillary staff person*--An individual who provides services for the residents other than activities of daily living.]

*Age in place or aging in place*--Receiving care and services at a licensed assisted living residence to accommodate [a resident's] changing needs and preferences in order to [allow the resident to] remain in the assisted living residence.

Agent--An individual authorized by the Department to enter, visit, inspect or conduct an investigation of an assisted living residence.

Ancillary staff person--An individual who provides services for the residents other than direct assistance with activities of daily living. Ancillary staff may include staff who do not provide direct care but who conduct assessment, care planning or care management activities, and who meet the direct care staff qualifications and training requirements. Ancillary staff may also include RNs, LPNs, dietitians, or skilled professionals who meet the requirements of their professional licensure and the direct care staff requirements, if they also provide

direct assistance with activities of daily living. Other ancillary staff may include activities planners, housekeepers, cooking staff or facilities staff.

Appropriate assessment agency--An organization serving adults who are older or adults with disabilities, such as a county mental health/mental retardation agency, a drug and alcohol agency, an area agency on aging or another human service agency or an individual in an occupation maintaining contact with adults who are older and adults with disabilities, such as medicine, nursing or rehabilitative therapies.

*Area agency on aging*--The local agency designated by the Department of Aging as defined in section 2202-A of The Administrative Code of 1929 (71 P. S. § 581-2).

Assessment – An instrument that includes screening of a resident or potential resident to determine whether the resident or potential resident requires the services of an assisted living residence.

*Assisted living residence or residence*--Any premises in which food, shelter, [personal care] assisted living services, assistance or supervision and supplemental health care services are provided for a period exceeding 24-hours for four or more adults who are not relatives of the operator, who require assistance or supervision in matters such as dressing, bathing, diet, financial management, evacuation from the residence in the event of an emergency or medication prescribed for self-administration.

*Assisted living residence administrator*--An individual who is charged with the general administration of an assisted living residence, whether or not the individual has an ownership interest in the residence or his function and duties are shared with other individuals.

*Assisted living services*— Services as defined in § 2800.220(b) (relating to service provision).

*[Agent*--An individual authorized by the Department to enter, visit, inspect or conduct an investigation of an assisted living residence.

*Appropriate assessment agency*--An organization serving adults who are older or adults with disabilities, such as a county mental health/mental retardation agency, a drug and alcohol agency, an area agency on aging or another human service agency or an individual in an occupation maintaining contact with adults who are older and adults with disabilities, such as medicine, nursing or rehabilitative therapies.]

*Basic cognitive support services* -- These services include the following:

(i) Intermittent cueing.

(ii) Redirecting.

(iii) Environmental cues.

(iv) Measures to address wandering.

(v) Dementia-specific activity programming.

(vi) Specialized communication techniques.

*CAM--Complementary and alternative medications--*Practices, substances and ideas used to prevent or treat illness or promote health and well-being outside the realm of modern conventional medicine. Alternative medicine is used alone or instead of conventional medicine. Complementary medicine is used along with or in addition to conventional medicine.

CPB—Cognitive, physical, behavioral.

*CPR--*Cardiopulmonary resuscitation.

*Cognitive support services--*

(i) Services provided to an individual who has memory impairments and other cognitive problems which significantly interfere with his ability to carry out ADLs without assistance and who requires that supervision, monitoring and programming be available 24 hours per day, 7 days per week, in order to reside safely in the setting of his choice.

(ii) The term includes assessment, health support services and a full range of dementia-capable activity programming and crisis management.

*Commercial boarding[ residence] home--*A type of residential living facility providing only food and shelter, or other services normally provided by a hotel,

for payment, for individuals who require no services beyond food, shelter and other services usually found in hotel or apartment rental.

Common living area—shall include any of the following:

(i) Dining room.

(ii) Indoor activity space.

(iii) Recreational space.

(iv) Swimming area, if located in the residence.

*Complaint*—A written or oral criticism, dispute or objection presented by or on behalf of a resident to the Department regarding the care, operations or management of an assisted living residence.

*Day*—Calendar day.

*Dementia*—A clinical syndrome characterized by a decline of long duration in mental function in an alert individual. Symptoms of dementia may include memory loss, personality change, chronic wandering and the loss or diminishing of other cognitive abilities, such as learning ability, judgment, comprehension, attention and orientation to time and place and to oneself.

*Department*—The Department of Public Welfare of the Commonwealth.

*Designated person*--An individual who may be chosen by the resident and documented in the resident's record, to be notified in case of an emergency, termination of service, assisted living residence closure or other situations as indicated by the resident or as required by this chapter. A designated person may be the resident's legal representative or an advocate.

*Designee*--A staff person authorized in writing to act in the administrator's absence.

*Direct care staff person*--A staff person who directly assists residents with activities of daily living, and instrumental activities of daily living and provides services or is otherwise responsible for the health, safety and well-being of the residents.

*Discharge*--Termination of an individual's residency in an assisted living residence.

*Distinct Part*--A portion of a building that is visually separated such as a wing or floor, or sections or parts of floors.

*Emergency medical plan*--A plan that ensures immediate and direct access to medical care and treatment for serious injury or illness, or both.

[*Exemplary compliance*--Three consecutive years of deficiency-free inspections.]

*Financial management*--

(i) [A personal care] An assisted living service requested or required by the resident in accordance with his support plan, which includes taking responsibility for or assisting with paying bills, budgeting, maintaining accurate records of income and disbursements, safekeeping funds and making funds available to the resident upon request.

(ii) The term does not include solely storing funds in a safe place as a convenience for a resident.

*Fire safety expert*--A member of a local fire department, fire protection engineer, Commonwealth-certified fire protection instructor, college instructor in fire science, county or Commonwealth fire school, volunteer trained and certified by a county or Commonwealth fire school, an insurance company loss control representative, Department of Labor and Industry building code inspector or construction code official.

*Health care or human services field*--Includes the following:

(i) Child welfare services.

(ii) Adult services.

(iii) Older adult services.

(iv) Mental health/mental retardation services.

(v) Drug and alcohol services.

(vi) Services for individuals with disabilities.

(vii) Medicine.

(viii) Nursing.

(ix) Rehabilitative services.

(x) Any other human service or occupation that maintains contact with adults who are older or adults and children with disabilities.

*Housekeeping*--The cleaning of the living unit and common living areas.

Cleaning of the living unit includes at least weekly dusting, sweeping, vacuuming, mopping, emptying trash, and cleaning of bathroom, counters, refrigerator and microwave oven, if these appliances are in the resident's living area.

Housekeeping for common living areas means keeping them in clean sanitary condition.

*IADL--Instrumental activities of daily living*--The term includes the following activities when done on behalf of a resident:

(i) Doing laundry.

(ii) Shopping.

(iii) Securing and using transportation.

(iv) Financial management.

- (v) Using a telephone.
- (vi) Making and keeping appointments.
- (vii) Caring for personal possessions.
- (viii) Writing correspondence.
- (ix) Engaging in social and leisure activities.
- (x) Using a prosthetic device.
- (xi) Obtaining and keeping clean, seasonal clothing.
- [(xii) Housekeeping.]

*Informed consent agreement*--A formal, mutually agreed upon, written understanding which:

(i) Results after thorough discussion among the assisted living residence staff, the resident and any individuals the resident wants to be involved.

(ii) Identifies how to balance the assisted living residence's responsibilities to the individuals it serves with a resident's choices and capabilities with the possibility that those choices will place the resident or other residents at risk of harm.

[(iii) Documents the resident's choice to accept or refuse a service offered by or at the residence.]

INRBI—Intense neurobehavioral rehabilitation after brain injury.

*Legal entity*--A person, society, corporation, governing authority or partnership legally responsible for the administration and operation of an assisted living residence.

*Legal representative*--An individual who holds a power of attorney, a court-appointed guardian or other person legally authorized to act for the resident.

*License*--A certificate of compliance issued by the Department permitting the operation of an assisted living residence, at a given location, for a specific period of time, for a specified capacity, according to Chapter 20 (relating to licensure or approval of facilities and agencies).

*Licensee*--A person legally responsible for the operations of an assisted living residence licensed in accordance with this chapter.

*Long-term care ombudsman*--A representative of the Office of the State Long-Term Care Ombudsman in the Department of Aging who investigates and seeks to resolve complaints made by or on behalf of individuals who are 60 years of age or older who are consumers of long-term care services. These complaints may relate to action, inaction or decisions of providers of long-term care services, of public agencies, of social service agencies or their representatives, which may adversely affect the health, safety, well-being or rights of these consumers.

LPN—Licensed practical nurse.

*Mobile resident--*

(i) A resident who is physically and mentally capable of vacating the assisted living residence on the resident's own power or with limited physical or oral assistance in the case of an emergency, including the capability to ascend or descend stairs if present on the exit path.

(A) Physical assistance means assistance in getting to one's feet or into a wheelchair, walker or prosthetic device.

(B) Oral assistance means giving instructions to assist the resident in vacating the assisted living residence.

(ii) The term includes an individual who is able to effectively operate an ambulation device required for moving from one place to another, and able to understand and carry out instructions for vacating the assisted living residence.

*Neglect--*The failure of an assisted living residence or its staff persons to provide goods or services essential to avoid a clear and serious threat to the physical or mental health of a resident. The failure or omission to provide the care, supervision and services that the assisted living residence has voluntarily, or by contract, agreed to provide and that are necessary to maintain the resident's health, safety and well-being, including [personal care] assisted living services, food, clothing, medicine, shelter, supervision and medical services. Neglect may be repeated conduct or a single incident.

*OTC*--Over-the-counter or nonprescription.

[*Personal care services*--Assistance or supervision in ADL or IADL, or both.]

*Premises*--The grounds and buildings on the same grounds, used for providing services required by residents.

*Protective services unit*--The local area agency on aging unit designated by the Department of Aging to investigate allegations of abuse of adults who are 60 years of age or older and assess the need for protective interventions.

*Referral agent*--An agency or individual who arranges for or assists, or both, with placement of a resident into an assisted living residence.

*Relative*--A spouse, parent, child, stepparent, stepchild, grandparent, grandchild, brother, sister, half-brother, half-sister, aunt, uncle, niece or nephew.

*Resident*-- An [individual] adult, unrelated to the legal entity, who resides in an assisted living residence, and who may require [personal care] assisted living services or supplemental health care services, or both.

*Resident with mobility needs*--An [individual] adult who is unable to move from one location to another, has difficulty in understanding and carrying out instructions without the continued full assistance of other individuals or is incapable of independently operating an ambulation device, such as a wheelchair, prosthesis, walker or cane to exit a building.

*Restraint*--A manual, chemical or mechanical device used to limit or restrict the movement or normal function of an individual or a portion of the individual's body.

*RN*--Registered nurse.

*SSI*--Supplemental Security Income.

*Secretary*--The Secretary of the Department.

*Special care designation*--A licensed assisted living residence or a distinct part of the residence which is specifically designated by the Department as capable of providing cognitive support services to residents with severe cognitive impairments, including dementia or Alzheimer's disease, in the least restrictive manner to ensure the safety of the resident and others in the residence while maintaining the resident's ability to age in place.

*Specialized cognitive support services*-- These services include the following:

(i) Non-pharmacological interventions.

(ii) Dining with dignity.

(iii) Routines and roles.

(iv) Close of day programming.

(v) Pain management and person-centered care planning.

(vi) Implementation and management.

*Staff person*--An individual who works for the assisted living residence for compensation either on payroll or under contract.

*Supplemental health care services*--The provision by an assisted living residence of any type of health care service [that allows residents to age in place], either directly or through contractors, subcontractors, agents or designated providers, except for any service that is required by law to be provided by a health care facility under the Health Care Facilities Act (35 P. S. §§ 448.101--448.901).

*Support plan*--A written document that describes for each resident the resident's care, service or treatment needs based on the assessment of the resident, and when the care, service or treatment will be provided, and by whom.

*Third-party provider* – Any contractor, subcontractor, agents or designated providers under contract with the resident or residence to provide services to any resident.

*Transfer*--Movement of a resident within the assisted living residence or to a temporary placement outside the assisted living residence.

*Volunteer*--

(i) An individual who, of his own free will, and without monetary compensation, provides direct care services for residents in the assisted living residence.

(ii) The term does not include visitors or individuals who provide nondirect services or entertainment on an occasional basis.

**§ 2800.5. Access.**

(a) The administrator [or a] , administrator designee or staff person designated under § 2800.56(c) (relating to administrator staffing) shall provide, upon request, immediate access to the residence, the residents and records to:

(1) Agents of the Department.

(2) Representatives of the area agency on aging.

(3) Representatives of the Long-Term Care Ombudsman Program.

(4) Representatives of the protection and advocacy system for individuals with disabilities designated under the Protection and Advocacy for Individual Rights Program of the Vocational Rehabilitation and Rehabilitation Services Act (29 U.S.C.A. § 794e), the Protection and Advocacy for Individuals with Mental Illness Act (42 U.S.C.A. §§ 10801--10851) and the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C.A. §§ 15041--15043).

(5) The resident's designated person, if so requested by the resident. The access to records under this paragraph is limited to the records of the resident.

(b) The administrator [or a] , administrator designee or staff person designated under § 2800.56(c) (relating to administrator staffing) shall permit community

service organizations and representatives of legal services programs to have access to the residence during visitation hours or by appointment for the purpose of assisting or informing the residents of the availability of services and assistance. A resident or a resident's designated person if so authorized may decline the services of the community service organization or the legal service program.

### **GENERAL REQUIREMENTS**

#### **§ 2800.11. Procedural requirements for licensure or approval of assisted living residences; special care designation and dual licensure.**

(a) Except for § 20.32 (relating to announced inspections), the requirements in Chapter 20 (relating to licensure or approval of facilities and agencies) apply to assisted living residences.

(b) Before a residence is initially licensed and permitted to open, operate or admit residents, it will be inspected by the Department and found to be in compliance with applicable laws and regulations including this chapter. The Department will reinspect newly licensed residences within 3 months of the date of initial licensure.

(c) After the Department determines that a residence meets the requirements for a license, the Department's issuance or renewal of a license to a residence is contingent upon receipt by the Department of the following fees based on the number of beds in the residence, as follows:

(1) A [~~\$500~~] \$300 license application or renewal fee.

(2) A [~~\$105~~] \$75 per bed fee that may be adjusted by the Department annually at a rate not to exceed the Consumer Price Index. The Department will publish a notice in the *Pennsylvania Bulletin* when the per bed fee is increased.

(d) A person, organization or program may not use the term "assisted living" in any name or written material, except as a licensee in accordance with this chapter. Corporate entities which own subsidiaries that are licensed as assisted living residences may not use the term "assisted living" in any written material to market programs that are not licensed in accordance with this chapter.

(e) Multiple buildings located on the same premises may apply for a single assisted living residence license.

(f) A licensed assisted living residence may submit an application and a \$150.00 application fee to the Department requesting special care designation. If the Department determines that the residences meets the requirements for special care designation, the residence will be issued a license indicating special care designation.

(g) Dual Licensure. A licensed personal care home may submit an application to the Department requesting dual licensure if the licensed personal care home and the assisted living residence are collocated in the same building and are each located in a distinct part of the building. If the Department determines that

the licensed facility meets all of the requirements of this chapter, the facility will be issued a dual license.

(1) A facility that is dually licensed shall not segregate residents or transfer residents from one licensed facility to another based on payment source.

(2) A facility that is dually licensed may request approval from the Department to share the administrator for the two licensed facilities by requesting a waiver of the administrator hourly staffing requirements contained in § 2800.56 (relating to administrator staffing). The qualifications for a shared administrator shall be as set forth in this chapter.

**§ 2800.12. Appeals.**

(a) Appeals related to the licensure or approval of the assisted living residence shall be made in accordance with 1 Pa. Code Part II (relating to General Rules of Administrative Practice and Procedure (GRAPP)).

(b) Appeals related to the licensure or approval of the assisted living residence shall be made by filing a petition within 30 days after service of notice of the action.

(c) Subsection (b) supersedes the appeal period of 1 Pa. Code § 35.20 (relating to appeals from actions of the staff).

**§ 2800.13. Maximum capacity.**

(a) The maximum capacity is the total number of residents who are permitted to reside in the residence at any time. A request to increase the capacity shall be submitted to the Department and other applicable authorities and approved prior to the admission of additional residents. The maximum capacity is limited by physical plant space and other applicable laws and regulations.

(b) The maximum capacity specified on the license may not be exceeded.

**§ 2800.14. Fire safety approval.**

(a) Prior to issuance of a license under this chapter, a written fire safety approval from the Department of Labor and Industry, the Department of Health or the appropriate local building authority under the Pennsylvania Construction Code Act (35 P. S. §§ 7210.101--7210.1103) is required.

(b) If the fire safety approval is withdrawn or restricted, the residence shall notify the Department orally immediately, and in writing, within 48 hours of the withdrawal or restriction.

(c) If a building is structurally renovated or altered after the initial fire safety approval is issued, the residence shall submit the new fire safety approval, or written certification that a new fire safety approval is not required, from the appropriate fire safety authority. This documentation shall be submitted to the Department within 15 days of the completion of the renovation or alteration.

(d) The Department will request additional fire safety inspections by the appropriate agency if possible fire safety violations are observed during an inspection by the Department.

(e) Fire safety approval must be renewed at least every 3 years, or more frequently, if requested by the Department.

**§ 2800.15. Abuse reporting covered by law.**

(a) The residence shall immediately report suspected abuse of a resident served in the residence in accordance with the Older Adult Protective Services Act (35 P. S. §§ 10225.701--10225.707) and 6 Pa. Code §§ 15.21--15.27 (relating to reporting suspected abuse, neglect, abandonment or exploitation) and comply with the requirements regarding restrictions on staff persons.

(b) If there is an allegation of abuse of a resident involving a residence's staff person, the residence shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

(c) The residence shall immediately submit to the Department's assisted living residence office a plan of supervision or notice of suspension of the affected staff person.

(d) The residence shall immediately notify the resident and the resident's designated person of a report of suspected abuse or neglect involving the resident.

**§ 2800.16. Reportable incidents and conditions.**

(a) A reportable incident or condition includes the following:

(1) The death of a resident.

(2) A physical act by a resident to commit suicide.

(3) An injury, illness or trauma requiring treatment at a hospital or medical facility. This does not include minor injuries such as sprains or minor cuts.

(4) A violation of a resident's rights in §§ 2800.41--2800.44 (relating to resident rights).

(5) An unexplained absence of a resident for 24 hours or more, or when the support plan so provides, a period of less than 24 hours, or an absence of a resident from a special care unit.

(6) Misuse of a resident's funds by the residence's staff persons or legal entity.

(7) An outbreak of a serious communicable disease as defined in 28 Pa. Code § 27.2 (relating to specific identified reportable diseases, infections and conditions).

- (8) Food poisoning of residents.
- (9) A physical or sexual assault by or against a resident.
- (10) Fire or structural damage to the residence.
- (11) An incident requiring the services of an emergency management agency, fire department or law enforcement agency, except for false alarms.
- (12) A complaint of resident abuse, suspected resident abuse or referral of a complaint of resident abuse to a local authority.
- (13) A prescription medication error as defined in § 2800.188 (relating to medication errors).
- (14) An emergency in which the procedures under § 2800.107 (relating to emergency preparedness) are implemented.
- (15) An unscheduled closure of the residence or the relocation of the residents.
- (16) Bankruptcy filed by the legal entity.
- (17) A criminal conviction against the legal entity, administrator or staff that is subsequent to the reporting on the criminal history checks under § 2800.51 (relating to criminal history checks).
- (18) A termination notice from a utility.

(19) A violation of the health and safety laws under § 2800.18 (relating to applicable laws).

(20) An absence of staff [or inadequate staff to supervise residents] such that residents receive inadequate care as defined by the respective resident's support plan.

(b) The residence shall develop and implement written policies and procedures on the prevention, reporting, notification, investigation and management of reportable incidents and conditions.

(c) The residence shall report the incident or condition to the Department's assisted living residence office or the assisted living residence complaint hotline within 24 hours in a manner designated by the Department. The residence shall immediately report the incident or condition to the resident's family and the resident's designated person. Abuse reporting must also follow the guidelines in § 2800.15 (relating to abuse reporting covered by law).

(d) The residence shall submit a final report, on a form prescribed by the Department, to the Department's assisted living residence office immediately following the conclusion of the investigation.

(e) If the residence's final report validates the occurrence of the alleged incident or condition, the affected resident and other residents who could potentially be harmed or his designated person shall also be informed immediately following the conclusion of the investigation.

(f) The residence shall keep a copy of the report of the reportable incident or condition.

**§ 2800.17. Confidentiality of records.**

Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

**§ 2800.18. Applicable laws.**

A residence shall comply with applicable Federal, State and local laws, ordinances and regulations.

**§ 2800.19. Waivers.**

(a) A residence may submit a written request for a waiver of a specific requirement contained in this chapter. The waiver request must be on a form prescribed by the Department. The Secretary, or the Secretary's appointee, may grant a waiver of a specific requirement of this chapter if the following conditions are met:

(1) There is no jeopardy to the residents.

(2) There is an alternative for providing an equivalent level of health, safety and well-being protection of the residents.

(3) Residents will benefit from the waiver of the requirement.

(b) Following receipt of a waiver request, the Department will post the waiver request on the Department's website with a 30-day public comment period prior to final review and decision on the requested waiver.

[(b)] (c) The scope, definitions, applicability or residents' rights, assisted living service delivery requirements, special care designation requirements, staff training requirements, disclosure requirements, complaint rights or procedures, notice requirements to residents or the resident's family, contract requirements, reporting requirements, fire safety requirements, assessment, support plan or service delivery requirements under this chapter may not be waived.

[(c)] (d) At least 30 days prior to the submission of the completed written waiver request to the Department, the residence shall provide a copy of the completed written waiver request to the affected resident and designated person to provide the opportunity to submit comments to the Department. The residence shall provide the affected resident and designated person with the name, address and telephone number of the Department staff person to submit comments.

[(d)] (e) The residence shall discuss the waiver request with the affected resident and designated person upon the request of the resident or designated person.

[(e)] (f) The residence shall notify the affected resident and designated person of the approval or denial of the waiver. A copy of the waiver request and the Department's written decision shall be posted in a conspicuous and public place within the residence.

[(f)] (g) The Department will review waivers annually to determine compliance with the conditions required by the waiver. The Department may revoke the waiver if the conditions required by the waiver are not met. When the Department revokes a standing waiver from a residence that residence may appeal the revocation consistent with § 2800.12 (relating to appeals).

#### **§ 2800.20. Financial management.**

(a) A resident may manage his personal finances unless he has a guardian of his estate.

(b) If the residence provides assistance with financial management or holds resident funds, the following requirements apply:

(1) The residence shall keep a record of financial transactions with the resident, including the dates, amounts of deposits, amounts of withdrawals and the current balance.

(2) Resident funds shall be disbursed during normal business hours within 24 hours of the resident's request.

(3) The residence shall obtain a written receipt from the resident for cash disbursements at the time of disbursement.

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

(5) Commingling of resident funds and residence funds is prohibited.

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

(7) The legal entity, administrator and staff persons of the residence are prohibited from being assigned power of attorney or guardianship of a resident or a resident's estate.

(8) The residence shall give the resident and the resident's designated person, an itemized account of financial transactions made on the resident's behalf on a quarterly basis.

(9) A copy of the itemized account shall be kept in the resident's record.

(10) The residence shall provide the resident the opportunity to review his own financial record upon request during normal business hours.

**§ 2800.21. Offsite services.**

If services or activities are provided by the residence at a location other than the premises, the residence shall ensure that the residents' support plans are followed and that the [resident's] resident health and safety needs are met.

**§ 2800.22. Application and admission.**

(a) The following admission documents shall be completed for each resident:

(1) [Preadmission screening completed prior to admission on a form specified by the Department.

(2) ] Medical evaluation completed within 60 days prior to [or 15 days after] admission on a form specified by the Department. The medical evaluation may be completed within 15 days after admission if one of the following conditions applies:

(i) The resident is being admitted directly to the residence from an acute care hospital,

(ii) The resident is being admitted to escape from an abusive situation,

(iii) The resident has no alternative living arrangement.

[(3)] (2) Assisted living resident initial assessment completed [within 15 days after admission] within 30 days prior to admission on a form specified by the Department. The initial assessment may be completed within 15 days after admission subject to the provisions of § 2800.224 (relating to initial assessment and preliminary support plan).

[(4)] (3) [Support] Preliminary support plan developed [and implemented] within 30 days [after] prior to admission. The preliminary support plan may be completed within 15 days after admission if one of the following conditions applies:

(i) The resident is being admitted directly to the residence from an acute care hospital.

(ii) The resident is being admitted to escape from an abusive situation.

(iii) The resident has no alternative living arrangement.

(4) Final support plan developed and implemented within 30 days after admission.

(5) Resident-residence contract completed prior to admission or within 24 hours after admission.

(6) Medical evaluations, resident assessments and support plans may be subsequently updated as needed, but no less frequently than required in §§ 2800.225 and 2800.227 (relating to additional assessments and development of the final support plan).

(b.1) A certification shall be made, prior to admission, that the needs of the potential resident can be met by the services provided by the residence.

(b.2) The certification shall be may be made by one of the following persons:

(1) The administrator acting in consultation with the supplemental health care providers.

(2) The individual's physician or certified registered nurse practitioner.

(3) The medical director of the residence.

(b.3) A potential resident whose needs cannot be met by the residence shall be provided with a written decision denying his admission and provide a basis for the denial. The decision shall be confidential and may only be released with the consent of the potential resident or his designated person. The potential resident shall then be referred to a local appropriate assessment agency.

(c) A potential resident who requires assisted living services but does not currently require assistance in obtaining supplemental health care services may be admitted to the residence, provided the resident is only provided supplemental health care services required or requested by the resident. When supplemental

health care services are required, the residence shall develop a preliminary support plan as required in § 2800.224 (relating to initial assessment and preliminary support plan). This subsection applies to residents under any of the following circumstances:

(1) A resident who currently does not require assistance in obtaining supplemental health care services, but who may require supplemental health care services in the future.

(2) A resident who wishes to obtain assistance in obtaining supplemental health care services.

(3) A resident who resides in a residence in which supplemental health care services are available.

(d) Adults requiring the services of a licensed long-term care nursing facility, including those with mobility needs, may reside in a residence, provided that appropriate supplemental health care services are provided such residents and the design, construction, staffing and operation of the residence allows for their safe emergency evacuation.

[(b)](e) Upon application for residency and prior to admission to the residence, the licensee shall provide each potential resident or potential resident's designated person with written disclosures that include:

(1) A list of the nonwaivable resident rights.

(2) A copy of the [agreement] contract the resident will be asked to sign,

(3) A copy of residence rules and resident handbook. The resident handbook shall be approved by the Department.

(4) Specific information about the following:

(i) [What] The services and the core packages that are offered by the residence.

(ii) The cost of those services and of the core packages to the potential resident.

(iii) When a potential resident may require the services offered in a different core package.

(iv) The contact information for the Department.

[(iv)] (v) The licensing status of the most recent inspection reports and instructions for access to the Department's public website for information on the residence's most recent inspection reports.

(vi) The number of living units in the residence that comply with the Americans with Disabilities Act.

[(v)] (vii) Disclosure of any waivers that have been approved for the residence and are still in effect.

**§ 2800.23. Activities.**

(a) A residence shall provide each resident with assistance with ADLs and appropriate cueing for ADLs as indicated in the resident's assessment and support plan.

(b) A residence shall provide each resident with assistance with IADLs and appropriate cueing for IADLs as indicated in the resident's assessment and support plan.

**§ 2800.24. Personal hygiene.**

A residence shall provide the resident with assistance with personal hygiene and appropriate cueing to encourage personal hygiene as indicated in the resident's assessment and support plan. Personal hygiene includes one or more of the following:

- (1) Bathing.
- (2) Oral hygiene.
- (3) Hair grooming and shampooing.
- (4) Dressing, undressing and care of clothes.
- (5) Shaving.
- (6) Nail care.

(7) Foot care.

(8) Skin care.

**§ 2800.25. Resident-residence contract.**

(a) Prior to admission, or within 24 hours after admission, a written resident-residence contract between the resident and the residence must be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

(b) The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees. The contract must run month-to-month with automatic renewal unless terminated by the resident with 14 days' notice or by the residence with 30 days' notice in accordance with § 2800.228 (relating to transfer and discharge).

(c) At a minimum, the contract must specify the following:

(1) Each resident shall retain, at a minimum, the current personal needs allowance as the resident's own funds for personal expenditure. A contract to the contrary is not valid. A personal needs allowance is the amount that a resident shall be permitted to keep for his personal use.

(2) A fee schedule that lists the actual amount of charges for each of the assisted living services that are included in the [residence's] resident's core service package [assisted living services that the individual is purchasing including:

(i) Assistance with unscheduled ADLs and supplemental health care services.

(ii) Three meals a day and snacks as provided in § 2800.161 (relating to nutritional adequacy).

(iii) Laundry services as provided in § 2800.105 (relating to laundry).

(iv) Housekeeping as defined in § 2800.4 (relating to definitions).

(v) Transportation in accordance with § 2800.171 (relating to transportation).

(vi) Medication management or administration as provided in §§ 2800.181 and 2800.182 (relating to self-administration; and medication administration).

(vii) Daily planned social activities and socialization as provided in § 2800.221 (relating to activities program)] in accordance with § 2800.220 (relating to service provision).

(3) An explanation of the annual assessment, medical evaluation and support plan requirements and procedures, which shall be followed if either the assessment or the medical evaluation indicates the need for another and more appropriate level of care.

- (4) The party responsible for payment.
- (5) The method for payment of charges for long distance telephone calls.
- (6) The conditions under which refunds will be made, including the refund of admission fees and refunds upon a resident's death.
- (7) The financial arrangements if assistance with financial management is to be provided.
- (8) The residence's rules related to residence services, including whether the residence permits smoking.
- (9) The conditions under which the resident-residence contract may be terminated including residence closure as specified in § 2800.228 (relating to transfer and discharge).
- (10) A statement that the resident is entitled to at least 30 days' advance notice, in writing, of the residence's request to change the contract.
- (11) A list of [personal care] assisted living services or supplemental health care services, or both, to be provided to the resident based on the outcome of the resident's support plan, a list of the actual rates that the resident will be periodically charged for food, shelter and services and how, when and by whom payment is to be made.

(12) Charges to the resident for holding a bed during hospitalization or other extended absence from the residence.

(13) Written information on the resident's rights and complaint procedures as specified in § 2800.41 (relating to notification of rights and complaint procedures).

(d) A residence may not seek or accept payments from [a non-SSI] an SSI resident in excess of one-half of any funds received by the resident under the Senior Citizens Rebate and Assistance Act (72 P. S. §§ 4751-1--4751-12). If the residence will be assisting the resident to manage a portion of the rent rebate, the requirements of § 2800.20 (relating to financial management) may apply. There may be no charge for filling out this paperwork.

(e) The resident-residence contract must include whether the residence collects a portion of a resident's rent rebate under subsection (d).

(f) If the residence collects a resident's rent rebate under subsection (e), the resident-residence contract must include the following:

(1) The dollar amount or percentage of the rent rebate to be collected.

(2) The residence's intended use of the revenue collected from the rent rebate.

(g) A statement signed by the resident, and the resident's designated person if applicable, at the time of admission, informing the resident that the information required in subsections (e) and (f) is to be kept in the resident's record.

[(e)] (h) The resident, or a designated person, has the right to rescind the contract for up to 72 hours after the initial dated signature of the contract [or upon receipt of the initial support plan]. The resident shall pay only for the services received. Rescission of the contract must be in writing addressed to the residence.

[(f)] (i) The residence may not require or permit a resident to assign assets to the residence in return for a life care contract/guarantee. A life care contract/guarantee is an agreement between the legal entity and the resident that the legal entity will provide care to the resident for the duration of the resident's life. Continuing care communities that have obtained a Certificate of Authority from the Insurance Department and have provided a copy of the certificate to the Department are exempt from this requirement.

[(g)] (l) A copy of the signed resident-residence contract shall be given to the resident and a copy shall be filed in the resident's record.

[(h)] (k) The service needs addressed in the resident's support plan shall be available to the resident every day of the year.

[(i)] (l) The resident-residence contract shall identify the assisted living services included in the core service package the individual is purchasing [shall be the

contract] and the total price for those services. Supplemental health care services [must] shall be packaged, contracted and priced separately from the resident-residence contract. Services provided by or contracted for by the residence other than supplemental health care services must be priced separately from the service package in the resident-residence contract.

**§ 2800.26. Quality management.**

(a) The residence shall establish and implement a quality management plan.

(b) The quality management plan must address the periodic review and evaluation of the following, to assure compliance with law and with the relevant standard of care:

(1) The reportable incident and condition reporting procedures.

(2) Complaint procedures.

(3) Staff person training.

(4) Licensing violations and plans of correction, if applicable.

(5) Resident or family councils, or both, if applicable.

(c) The quality management plan must include the development and implementation of measures to address the areas needing improvement that are identified during the periodic review and evaluation.

**§ 2800.27. SSI recipients.**

(a) If a residence agrees to admit a resident eligible for SSI benefits, the residence's charges for actual rent and other services may not exceed the SSI resident's actual current monthly income reduced by the current personal needs allowance.

(b) The administrator or staff persons may not include funds received as lump sum awards, gifts or inheritances, gains from the sale of property or retroactive government benefits when calculating payment of rent for an SSI recipient or for a resident eligible for SSI benefits.

(c) The administrator or staff persons may not seek or accept any payments from funds received as retroactive awards of SSI benefits, but may seek and accept the payments only to the extent that the retroactive awards cover periods of time during which the resident actually resided in the residence and for which full payment has not been received.

(d) The 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:

(1) Necessary personal hygiene items, such as a comb, toothbrush, toothpaste, soap and shampoo. Cosmetic items are not included.

(2) Laundry services for personal laundry, bed linens and towels, but not including dry cleaning or other specialized services.

(3) [Personal care services] Assistance or supervision in ADL or IADL, or both.

(e) Third-party payments made on behalf of an SSI recipient and paid directly to the residence are permitted. These payments may not be used for food, clothing or shelter because to do so would reduce SSI payments. See 20 CFR 416.1100 and 416.1102 (relating to income and SSI eligibility; and what is income). These payments may be used to purchase items or services for the resident that are not food, clothing or shelter.

#### **§ 2800.28. Refunds.**

(a) If, after the residence gives notice of transfer or discharge in accordance with § 2800.228(b) (relating to transfer and discharge), and the resident moves out of the residence before the 30 days are over, the residence shall give the resident a refund equal to the previously paid charges for rent, [personal care] assisted living services and supplemental health care services, if applicable, for the remainder of the 30-day time period. The refund shall be issued within 30-days of transfer or discharge. The resident's personal needs allowance shall be refunded within 2 business days of transfer or discharge.

(b) After a resident gives notice of the intent to leave in accordance with § 2800.25(b) (relating to resident-residence contract) and if the resident moves out of the residence before the expiration of the required 14 days, the resident

owes the residence the charges for rent and [personal care] assisted living services and supplemental health care services, or both, for the entire length of the 14-day time period for which payment has not been made.

(c) If no notice is required, as set forth in subsection (d), the resident shall be required to pay only for the nights spent in the residence.

(d) If the residence 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 30 days of the date the resident moved from the residence.

(e) In the event of the death of a resident under 60 years of age, the administrator shall refund the remainder of previously paid charges to the resident's estate within 30 days from the date the living unit is cleared of the resident's personal property. In the event of the death of a resident 60 years of age and older, the residence shall provide a refund in accordance with the Elder Care Payment Restitution Act (35 P. S. §§ 10226.101–10226.107). The residence shall keep documentation of the refund in the resident's record.

(f) Within 30 days of either the termination of service by the residence or the resident's leaving the residence, the resident shall receive an itemized written account of the resident's funds, including notification of funds still owed the residence by the resident or a refund owed the resident by the residence.

Refunds shall be made within 30 days of discharge.

(g) Upon discharge of the resident or transfer of the resident, the administrator shall return the resident's funds being managed or stored by the residence to the resident within 2 business days from the date the living unit is cleared of the resident's personal property.

**§ 2800.29. Hospice care and services.**

Hospice care and services that are licensed by the Department of Health as a hospice may be provided in an assisted living residence.

**§ 2800.30. Informed consent process.**

(a) *Initiation of process.*

(1) When a licensee determines that a competent resident's decision, behavior or action creates a dangerous situation and places the competent resident, other residents or staff members at [imminent] risk of [substantial] harm by the competent resident's wish to exercise independence in directing the manner in which [they receive] the competent resident receives care, the licensee may initiate an informed consent process to address the identified risk and to reach a mutually agreed-upon plan of action with the competent resident or the resident's designated person. The initiation of an informed consent process does not guarantee that an informed consent agreement, which is agreeable to all parties, will be reached and executed.

(2) When a competent resident wishes to exercise independence in directing the manner in which the competent resident receives care, the competent resident may initiate an informed consent process to modify the support plan and attempt to reach a mutually agreed upon plan of action with the licensee. [A cognitively impaired]

(3) An incompetent resident shall be eligible for an informed consent agreement only if the resident's legal representative is included in the negotiation of the informed consent agreement and executes the agreement.

*(b) Notification.*

(1) When the licensee chooses to initiate an informed consent process, the provider shall do so by notifying the competent resident and, if applicable, the resident's designated person in writing and orally. The notification must include [a statement that the long-term care ombudsman is available to assist in the process and include] the contact information for the ombudsman. For [cognitively impaired] incompetent residents, the ombudsman shall be automatically notified by the licensee. Notification shall be documented in the resident's file by the licensee.

(2) When a competent resident chooses to initiate an informed consent negotiation, the competent resident shall do so by notifying the licensee in writing and orally. Notification shall be documented in the competent resident's file by the licensee. When a [or, if applicable, the resident's] legal representative for an

incompetent resident chooses to initiate an informed consent negotiation, the [resident or the resident's] legal representative shall do so by notifying the licensee in writing or orally. Notification shall be documented in the incompetent resident's file by the licensee.

(c) *Resident's involvement.* A resident who is not [cognitively impaired] incompetent shall be entitled, but is not required, to involve his legal representative and physician, and any other individual the competent resident wants involved, to participate or assist in the discussion of the competent resident's wish to exercise independence and, if necessary, in developing a satisfactory informed consent agreement that balances the competent resident's choices and capabilities with the possibility that the choices will place the resident [or], other residents or staff members at risk of harm.

(d) *Informed consent meeting.*

(1) In a manner the competent resident can understand, the licensee shall discuss the competent resident's wish to exercise independence in directing the manner in which he receives care. The discussion must relate to the decision, behavior or action that places the competent resident [or persons other than the resident], other residents or staff members [in imminent] at risk of [substantial] harm and hazards inherent in the resident's action. The discussion must include reasonable alternatives, if any, for mitigating the risk, the significant benefits and disadvantages of each alternative and the most likely outcome of each alternative. In the case of [a] an incompetent resident [with a cognitive

impairment], the incompetent resident's legal representative shall participate in the discussion.

(2) A resident may not have the right to place [persons other than himself] other residents or staff members at risk, but, consistent with statutory and regulatory requirements, may elect to proceed with a decision, behavior or action affecting only his own safety or health status, foregoing alternatives for mitigating the risk, after consideration of the benefits and disadvantages of the alternatives including his wish to exercise independence in directing the manner in which he receives care. The licensee shall evaluate whether the competent resident understands and appreciates the nature and consequences of the risk, including the significant benefits and disadvantages of each alternative considered, and then shall further ascertain whether the competent resident is consenting to accept or mitigate the risk with full knowledge and forethought.

(e) *Successful negotiation.* If the parties agree, the informed consent agreement shall be reduced to writing and signed by all parties, including all individuals engaged in the negotiation at the request of the competent resident, and shall be retained in the resident's file as part of the service plan.

(f) *Unsuccessful negotiation.* If the parties do not agree, the licensee shall notify the resident, the resident's legal representative and the individuals engaged in the informed consent negotiation at the request of the resident. The residence shall include contact information on the local ombudsman or the

appropriate advocacy organization [for assistance relating to the disposition] and whether the licensee will issue a notice of discharge.

(g) *Freedom from duress.* An informed consent agreement must be voluntary and free of force, fraud, deceit, duress, coercion or undue influence, provided that a licensee retains the right to issue a notice of involuntary discharge in the event a resident's decision, behavior or action creates a dangerous situation and places [persons other than the resident] other residents or staff members at [imminent] risk of [substantial] harm and, after a discussion of the risk, the resident declines alternatives to mitigate the risk.

(h) *Individualized nature.* An informed consent agreement must be unique to the resident's situation and his wish to exercise independence in directing the manner in which he receives care. The informed consent agreement shall be utilized only when a resident's decision, behavior or action creates a situation and places the resident [or persons other than the resident], other residents or staff members at [imminent] risk of [substantial] harm. A licensee may not require execution of an informed consent agreement as a standard condition of admission.

(i) *Liability.* Execution of an informed consent agreement does not constitute a waiver of liability beyond the scope of the agreement or with respect to acts of negligence, [or] tort, products defect, breach of fiduciary duty, contract violation, or any other claim or cause of action. An informed consent agreement does not relieve a licensee of liability for violation of statutory or regulatory requirements

promulgated under this chapter nor does it affect the enforceability of regulatory provisions including those provisions governing admission or discharge or the permissible level of care in an assisted living residence.

(j) *Change in resident's condition.* An informed consent agreement must be updated following a significant change in the resident's condition that affects the risk potential to the resident [or persons other than the resident], other residents or staff members.

(k) Either party has a right to rescind the informed consent agreement within 30 days of execution of the agreement.

## RESIDENT RIGHTS

### § 2800.41. Notification of rights and complaint procedures.

(a) Upon admission, each resident and, if applicable, the resident's designated person, shall be informed of resident rights and the right to lodge complaints without intimidation, retaliation or threats of retaliation by the residence or its staff persons against the reporter. Retaliation includes transfer or discharge from the residence.

(b) Notification of rights and complaint procedures shall be communicated in an easily understood manner and in a language understood by or mode of communication used by the resident and, if applicable, the resident's designated person.

(c) The Department's poster of the list of resident's rights shall be posted in a conspicuous and public place in the residence.

(d) A copy of the resident's rights and complaint procedures shall be given to the resident and, if applicable, the resident's designated person, upon admission.

(e) A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

**§ 2800.42. Specific rights.**

(a) A resident may not be discriminated against because of race, color, religious creed, disability, ancestry, sexual orientation, national origin, age or sex.

(b) A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way. A resident must be free from mental, physical, and sexual abuse and exploitation, neglect, financial exploitation and involuntary seclusion.

(c) A resident shall be treated with dignity and respect.

(d) A resident shall be informed of the rules of the residence and given 30 days' written notice prior to the effective date of a new residence rule.

(e) A resident shall have access to a telephone in the residence to make calls in privacy. Nontoll calls must be without charge to the resident.

(f) A resident has the right to receive and send mail.

(1) Outgoing mail may not be opened or read by staff persons unless the resident requests.

(2) Incoming mail may not be opened or read by staff persons unless upon the request of the resident or the resident's designated person.

(g) A resident has the right to communicate privately with and access the local ombudsman.

(h) A resident has the right to practice the religion or faith of the resident's choice, or not to practice any religion or faith.

(i) A resident shall receive assistance in accessing health care services, including supplemental health care services.

(j) A resident shall receive assistance in obtaining and keeping clean, seasonal clothing. A resident's clothing may not be shared with other residents.

(k) A resident and the resident's designated person, and other individuals upon the resident's written approval shall have the right to access, review and request corrections to the resident's record.

(l) A resident has the right to furnish his living unit and purchase, receive, use and retain personal clothing and possessions.

(m) A resident has the right to leave and return to the residence at times consistent with the residence rules and the resident's support plan.

(n) A resident has the right to relocate and to request and receive assistance, from the residence, in relocating to another facility. The assistance must include helping the resident get information about living arrangements, making telephone calls and transferring records.

(o) A resident has the right to freely associate, organize and communicate privately with his friends, family, physician, attorney and other persons.

(p) A resident shall be free from restraints.

(q) A resident shall be compensated in accordance with State and Federal labor laws for labor performed on behalf of the residence. Residents may voluntarily and without coercion perform tasks related directly to the resident's personal space or common areas of the residence.

(r) A resident has the right to receive visitors at any time provided that the visits do not adversely affect other residents. A residence may adopt reasonable policies and procedures related to visits and access. If the residence adopts those policies and procedures, they will be binding on the [residents] residence.

(s) A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

(t) A resident has the right to file complaints [on behalf of himself and others], grievances or appeals with any individual or agency and recommend changes in policies, residence rules and services of the residence without intimidation, retaliation or threat of discharge.

(u) A resident has the right to remain in the residence, as long as it is operating with a license, except as specified in § 2800.228 (relating to transfer and discharge).

(v) A resident has the right to receive services contracted for in the resident-residence contract.

(w) A resident has the right to use both the residence's procedures and external procedures[, if any,] to appeal involuntary discharge.

(x) A resident has the right to a system to safeguard a resident's money and property.

(y) To the extent prominently displayed in the written resident-residence contract, a residence may require residents to use providers of supplemental health care services as provided in § 2800.142 (relating to assistance with [health] medical care and supplemental health care services). When the

residence does not designate, the resident may choose the supplemental health care service provider. The actions and procedures utilized by a supplemental health care service provider chosen by a resident must be consistent with the residence's systems for caring for residents. This includes the handling and assisting with the administration of resident's medications, and shall not conflict with Federal laws governing residents.

(z) The resident has the right to choose his primary care physician.

**§ 2800.43. Prohibition against deprivation of rights.**

- (a) A resident may not be deprived of his rights.
- (b) A resident's rights may not be used as a reward or sanction.
- (c) Waiver of any resident right shall be void.

**§ 2800.44. Complaint procedures.**

(a) Prior to admission, the residence shall inform the resident and the resident's designated person of the right to file and the procedure for filing a complaint with the Department's Assisted Living Residence Licensing Office, local ombudsman or protective services unit in the area agency on aging, [Pennsylvania Protection & Advocacy, Inc.] the Disability Rights Network or law enforcement agency.

(b) The residence shall permit and respond to oral and written complaints from any source regarding an alleged violation of resident rights, quality of care or other matter without retaliation or the threat of retaliation.

(c) If a resident indicates that he wishes to make a written complaint, but needs assistance in reducing the complaint to writing, the residence shall assist the resident in writing the complaint.

(d) The residence shall ensure investigation and resolution of complaints. The residence shall designate the staff person responsible for receiving complaints and determining the outcome of the complaint. The residence shall keep a log of all complaints and the outcomes of the complaints.

(e) Within 2 business days after the submission of a written complaint, a status report shall be provided by the residence to the complainant. If the resident is not the complainant, the resident and the resident's designated person shall receive the status report unless contraindicated by the support plan. The status report must indicate the steps that the residence is taking to investigate and address the complaint.

(f) Within 7 days after the submission of a written complaint, the residence shall give the complainant and, if applicable, the designated person, a written decision explaining the residence's investigation findings and the action the residence plans to take to resolve the complaint. If the resident is not the complainant, the affected resident shall receive a copy of the decision unless

contraindicated by the support plan. If the residence's investigation validates the complaint allegations, a resident who could potentially be harmed or his designated person shall receive a copy of the decision, with the name of the affected resident removed, unless contraindicated by the support plan.

(g) The telephone number of the Department's Assisted Living Residence Licensing Office, the local ombudsman or protective services unit in the area agency on aging, [Protection & Advocacy, Inc.] the Disability Rights Network, the local law enforcement agency, the Commonwealth Information Center and the assisted living residence complaint hotline shall be posted in large print in a conspicuous and public place in the residence.

(h) Nothing in this section shall affect in any way the right of the resident to file suit or claim for damages.

## STAFFING

### § 2800.51. Criminal history checks.

(a) Criminal history checks [and hiring policies] shall be in accordance with the Older Adult Protective Services Act (35 P. S. §§ 10225.101--10225.5102), and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

(b) The hiring policies shall be in accordance with the Department of Aging's Older Adult Protective Services Act policy as posted on the Department of Aging's website.

**§ 2800.52. Staff hiring, retention and utilization.**

Hiring, retention and utilization of staff persons shall be in accordance with the Older Adult Protective Services Act (35 P. S. §§ 10225.101--10225.5102), 6 Pa. Code Chapter 15 (relating to protective services for older adults) and other applicable regulations.

**§ 2800.53. Qualifications and responsibilities of administrators.**

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

(1) A license as a registered nurse from the Department of State and 1 year, in the prior 10 years, of direct care or administrative experience in a health care or human services field.

(2) An associate's degree or 60 credit hours from an accredited college or university in a human services field and 1 year, in the prior 10 years, of direct care or administrative experience in a health care or human services field.

(3) An associate's degree or 60 credit hours from an accredited college or university in a field that is not related to human services and 2 years, in the prior 10 years, of direct care or administrative experience in a health care or human services field.

(4) A license as a licensed practical nurse from the Department of State and 1 year, in the prior 10 years, of direct care or administrative experience in a health care or human services field.

(5) A license as a nursing home administrator from the Department of State and 1 year, in the prior 10 years, of direct care or administrative experience in a health care or human services field.

(6) With the exception of administrators qualified under § 2600.53(a)(5) (relating to qualifications and responsibilities of administrators), experience as a personal care home administrator, if the following requirements are met:

(i) Employed as a personal care home administrator for 2 years prior to the effective date of this regulation.

(ii) Completed the administrator training requirements and pass the Department-approved competency-based training test at § 2800.64 (relating to administrator training and orientation) within 1 year of the effective date of the regulation.

(b) The administrator shall be 21 years of age or older.

(c) The administrator shall be responsible for the administration and management of the residence, including the health, safety and well-being of the residents, implementation of policies and procedures and compliance with this chapter.

(d) The administrator shall have the ability to provide [personal care] assisted living services or to supervise or direct the work to provide [personal care] assisted living services.

(e) The administrator shall have knowledge of this chapter.

(f) The administrator shall have the ability to comply with applicable laws, rules and regulations, including this chapter.

(g) The administrator shall have the ability to maintain or supervise the maintenance of financial and other records.

(h) [The] At all times the administrator shall be free from a medical condition, including drug or alcohol addiction that would limit the administrator from performing duties with reasonable skill and safety.

**§ 2800.54. Qualifications for direct care staff persons.**

(a) Direct care staff persons shall have the following qualifications:

(1) Be 18 years of age or older, except as permitted in subsection (d).

(2) Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

(3) Be free from a medical condition, including drug or alcohol addiction, that would limit direct care staff persons from providing necessary [personal care] assisted living services with reasonable skill and safety.

(4) Be able to communicate in a mode or manner understood by the resident. Strategies that promote interactive communication on the part of direct care staff and individual residents shall be developed in accordance with the resident's final support plan under § 2800.227(e)(relating to development of the final support plan).

(b) A volunteer who performs or provides ADLs shall meet the direct staff person qualifications and training requirements specified in this chapter.

(c) A resident receiving [personal care] assisted living services who voluntarily performs tasks in the residence will not be considered a volunteer under this chapter.

(d) Food services or housekeeping staff may be 16 or 17 years of age.

**§ 2800.55. Portability of staff [qualifications and] training.**

A staff person who transfers to another licensed residence, or from a licensed personal care home shall be given credit for any completed hours of training that are required on an annual basis, provided however, that the staff person shall complete any additional training required by these regulations for assisted living residence direct care staff.

**§ 2800.56. Administrator staffing.**

(a) [The] Except for temporary absences under subsection (b), the administrator shall be present in the residence an average of [40] 36 hours or

more per week, in each calendar month. At least 30 hours per [month] week shall be during normal business hours.

(b) If the administrator is unavailable to meet the hourly requirements in subsection (a) due to a temporary absence, the administrator shall assign an administrator designee in writing to supervise the residence during the administrator's temporary absence. The administrator designee shall meet the following requirements:

(1) Have 3,000 hours of direct operational responsibility for a senior housing facility, health care facility, residential care facility, adult daily living facility or other group home licensed or approved by the Commonwealth.

(2) Pass the Department-approved competency-based administrator training test under § 2800.64(a)(3) (relating to administrator training and orientation).

(3) Meet the qualification and training requirements of a direct care staff person under §§ 2800.54 and 2800.65 (relating to qualifications for direct care staff persons; and staff orientation and direct care staff person training and orientation.)

(c) The administrator shall [designate] assign a staff person in writing to supervise the residence [in] during the administrator's or administrator designee's absence. [The designee shall have the same training required for

an administrator.] The staff person shall meet the qualification and training requirements of a direct care staff person under §§ 2800.54 and 2800.65 (relating to qualifications for direct care staff persons; and staff orientation and direct staff person training and orientation).

(d) During the administrator's and administrator designee's absence, the administrator or administrator designee shall be on-call.

**§ 2800.57. Direct care staffing.**

(a) At all times one or more residents are present in the residence, a direct care staff person who is 21 years of age or older [and who serves as the designee] shall be present in the residence. The direct care staff person may be the administrator if the administrator provides direct care services.

(b) Direct care staff persons shall be available to provide at least 1 hour per day of [personal care] assisted living services to each mobile resident.

(c) Direct care staff persons shall be available to provide at least 2 hours per day of [personal care] assisted living services to each resident who has mobility needs.

(d) At least 75% of the [personal care] assisted living service hours specified in subsections (b) and (c) shall be available during waking hours.

**§ 2800.58. Awake staff persons.**

Direct care staff persons on duty in the residence shall be awake at all times.

**§ 2800.59. Multiple buildings.**

[(a) For a residence with multiple buildings on the same premises that are within 300 feet of one another, the direct care staff person required in § 2800.57 (relating to direct care staffing) shall be on the premises and available by a two-way communication system at all times residents are present in the residence.

(b)] For a residence with multiple buildings on the same premises regardless of the distance between buildings, the direct care staffing requirements in § 2800.57 (relating to direct care staffing) apply at all times residents are present in the residence.

**§ 2800.60. Additional staffing based on the needs of the residents.**

(a) Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan. Residence staff or service providers who provide services to the residents in the residence shall meet the applicable professional licensure requirements.

(b) The staffing level in this chapter is minimum only. The Department may require additional staffing as necessary to protect the health, safety and well-being of the residents. Requirements for additional staffing will be based on the resident's assessment and support plan, the design and construction of the residence and the operation and management of the residence.

(c) Additional staff hours, or contractual hours, shall be provided as necessary to meet the transportation, laundry, food service, housekeeping and maintenance needs of the [residence] residents.

(d) In addition to the staffing requirements in this chapter, the residence shall have a licensed nurse available in the building or on call at all times. The [on-call] licensed nurse shall be either an employee of the residence or under contract with the residence.

(e) The residence shall have a dietician on staff or under contract to provide for any special dietary needs of a resident as indicated in his support plan.

**§ 2800.61. Substitute personnel.**

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 as specified in §§ 2800.54 and 2800.65 (relating to qualifications for direct care staff persons; and staff orientation and direct care staff person training and orientation).

**§ 2800.62. List of staff persons.**

The administrator shall maintain a current list of the names, addresses and telephone numbers of staff persons including substitute personnel and volunteers.

**§ 2800.63. First aid, CPR and obstructed airway training.**

(a) [There shall be sufficient staff] For every 35 residents, there shall be at least one staff person trained in first aid and certified in obstructed airway techniques and CPR present in the residence at all times to meet the needs of the residents.

(b) Current training in first aid and certification in obstructed airway techniques and CPR shall be provided by an individual certified as a trainer by a hospital or other recognized health care organization.

(c) Licensed, certified and registered medical personnel meet the qualifications in subsection (a) and are exempt from the training requirements in subsections (a) and (b).

(d) A staff person who is trained in first aid or certified in obstructed airway techniques or CPR shall provide those services in accordance with his training, unless the resident has a do not resuscitate order.

**§ 2800.64. Administrator training and orientation.**

(a) Prior to initial employment as an administrator, a candidate shall successfully complete the following:

(1) An orientation program approved and administered by the Department.

(2) A 100-hour standardized Department-approved administrator training course. The training provided for in § 2800.69 (relating to additional dementia-specific training) shall be in addition to the 100-hour training course.

(3) A Department-approved competency-based training test with a passing score.

(b) The standardized Department-approved administrator training course specified in subsection (a)(2) must include the following:

(1) Fire prevention and emergency preparedness.

(2) Medication procedures, medication effects and side effects, universal precautions and personal hygiene.

(3) Certification in CPR and obstructed airway techniques and training in first aid.

(4) [Personal care] Assisted living services.

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

(6) Nutrition, food handling and sanitation.

(7) Recreation.

(8) Care for residents with mental illness.

(9) Resident rights.

(10) Care for residents with cognitive and neurological impairments and other special needs.

(11) Care for residents with mental retardation.

(12) Community resources, social services and activities in the community.

(13) Staff supervision and staff person training including developing orientation and training guidelines for staff.

(14) Budgeting, financial recordkeeping and resident records including:

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

(ii) Resident-residence contracts.

(15) Gerontology.

(16) Abuse and neglect prevention and reporting.

(17) Cultural competency.

(18) Infection control.

(19) Training specific to the resident composition.

(20) Training on person-centered care, informed consent, aging in place and the availability of services to support aging in place.

(21) Incident management and incident reporting.

(22) The requirements of this chapter.

(c) An administrator shall have at least 24 hours of annual training relating to the job duties. The Department-approved administrator training course specified in subsection (a) fulfills the annual training requirement for the first year.

(d) Annual training shall be provided by Department-approved training sources listed in the Department's assisted living residence training resource directory or by an accredited college or university, courses approved for credit by National Continuing Education Review Service/National Association of Boards of Examiners of Long-Term Care Administrators or the Bureau of Professional and Occupational Affairs in the Department of State.

(e) An administrator who has successfully completed the training in subsections (a)–(d) shall provide written verification of successful completion to the Department's Assisted Living Residence Licensing Office.

(f) A record of training including the individual trained, date, source, content, length of each course and copies of certificates received shall be kept.

(g) A licensed nursing home administrator who is employed as an administrator prior to the effective date of this regulation, is exempt from the qualification and training requirements under §§ 2800.53 and 2800.64 (relating to qualifications and responsibilities of administrators; and administrator training and orientation) if the administrator continues to meet the applicable licensing requirements. A licensed nursing home administrator hired as an administrator after the effective

date of this regulation shall complete and pass the Department-approved assisted living administrator competency-based test.

**§ 2800.65. [Direct] Staff orientation and direct care staff person training and orientation.**

(a) Prior to or during the first work day, direct care staff persons and other staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

- (1) Evacuation procedures.
- (2) Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location, if applicable.
- (3) The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
- (4) Smoking safety procedures, the residence's smoking policy and location of smoking areas, if applicable.
- (5) The location and use of fire extinguishers.
- (6) Smoke detectors and fire alarms.
- (7) Telephone use and notification of emergency services.

(b) Direct care staff persons shall complete an initial orientation approved by the Department before providing direct care to residents.

(c) Direct care staff persons shall be certified in first aid and CPR before providing direct care to residents.

(d) A sufficient number of direct care staff persons shall be certified in obstructed airway techniques to meet the staff to resident ratios under § 2800.63(a) (relating to first aid, CPR and obstructed airway training) before providing direct care to residents.

[(b)] (e) Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation training that includes the following:

- (1) Resident rights.
- (2) Emergency medical plan.
- (3) Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P. S. §§ 10225.101–10225.5102).
- (4) Reporting of reportable incidents and conditions.
- (5) Safe management techniques.
- (6) Core competency training that includes the following:

- (i) Person-centered care.
- (ii) Communication, problem solving and relationship skills.
- (iii) Nutritional support according to resident preference.

[(c)] (f) Ancillary staff persons shall have a general orientation to their specific job functions as it relates to their position prior to working in that capacity.

[(d)] (g) Direct care staff persons may not provide unsupervised [ADL] assisted living services until completion of 18 hours of training in the following areas:

- (1) Training that includes a demonstration of job duties, followed by supervised practice.
- (2) Successful completion and passing the Department-approved direct care training course and passing of the competency test.
- (3) Initial direct care staff person training to include the following:
  - (i) Safe management techniques.
  - (ii) Assisting with ADLs and IADLs.
  - (iii) Personal hygiene.
  - (iv) Care of residents with mental illness, neurological impairments, mental retardation and other mental disabilities.

- (v) The normal aging-cognitive, psychological and functional abilities of individuals who are older.
- (vi) Implementation of the initial assessment, annual assessment and support plan.
- (vii) Nutrition, food handling and sanitation.
- (viii) Recreation, socialization, community resources, social services and activities in the community.
- (ix) Gerontology.
- (x) Staff person supervision, if applicable.
- (xi) Care and needs of residents with special emphasis on the residents being served in the residence.
- (xii) Safety management and hazard prevention.
- (xiii) Universal precautions.
- (xiv) The requirements of this chapter.
- (xv) [Infection] The signs and symptoms of infections and infection control.
- (xvi) Care for individuals with mobility needs, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, if applicable to the residents served in the residence.

(xvii) Behavioral management techniques.

(xviii) Understanding of the resident's assessment and how to implement the resident's support plan.

(xix) Person-centered care and aging in place.

[(e)] (h) Direct care staff persons shall have at least [12] 16 hours of annual training relating to their job duties. The training required in § 2800.69 (relating to additional dementia-specific training) shall be in addition to the [12] 16 hour annual training.

[(f)] (i) Training topics for the annual training for direct care staff persons must include the following:

- (1) Medication self-administration training.
- (2) Instruction on meeting the needs of the residents as described in the [preadmission screening form,] assessment tool, medical evaluation and support plan.
- (3) Care for residents with dementia, [and] cognitive and neurological impairments.
- (4) Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.

(5) [Personal care] Assisted living service needs of the resident.

(6) Safe management techniques.

(7) Care for residents with mental illness or mental retardation, or both, if the population is served in the residence.

[(g)] (i) Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

(1) Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos 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) Emergency preparedness procedures and recognition and response to crises and emergency situations.

(3) Resident rights.

(4) The Older Adult Protective Services Act.

(5) Falls and accident prevention.

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

[(h)] (k) If a staff person has completed the required initial direct care staff person training within the past year as a direct care staff person at another residence, the requirement for initial direct care staff person training in this section does not apply if the staff person provides written verification of completion of the training.

[(i)] (l) A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

#### **§ 2800.66. Staff training plan.**

(a) A staff training plan shall be developed annually.

(b) The plan must include training aimed at improving the knowledge and skills of the residence's direct care staff persons in carrying out their job responsibilities. The staff training plan must include the following:

(1) The name, position and duties of each direct care staff person.

(2) The required training courses for each staff person.

(3) The dates, times and locations of the scheduled training for each staff person for the upcoming year.

(c) Documentation of compliance with the staff training plan shall be kept.

#### **§ 2800.67. Training institution registration.**

(a) An institution and the course of study offered by an educational institution, association, professional society or organization for the purpose of educating and qualifying applicants for certification as assisted living residence administrators shall be registered and approved by the Department prior to offering the course of study.

(b) An application for registration of an institution and approval of a course of study shall be submitted to the Department on a form provided by the Department and include the following information:

(1) The full name, address, telephone number, facsimile number and electronic mail address of the prospective training provider, each instructor and the program coordinator.

(2) The training objectives, instructional materials, content and teaching methods to be used and the number of clock hours.

(3) The recommended class size.

(4) The attendance certification method.

(5) Proof that each course instructor is certified by the Department to conduct administrator training.

(6) The subject that each instructor will teach and documentation of the instructor's academic credentials, instructional experience and work experience to teach the subject.

(7) The location of the training site, which shall accommodate the number of anticipated participants.

(c) A request to amend a Department-approved course of study shall be submitted for the Department's review and approval prior to implementation of a change in the course of study.

(d) The training institution shall issue a training certificate to each participant who successfully completes the Department-approved course and passes the competency test. Each training certificate must indicate the participant's name, the name of the training institution, the date and location of the training and the number of clock hours completed for each training topic.

**§ 2800.68. Instructor approval.**

(a) Training for assisted living residence administrators provided by an individual who is not certified as an instructor by the Department will not be considered valid training.

(b) To receive the Department's certification as an approved instructor for assisted living residence administrators, an instructor shall successfully complete the Department's train-the-trainer course. The train-the-trainer course is designed to provide and reinforce basic training skills, including the roles and responsibilities of the trainer, training methodology, the use of instructional aids and recordkeeping.

(c) An instructor shall demonstrate competent instructional skills and knowledge of the applicable topic and meet the Department's qualifications for the topic being taught.

(d) An instructor is subject to unannounced monitoring by the Department while conducting training.

(e) The Department will establish approval standards that include the following:

(1) The mechanism to measure the quality of the training being offered.

(2) The criteria for selecting and evaluating instructors, subject matter and instructional materials.

(3) The criteria for evaluating requests to amend a course.

(4) The criteria for evaluating the effectiveness of each course.

(5) The instructor qualifications for each subject being taught.

(f) The Department may withdraw approval under the following conditions:

(1) Failure to follow the approved curriculum.

(2) Lack of trainer competency.

(3) A pattern of violations of this chapter by a residence conducting the training.

**§ 2800.69. Additional dementia-specific training.**

Administrative staff, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall receive at least 4 hours of dementia-specific training within 30 days of hire and at least 2 hours of dementia-specific training annually thereafter in addition to the training requirements of this chapter.

**PHYSICAL SITE**

**§ 2800.81. Physical accommodations and equipment.**

(a) The residence 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 the residence and exiting from the residence.

(b) Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

**§ 2800.82. Poisons.**

(a) Poisonous materials shall be stored in their original, labeled containers.

(b) Poisonous materials shall be stored separately from food, food preparation surfaces and dining surfaces.

(c) Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the residence are able to safely use or avoid poisonous materials.

**§ 2800.83. Temperature.**

(a) The indoor temperature, in areas used by the residents, must be at least 70° F when residents are present in the residence.

(b) A residence in existence prior to \_\_\_\_\_ (*Editor's Note:* The blank refers to the effective date of adoption of this proposed rulemaking.) shall provide central air conditioning. If central air conditioning is not feasible or is cost prohibitive, window air conditioning units shall be provided. The residence shall submit justification to the Department for the use of window air conditioning units.

(c) For new construction after \_\_\_\_\_ (*Editor's Note:* The blank refers to the effective date of adoption of this proposed rulemaking.), the residence shall provide central air conditioning.

**§ 2800.84. Heat sources.**

Heat sources, such as steam and hot heating pipes, water pipes, fixed space heaters, hot water heaters and radiators exceeding 120° F that are accessible to the resident must be equipped with protective guards or insulation to prevent the resident from coming in contact with the heat source.

**§ 2800.85. Sanitation.**

(a) Sanitary conditions shall be maintained.

(b) There may be no evidence of infestation of insects or rodents in the residence.

(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.

(e) Trash outside the residence shall be kept in covered receptacles that prevent the penetration of insects and rodents.

(f) For a residence serving 9 or more residents that is not connected to a public sewer system, there shall be a written sanitation approval for its sewage system by the sewage enforcement official of the municipality in which the residence is located.

**§ 2800.86. Ventilation.**

(a) All areas of the residence that are used by the resident shall be ventilated.

Ventilation includes an operable window, air conditioner, fan or mechanical ventilation that ensures airflow.

(b) A bathroom that does not have an operable, outside window must be equipped with an exhaust fan for ventilation.

**§ 2800.87. Lighting.**

The residence's rooms, hallways, interior stairs, outside steps, outside doorways, porches, ramps, evacuation routes, outside walkways and fire escapes must be lighted and marked to ensure that residents, including those with vision impairments, can safely move through the residence and safely evacuate.

**§ 2800.88. Surfaces.**

(a) Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

(b) The residence may not use asbestos products for renovations or new construction.

(c) If asbestos is found in a residence or contained in any part of the residence, the residence shall have a certification from an asbestos remediation company that the residence is safe for residents and that the asbestos does not pose a risk.

**§ 2800.89. Water.**

(a) The residence must have hot and cold water under pressure in each bathroom, kitchen and laundry area to accommodate the needs of the residents in the residence.

(b) Hot water temperature in areas accessible to the resident may not exceed 120° F.

(c) A residence that is not connected to a public water system shall have a coliform water test at least every 3 months, by a Department of Environmental Protection-certified laboratory, stating that the water is below maximum contaminant levels. A public water system is a system that provides water to the public for human consumption, which has at least 15 service connections or regularly serves an average of at least 25 individuals daily at least 60 days out of the year.

(d) If the water is found to be above maximum contaminant levels, the residence shall conduct remediation activity to reduce the level of contaminants to below the maximum contaminant level. During remediation activity, an alternate source of drinking water shall be provided to the residents.

(e) The residence shall keep documentation of the laboratory certification, in addition to the results and corrections made to ensure safe water for drinking.

**§ 2800.90. Communication system.**

(a) The residence shall have a working, noncoin operated, landline telephone that is accessible in emergencies and accessible to individuals with disabilities.

(b) For a residence serving 9 or more residents, there shall be a system or method of communication such as an intercom, public address, pager or cell phone system that enables staff persons to immediately contact other staff persons in the residence for assistance in an emergency.

**§ 2800.91. Emergency telephone numbers.**

Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and assisted living residence complaint hotline shall be posted on or by each telephone with an outside line.

**§ 2800.92. Windows and screens.**

Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

**§ 2800.93. Handrails and railings.**

(a) Each ramp, interior stairway, hallway and outside steps must have a well-secured handrail.

(b) Each porch must have a well-secured railing.

**§ 2800.94. 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 must have a landing, which is a minimum of 3 feet by 3 feet.

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

(c) Stairs must have strips for those with vision impairments.

**§ 2800.95. Furniture and equipment.**

Furniture and equipment must be in good repair, clean and free of hazards.

**§ 2800.96. First aid kit.**

(a) The residence shall have a first aid kit in each building on the premises that includes [an automatic electronic defibrillation device,] nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers. The residence shall have an automatic external defibrillation device located in each building on the premises.

(b) Staff persons shall know the location of the first aid kit.

(c) The first aid kit must be in a location that is easily accessible to staff persons.

**§ 2800.97. Elevators and stair glides.**

Each elevator and stair glide must have a certificate of operation from the Department of Labor and Industry or the appropriate local building authority in accordance with 34 Pa. Code Chapter 405 (relating to elevators and other lifting devices).

**§ 2800.98. Indoor activity space.**

(a) The residence shall have at least two indoor wheelchair accessible common rooms for all residents for activities such as reading, recreation and group activities. One of the common rooms shall be available for resident use at any time, provided the use does not affect or disturb others.

(b) The residence shall have at least one furnished living room or lounge area for residents, their families and visitors. The combined living room or lounge areas must accommodate all residents at one time. There must be at least 15 square feet per living unit for up to 50 living units. There must be a total of 750 square feet if there are more than 50 living units. These rooms or areas must contain tables, chairs and lighting to accommodate the residents, their families and visitors.

(c) The residence shall have a working television and radio available to residents in a living room or lounge area.

**§ 2800.99. Recreation space.**

The residence shall provide regular access to outdoor and indoor recreation space and recreational items, such as books, newspapers, magazines, puzzles, games, cards and crafts.

**§ 2800.100. Exterior conditions.**

(a) The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

(b) The residence shall ensure that ice, snow and obstructions are removed from outside walkways, ramps, steps, recreational areas and exterior fire escapes.

**§ 2800.101. Resident living units.**

(a) A residence shall provide a resident with the resident's own living unit unless the conditions of subsection (c) are met.

(b)(1) For new construction of residences after \_\_\_\_\_ (*Editor's Note: The blank refers to the effective date of adoption of this proposed rulemaking.*), each living unit for a single resident must have at least [250] 225 square feet of floor space measured wall-to-wall, excluding bathrooms and closet space. If two residents share a living unit, there must be [an additional 80] a total of 300 square feet in the living unit. Exceptions to the size of the living unit may be made at the Department's discretion.

(2) For [residences] facilities in existence prior to \_\_\_\_\_ (*Editor's Note: The blank refers to the effective date of adoption of this proposed rulemaking.*), each living unit must have at least [175] 160 square feet measured wall to wall, excluding bathrooms and closet space. If two residents share a living unit, there must be [an additional 80] a total of 210 square feet in the living unit. Exceptions to the size of the living unit may be made at the Department's discretion.

(3) Each living unit must have a telephone jack and individually controlled thermostats for heating and cooling.

(4) The doors in living units, including entrance doors, must be accessible or adaptable for wheelchair use.

(c) Two residents may voluntarily agree to share one living unit provided that the agreement is in writing and contained in each of the resident-residence contract of those residents. A licensee may not require residents to share a living unit. The maximum number of residents in any living unit shall be two residents.

(d) Kitchen capacity requirements are as follows:

(1) *New construction.* For new construction of residences after \_\_\_\_\_ (*Editor's Note:* The blank refers to the effective date of adoption of this proposed rulemaking.), the kitchen capacity, at a minimum, must contain [a small refrigerator with a freezer compartment,] a cabinet for food storage, a small bar-type sink with hot and cold running water and space with electrical outlets suitable for small [cooking] appliances such as a microwave oven and a small refrigerator. [The cooking appliances shall be designed so that they can be disconnected and removed for resident safety or if the resident chooses not to have cooking capability in his living unit.]

(i) Upon entering the assisted living residence, the resident or his designated person shall be asked if the resident wishes to have a cooking appliance or small refrigerator, or both. The cooking appliance or small refrigerator, or both, shall

be provided by the residence if desired by the resident or his designated person.

If the resident or his designated person wishes to provide his own cooking appliance or small refrigerator, or both, it shall meet the residence's safety standards.

(ii) An appliance shall be designed so it can be disconnected and removed for resident safety or if the resident chooses not to have the appliance within his living unit.

(2) *Existing facilities.* Facilities that convert to residences after \_\_\_\_\_ (*Editor's Note: The blank refers to the effective date of adoption of this proposed rulemaking.*), must meet the following requirements related to kitchen capacity:

(i) [The residence shall provide a small refrigerator in each living unit.

(ii) The residence shall provide a microwave oven in each living unit.] The residence shall provide space with electrical outlets suitable for small appliances, such as a microwave oven and small refrigerator.

(A) Upon entering the assisted living residence, the resident or his designated person shall be asked if the resident wishes to have a cooking appliance or small refrigerator, or both. The cooking appliance or small refrigerator, or both, shall be provided by the residence if desired by the resident or his designated person. If the resident or his designated person wishes to provide his own cooking appliance or small refrigerator, or both, it shall meet the residence's safety standards.

(B) An appliance shall be designed so it can be disconnected and removed for resident safety or if the resident chooses not to have the appliance within his living unit.

[(iii)] (ii) The residence shall provide access to a sink for dishes, a stovetop for hot food preparation and a food preparation area in a common area. A common resident kitchen may not include the kitchen used by the residence staff for the preparation of resident or employee meals, or the storage of goods.

(e) Ceiling height in each living unit must be an average of at least 7 feet.

(f) Each living unit must have at least one window with direct exposure to natural light.

(g) A resident's bedroom in the living unit shall be used only by the occupying resident unless two consenting adult residents agree to share a bedroom and the requirements of subsection (c) are met.

(h) Each living unit must have a door with a lock, except where a lock in a unit under a special care designation would pose a risk or be unsafe. The administrator shall maintain a master key that can open all locks in the event of an emergency.

(i) A resident shall have access to his living unit at all times.

(j) Each resident shall have the following in the living unit:

- (1) A bed with a solid foundation and fire retardant mattress that is in good repair, clean and supports the resident. An exception will be permitted for residents who wish to provide their own mattresses.
- (2) A chair for each resident that meets the resident's needs.
- (3) Pillows, bed linens and blankets that are clean and in good repair.
- (4) A storage area for clothing that includes a chest of drawers and a closet or wardrobe space with clothing racks or shelves accessible to the resident.
- (5) A bedside table or a shelf.
- (6) A mirror.
- (7) An operable lamp or other source of lighting that can be turned on at bedside.
- (8) If a resident shares a bedroom with another resident, the items specified in paragraphs (4)–(7) may be shared with one other resident.
- (k) Cots and portable beds are prohibited.
- (l) Bunk beds or other raised beds that require residents to climb steps or ladders to get into or out of bed are prohibited.
- (m) A living unit may not be used as an exit from or used as a passageway to another part of the residence unless in an emergency situation.

(n) The living unit must have walls, floors and ceilings, which are finished, clean and in good repair.

(o) In living units with a separate bedroom, there must be a door on the bedroom.

(p) Space for storage of personal property shall be provided in a dry, protected area.

(q) There must be drapes, shades, curtains, blinds or shutters on the living unit windows. Window coverings must be clean, in good repair, provide privacy and cover the entire window when drawn.

(r) Each living unit must be equipped with an emergency notification system to notify staff in the event of an emergency.

**§ 2800.102. Bathrooms.**

(a) There shall be one functioning flush toilet in the bathroom in the living unit.

(b) There shall be at least one sink and wall mirror in the bathroom of the living unit.

(c) There shall be at least one bathtub or shower in the bathroom of the living unit.

(d) Toilet and bath areas in the living unit must have grab bars, hand rails or assist bars. Bathtubs and showers must have slip-resistant surfaces.

(e) Privacy in the living unit shall be provided for toilets, showers and bathtubs by partitions or doors. Bathroom doors in a double occupancy living unit must be lockable by the resident, unless contraindicated by the support plan.

(f) An individual towel, washcloth and soap shall be provided for each resident unless the resident provides his own supplies of these items.

(g) Individual toiletry items including toothpaste, toothbrush, shampoo, deodorant, comb and hairbrush shall be made available to residents who are not recipients of SSI. If the residence charges for these items, the charges shall be indicated in the resident-residence contract. Availability of toiletry items for residents who are recipients of SSI is specified in § 2800.27(d)(1) (relating to SSI recipients).

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

(i) [A] Bar soap or a dispenser with soap shall be provided within reach of each bathroom sink. Bar soap, however, is not permitted when a living unit is shared unless there is a separate bar clearly labeled for each resident [who shares a bathroom] sharing the living unit.

(j) Towels and washcloths shall be in the possession of the resident in the resident's living unit unless the resident has access to the residence's linen supply.

(k) Use of a common towel is prohibited.

(l) Shelves or hooks for the resident's towel and clothing shall be provided.

(m) A residence shall have at least one public restroom [that meets applicable local, State and Federal laws and guidelines and] that is convenient to common areas and wheelchair accessible.

(n) Each bathroom must be equipped with an emergency notification system to notify staff in the event of an emergency.

**§ 2800.103. Food service.**

(a) A residence shall have access on the grounds to an operable kitchen with a refrigerator, sink, stove, oven, cooking equipment and cabinets or shelves for storage. If the kitchen is not in the residence, the residence shall have a kitchen area with a refrigerator, cooking equipment, a sink and food storage space.

(b) Kitchen surfaces must be of a nonporous material and cleaned and sanitized after each meal.

(c) Food shall be protected from contamination while being stored, prepared, transported and served.

(d) Food shall be stored off the floor.

(e) Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

(f) Food requiring refrigeration shall be stored at or below 40° F. Frozen food shall be kept at or below 0° F. Thermometers are required in refrigerators and freezers.

(g) Food shall be stored in closed or sealed containers.

(h) Food shall be thawed either in the refrigerator, microwave oven, under cool water or as part of the cooking process.

(i) Outdated or spoiled food or dented cans may not be used.

(j) Eating, drinking and cooking utensils shall be washed, rinsed and sanitized after each use by a method specified in 7 Pa. Code Chapter 46, Subchapter D (relating to equipment, utensils and linen).

#### **§ 2800.104. Dining room.**

(a) An assisted living residence shall have an accessible common dining space outside the resident living units. A dining room area must be equipped with tables and chairs and able to accommodate the maximum number of residents scheduled for meals at any one time. There must be at least 15 square feet per person for residents scheduled for meals at any one time.

(b) Dishes, glassware and utensils shall be provided for eating, drinking, preparing and serving food. These utensils must be clean, and free of chips and cracks. Plastic and paper plates, utensils and cups for meals may not be used on a regular basis.

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

(d) Adaptive eating equipment or utensils shall be available, if needed, to assist residents in eating at the table.

(e) Breakfast, midday and evening meals shall be served to residents in a dining room except in the following situations:

(1) Service in the resident's living unit shall be available at no additional charge when the resident is unable to come to the dining room due to illness.

(2) When room service is available in a residence, a resident may choose to have a meal served in the resident's living unit. This service shall be provided at the resident's request and may not replace daily meals in a dining room.

**§ 2800.105. Laundry.**

(a) Laundry service for bed linens, towels and personal clothing shall be provided by the residence, at no additional charge, to residents who are recipients of or eligible applicants for SSI benefits. Laundry service does not include dry cleaning.

(b) Laundry service for bed linens, towels and personal clothing for the residents who are not recipients of SSI shall be provided by the residence unless otherwise indicated in the resident-residence contract. If a residence provides laundry facilities, there shall be no prohibition against residents doing their own laundry.

(c) The supply of bed linens and towels must be sufficient to ensure a complete change of bed linen and towels at least once per week.

(d) Bed linens and towels shall be changed at least once every week and more often as needed to maintain sanitary conditions.

(e) Clean linens and towels shall be stored in an area separate from soiled linen and clothing.

(f) Measures shall be implemented to ensure that residents' clothing are not lost or misplaced during laundering or cleaning. The resident's clean clothing shall be returned to the resident within 24 hours after laundering.

(g) To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

**§ 2800.106. Swimming areas.**

If a residence operates a swimming area, the following requirements apply:

(1) Swimming areas shall be operated in accordance with applicable laws and regulations.

(2) Written policy and procedures to protect the health, safety and well-being of the residents shall be developed and implemented.

**§ 2800.107. Emergency preparedness.**

(a) The administrator shall have a copy and be familiar with the emergency preparedness plan for the municipality in which the residence is located.

(b) The residence shall have written emergency procedures that include the following:

(1) Contact information for each resident's designated person.

(2) The residence's plan to provide the emergency medical information for each resident that ensures confidentiality.

(3) Contact telephone numbers of local and State emergency management agencies and local resources for housing and emergency care of residents.

(4) Means of transportation in the event that relocation is required.

(5) Duties and responsibilities of staff persons during evacuation, transportation and at the emergency location. These duties and responsibilities shall be specific to each resident's emergency needs.

(6) Alternate means of meeting resident needs in the event of a utility outage.

(c) The residence shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

(d) The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

**§ 2800.108. Firearms and weapons.**

(a) A residence shall have a written policy regarding firearms, weapons and ammunition where these items are on the premises or in possession of any resident or staff member. A residence is not required to permit firearms, weapons and ammunition.

(b) The policy must include, at a minimum, procedures regarding the safety, access and use of firearms, weapons and ammunition.

(c) Firearms, weapons and ammunition shall be permitted on the licensed premises of a residence only when the following conditions are met:

(1) Firearms and weapons shall be contained in a locked cabinet located in a place other than the residents' living unit or in a common living area.

(2) Ammunition shall be contained in a locked area separate from firearms and weapons, and located in a place other than the residents' living unit or in a common living area.

(3) The key to the locked cabinet containing the firearms, weapons and ammunition shall be in the possession of the administrator or a designee.

(4) The administrator or designee shall be the only individual permitted to open the locked cabinet containing the firearms and weapons and the locked area containing the ammunition.

(d) If a firearm, weapon or ammunition is the property of a resident, there shall be a written policy and procedures regarding the safety, access and use of firearms, weapons and ammunition. A resident may not take a firearm, weapon or ammunition out of the locked cabinet into the common living area.

**§ 2800.109. Pets.**

(a) The residence rules must specify whether the residence permits pets on the premises.

(b) Cats and dogs present at the residence shall have a current rabies vaccination. A current certificate of rabies vaccination from a licensed veterinarian shall be kept.

(c) Pets that are accessible to the residents shall be in good health and nonaggressive to the residents.

(d) If a residence has additional charges for pets, the charges shall be included in the resident-residence contract.

(e) A residence shall disclose to applicants whether pets are permitted and present in the residence.

## FIRE SAFETY

### § 2800.121. Unobstructed egress.

(a) Stairways, hallways, doorways, passageways and egress routes from living units and from the building must be unlocked and unobstructed.

(b) Except as provided in § 2800.101 (relating to resident living units), doors used for egress routes from living units 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, unless the residence has written approval or a variance from the Department of Labor and Industry, the Department of Health or the appropriate local building authority.

### § 2800.122. Exits.

Unless otherwise regulated by the Department of Labor and Industry, the Department of Health or the appropriate local building authority, all buildings must have at least two independent and accessible exits from every floor, arranged to reduce the possibility that both will be blocked in an emergency situation.

### § 2800.123. Emergency evacuation.

(a) Exit doors must be equipped so that they can be easily opened by residents from the inside without the use of a key or other manual device that can be removed, misplaced or lost.

(b) Copies of the emergency procedures as specified in § 2800.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the residence and a copy shall be kept.

(c) For a residence serving nine or more residents, an emergency evacuation diagram of each floor showing corridors, line of travel to exit doors and location of the fire extinguishers and pull signals shall be posted in a conspicuous and public place on each floor.

(d) If the residence serves one or more residents with mobility needs above or below grade level of the residence, there shall be a fire-safe area, as specified in writing within the past year by a fire safety expert, on the same floor as each resident with mobility needs.

**§ 2800.124. Notification of local fire officials.**

The residence shall notify the local fire department in writing of the address of the residence, location of the living units and bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

**§ 2800.125. Flammable and combustible materials.**

(a) Combustible and flammable materials may not be located near heat sources or hot water heaters.

(b) Combustible materials shall be inaccessible to residents.

**§ 2800.126. Furnaces.**

(a) A professional furnace cleaning company or trained maintenance staff person shall inspect furnaces at least annually. Documentation of the inspection shall be kept.

(b) Furnaces shall be cleaned according to the manufacturer's instructions. Documentation of the cleaning shall be kept.

**§ 2800.127. Space heaters.**

(a) Portable space heaters are prohibited.

(b) Nonportable space heaters must be well vented and installed with permanent connections and protectors.

**§ 2800.128. Supplemental heating sources.**

(a) The use of kerosene burning heaters is prohibited.

(b) Wood and coal burning stoves shall be used only if a local fire department or other municipal fire safety authority, professional cleaning company or trained maintenance staff person inspects and approves them annually. Wood and coal burning stoves that are used as a regular heating source shall be cleaned every year according to the manufacturer's instructions. Documentation of wood and coal burning stove inspections and cleanings shall be kept.

(c) Wood and coal burning stoves must be securely screened or equipped with protective guards while in use.

**§ 2800.129. Fireplaces.**

(a) A fireplace must be securely screened or equipped with protective guards while in use.

(b) A fireplace chimney and flue shall be cleaned when there is an accumulation of creosote. Written documentation of the cleaning shall be kept.

(c) A fireplace chimney and flue that is used must be serviced annually and written documentation of the servicing shall be kept.

**§ 2800.130. Smoke detectors and fire alarms.**

(a) There shall be an operable automatic smoke detector located in each living unit.

(b) Smoke detectors and fire alarms must be of a type approved by the Department of Labor and Industry, the appropriate local building authority or local fire safety expert, or listed by Underwriters Laboratories.

(c) If the residence serves nine or more residents, there shall be at least one smoke detector on each floor interconnected and audible throughout the residence or an automatic fire alarm system that is interconnected and audible throughout the residence.

(d) If one or more residents or staff persons are not able to hear the smoke detector or fire alarm system, a signaling device approved by a fire safety expert shall be used and tested so that each resident and staff person with a hearing impairment will be alerted in the event of a fire.

(e) Smoke detectors and fire alarms shall be tested for operability at least once per month. A written record of the monthly testing shall be kept.

(f) If a smoke detector or fire alarm becomes inoperative, repair shall be completed within 48 hours of the time the detector or alarm was found to be inoperative.

(g) The residence's emergency procedures shall indicate the procedures that will be immediately implemented until the smoke detector or fire alarms are operable.

(h) In residences housing five or more residents with mobility needs, the fire alarm system shall be directly connected to the local fire department or 24-hour monitoring service approved by the local fire department, if this service is available in the community.

**§ 2800.131. Fire extinguishers.**

(a) There shall be at least one operable fire extinguisher with a minimum 2-A rating for each floor [and living unit], including public walkways and common living areas every 3,000 square feet, the basement and attic.

(b) If the indoor floor area on a floor including the basement or attic is more than 3,000 square feet, there shall be an additional fire extinguisher with a minimum 2-A rating for each additional 3,000 square feet of indoor floor space.

(c) A fire extinguisher with a minimum 2A-10BC rating shall be located in each kitchen [and in the living units] of the residence. The kitchen extinguisher must meet the requirements for one floor as required in subsection (a).

(d) Fire extinguishers must be listed by Underwriters Laboratories or approved by Factory Mutual Systems.

(e) Fire extinguishers shall be accessible to staff persons. Fire extinguishers shall be kept locked if access to the extinguisher by a resident could cause a safety risk to the resident. If fire extinguishers are kept locked, each staff person shall be able to immediately unlock the fire extinguisher in the event of a fire emergency.

(f) Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

**§ 2800.132. Fire drills.**

(a) An unannounced fire drill shall be held at least once a month.

(b) A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

(c) A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the residence at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

(d) Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the residence.

(e) A fire drill shall be held during sleeping hours once every 6 months.

(f) Alternate exit routes shall be used during fire drills.

(g) Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

(h) Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

(i) A fire alarm or smoke detector shall be set off during each fire drill.

(j) Elevators may not be used during a fire drill or a fire.

**§ 2800.133. Exit signs.**

The following requirements apply for a residence serving nine or more residents:

- (1) Signs bearing the word "EXIT" in plain legible letters shall be placed at all exits.
- (2) Access to exits shall be marked with readily visible signs indicating the direction to travel.
- (3) Exit sign letters must be at least 6 inches in height with the principal strokes of letters at least 3/4 inch wide.

**RESIDENT HEALTH**

**§ 2800.141. Resident medical evaluation and health care.**

(a) A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department [within 60 days prior to admission], subject to the provisions of § 2800.22 (relating to application and admission). The evaluation must include the following:

- (1) A general physical examination by a physician, physician's assistant or nurse practitioner.

- (2) Medical diagnosis including physical or mental disabilities of the resident, if any.
- (3) Medical information pertinent to diagnosis and treatment in case of an emergency.
- (4) Special health or dietary needs of the resident.
- (5) Allergies.
- (6) Immunization history.
- (7) Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
- (8) Body positioning and movement stimulation for residents, if appropriate.
- (9) Health status.
- (10) Mobility assessment, updated annually or at the Department's request.
- (11) An indication that a tuberculin skin test has been administered with negative results within 2 years; or if the tuberculin skin test is positive, the result of a chest X-ray. In the event a tuberculin skin test has not been administered, the test shall be administered within 15 days after admission.
- (12) Information about a resident's day-to-day [personal care] assisted living service needs.

(b) A resident shall have a medical evaluation:

(1) At least annually.

(2) If the medical condition of the resident changes prior to the annual medical evaluation.

**§ 2800.142. Assistance with [health] medical care and supplemental health care services.**

(a) Each residence shall demonstrate the ability to provide or arrange for the provision of supplemental health care services in a manner protective of the health, safety and well-being of its residents utilizing employees, independent contractors or contractual arrangements with other health care facilities or practitioners licensed, registered or certified to the extent required by law to provide the service.

(b) The residence shall assist the resident to secure medical care and supplemental health care services. [To the extent prominently displayed in the written admission agreement, a residence may require residents to use providers of supplemental health care services approved or designated by the residence. If the resident has health care coverage for the supplemental health care services, the approval may not be unreasonably withheld. The residence shall document the resident's need for the medical care, including updating the resident's assessment and support plan.]

(i) The residence shall permit a resident to select or retain his primary care physician.

(ii) To the extent prominently displayed in the written admission agreement, a residence may require residents to use providers of supplemental health care services approved or designated by the residence.

(iii) The residence shall document the resident's need for the medical care, including updating the resident's assessment and support plan.

[(b)] (c) If a resident refuses routine medical or dental examination or treatment, the refusal and the continued attempts to educate and inform the resident about the need for [health] medical care shall be documented in the resident's record.

[(c)] (d) If a resident has a serious medical or dental condition, reasonable efforts shall be made to obtain consent for treatment from the resident or the resident's designated person.

[(d)] (e) The residence shall assist the resident to secure preventative medical, dental, vision and behavioral health care as requested by a physician, physician's assistant or certified registered nurse practitioner.

#### **§ 2800.143. Emergency medical plan.**

(a) The residence shall have a written emergency medical plan that includes the following:

(1) The hospital or source of health care that will be used in an emergency.

This shall be the resident's choice, if possible.

(2) Emergency transportation to be used.

(3) An emergency staffing plan.

(b) The following current emergency medical and health information shall be available at all times for each resident and shall accompany the resident when the resident needs emergency medical attention:

(1) The resident's name and birth date.

(2) The resident's Social Security number.

(3) The resident's medical diagnosis.

(4) The resident's physician's name and telephone number.

(5) Current medication, including the dosage and frequency.

(6) A list of allergies.

(7) Other relevant medical conditions.

(8) Insurance or third party payer and identification number.

(9) The power of attorney for health care or health care proxy, if applicable.

(10) The resident's designated person with current address and telephone number.

(11) Personal information and related instructions regarding advance directives, do not resuscitate orders or organ donation, if applicable.

(12) A speech, hearing or vision need which requires accommodation or awareness, such as written communication or American sign language.

(13) A language need which requires accommodation or awareness, such as an interpreter of translation.

**§ 2800.144. Use of tobacco.**

(a) A residence may permit smoking tobacco in a designated smoking room of the residence.

(b) The residence rules must specify whether the residence is designated as smoking or nonsmoking.

(c) A residence that permits smoking inside or outside of the residence shall develop and implement written fire safety policy and procedures that include the following:

(1) Proper safeguards inside and outside of the residence to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room

through other parts of the residence, extinguishing procedures, fire resistant furniture both inside and outside the residence and fire extinguishers in the smoking rooms.

(2) Location of a smoking room or outside smoking area a safe distance from heat sources, hot water heaters, combustible or flammable materials and away from common walkways and exits.

(3) Prohibition of the use of tobacco during transportation by the residence.

(d) Smoking outside of the smoking room is prohibited.

## NUTRITION

### § 2800.161. Nutritional adequacy.

(a) Meals shall be offered that meet the recommended dietary allowances established by the United States Department of Agriculture.

(b) At least three nutritionally well-balanced meals shall be offered daily to the resident. Each meal shall include an alternative food and drink item from which the resident may choose.

(c) Additional portions of meals and beverages at mealtimes shall be available for the resident.

(d) A resident's special dietary needs as prescribed by a physician, physician's assistant, certified registered nurse practitioner or dietitian shall be met.

Documentation of the resident's special dietary needs shall be kept in the resident's record.

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

(f) Drinking water shall be available to the resident at all times.

(g) Between-meal snacks and beverages shall be available at all times for each resident, unless medically contraindicated as documented in the resident's support plan.

(h) Residents have the right to purchase groceries and prepare their own food in addition to the three meal plan required in § 2800.220(b) (relating to [assisted living residence services] service provision) in their living units unless it would be unsafe for them to do so consistent with their support plan.

#### **§ 2800.162. Meals.**

(a) There may not be more than 15 hours between the evening meal and the first meal of the next day. There may not be more than 6 hours between breakfast and lunch, and between lunch and supper. This requirement does not apply if a resident's physician has prescribed otherwise.

(b) When a resident misses a meal, food adequate to meet daily nutritional requirements shall be available and offered to the resident.

(c) Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the residence.

(d) Past menus of meals that were served, including changes, shall be kept for at least 1 month.

(e) A change to a menu shall be posted in a conspicuous and public place in the residence and shall be accessible to a resident in advance of the meal. Meal substitutions shall be made in accordance with § 2800.161 (relating to nutritional adequacy).

(f) A resident shall receive adequate physical assistance with eating or be provided with appropriate adaptive devices, or both, as indicated in the resident's support plan.

(g) Appropriate cueing shall be used to encourage and remind residents to eat and drink, as indicated in the resident's support plan.

**§ 2800.163. Personal hygiene for food service workers.**

(a) Staff persons, volunteers and residents involved in the storage, preparation, serving and distributing of food shall wash their hands with hot water and soap prior to working in the kitchen areas and after using the bathroom.

(b) Staff persons, volunteers and residents shall follow sanitary practices while working in the kitchen areas.

(c) Staff persons, volunteers and residents involved with the storage, preparation, serving and distributing of food shall be in good health.

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

**§ 2800.164. Withholding or forcing of food prohibited.**

(a) A residence may not withhold meals, beverages, snacks or desserts as punishment. Food and beverages may be withheld in accordance with prescribed medical or dental procedures.

(b) A resident may not be forced to eat food.

(c) If a resident refuses to eat or drink continuously during a 24-hour period, the resident's primary care physician and the resident's designated person shall be immediately notified.

(d) If a resident has a cognitive impairment that affects the resident's ability to consume adequate amounts of food and water, a staff person shall encourage and remind the resident to eat and drink.

**TRANSPORTATION**

**§ 2800.171. Transportation.**

(a) A residence shall be required to provide or [coordinate] arrange for transportation [to and from medical and social appointments] on a regular weekly basis that permits residents to schedule medical and social appointments within a reasonable local area.

(b) The following requirements apply whenever staff persons or volunteers of the residence provide transportation for the resident:

(1) The occupants of the vehicle shall be in an appropriate safety restraint at all times the vehicle is in motion.

(2) The driver of a vehicle shall be 18 years of age or older and possess a valid driver's license.

(3) The driver of the residence vehicle cannot be a resident.

(4) At least one staff member transporting or accompanying the residents shall have completed the initial new hire direct care staff person training as specified in § 2800.65 (relating to staff orientation and direct care staff training and orientation).

(5) The vehicle must have a first aid kit with the contents as specified in § 2800.96 (relating to first aid kit). The inclusion of an automatic external defibrillation device in a vehicle is optional.

(6) During vehicle operations, the driver may only use a hands-free cellular telephone.

(7) Transportation must include, when necessary, an assistant to the driver who assists the driver to escort residents in and out of the residence and provides assistance during the trip.

(c) The residence shall maintain current copies of the following documentation for each of the residence's vehicles used to transport residents:

(1) Vehicle registration.

(2) Valid driver's license for vehicle operator.

(3) Vehicle insurance.

(4) Current inspection.

(5) Commercial driver's license for vehicle operator if applicable.

(d) If a residence supplies its own [vehicle] vehicles for transporting residents to and from medical and social appointments, a minimum of one vehicle used for this purpose shall be accessible to resident wheelchair users and any other assistive equipment the resident may need.

(1) The residence shall schedule a pick-up time to transport the resident to the medical or social appointment. The residence shall make every reasonable effort to pick-up the resident within 15 minutes before or after the scheduled pick-up time.

(2) The resident may not be dropped off at the medical or social appointment more that 1 hour prior to the time of the appointment.

(3) The residence shall make every reasonable effort to pick-up a resident from a medical appointment no later than 1 hour after the medical appointment.

(4) The residence shall make every reasonable effort to pick-up a resident from a social appointment no later than 1 hour after the end of the social appointment.

(e) If a residence arranges for transportation for residents to and from medical and social appointments the following shall apply:

(1) The residence shall schedule a pick-up time for the resident to be transported to the medical or social appointment. The residence shall make every reasonable effort for a resident to be picked-up within 15 minutes before or after the scheduled pick-up time.

(2) The residence shall make every reasonable effort for a resident to not be dropped off at the medical or social appointment more that 1 hour prior to the time of the appointment.

(3) The residence shall make every reasonable effort for a resident to be picked-up from the medical appointment no later than 1 hour after the medical appointment.

(4) The residence shall make every reasonable effort for a resident to be picked-up from the social appointment no later than 1 hour after the end of the social appointment.

## MEDICATIONS

### § 2800.181. Self-administration.

(a) A residence shall provide residents with assistance, as needed, with medication prescribed for the resident's self-administration. 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.

(b) If assistance includes helping the resident to remember the schedule for taking the medication, the resident shall be reminded of the prescribed schedule. Appropriate cueing shall be used to remind residents to take their medication.

(c) The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2800.227(e) (relating to development of the final support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

(d) If the resident does not need assistance with medication, medication may be stored in a resident's living unit for self-administration. Medications stored in the resident's living unit shall be kept in a safe and secure location to protect against contamination, spillage and theft. The residence shall provide a lockable storage unit for this purpose.

(e) To be considered capable to self-administer medications, a resident shall:

(1) Be able to recognize and distinguish his medication.

(2) Know how much medication is to be taken.

(3) Know when medication is to be taken.

(f) The resident's record shall include a current list of prescription, CAM and OTC medications for each resident who is self-administering his medication.

**§ 2800.182. Medication administration.**

(a) A residence shall provide medication administration services for a resident who is assessed to need medication administration services in accordance with § 2800.181 (relating to self-administration) and for a resident who chooses not to self-administer medications.

(b) Prescription medication that is not self-administered by a resident shall be administered by one of the following:

(1) A physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse or licensed paramedic.

(2) A graduate of an approved nursing program functioning under the direct supervision of a professional nurse who is present in the residence.

(3) A student nurse of an approved nursing program functioning under the direct supervision of a member of the nursing school faculty who is present in the residence.

(4) A staff person who has completed the medication administration training as specified in § 2800.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

(c) Medication administration includes the following activities, based on the needs of the resident:

(1) Identify the correct resident.

(2) If indicated by the prescriber's orders, measure vital signs and administer medications accordingly.

(3) Remove the medication from the original container.

(4) Crush or split the medication as ordered by the prescriber.

(5) Place the medication in a medication cup or other appropriate container, or in the resident's hand.

(6) Place the medication in the resident's hand, mouth or other route as ordered by the prescriber, in accordance with the limitations specified in subsection (b)(4).

(7) Complete documentation in accordance with § 2800.187 (relating to medication records).

**§ 2800.183. Storage and disposal of medications and medical supplies.**

(a) Prescription medications, OTC medications and CAM 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 insulin and epinephrine injections and sterile liquids shall be provided immediately upon removal of the medication from its container.

(b) Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes unless kept in the resident's living unit.

(c) Prescription medications, OTC medications and CAM stored in a refrigerator shall be kept in an area or container that is locked unless the resident has the capacity to store the medications in the resident's own refrigerator in the resident's living unit.

(d) Only current prescription, OTC medications, sample and CAM for individuals living in the residence may be kept in the residence.

(e) Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

(f) Prescription medications, OTC medications and CAM that are discontinued, expired or for residents who are no longer served at the residence shall be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations. When a resident permanently leaves the residence, 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 residence.

(g) Subsections (a) and (e) do not apply to a resident who self-administers medication and stores the medication in his living unit.

**§ 2800.184. Labeling of medications.**

(a) The original container for prescription medications must be labeled with a pharmacy label that includes the following:

- (1) The resident's name.
- (2) The name of the medication.

(3) The date the prescription was issued.

(4) The prescribed dosage and instructions for administration.

(5) The name and title of the prescriber.

(b) If the OTC medications and CAM belong to the resident, they must be identified with the resident's name.

(c) Sample prescription medications must have written instructions from the prescriber that include the components specified in subsection (a).

**§ 2800.185. Accountability of medication and controlled substances.**

(a) The residence shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

(b) At a minimum, the procedures must include:

(1) Documentation of the receipt of controlled substances and prescription medications.

(2) A process to investigate and account for missing medications and medication errors.

(3) Limited access to medication storage areas.

(4) Documentation of the administration of prescription medications, OTC medications and CAM for residents who receive medication administration services or assistance with self-administration. This requirement does not apply to a resident who self-administers medication without the assistance of a staff person and stores the medication in his living unit.

(5) To the extent indicated in the resident's support plan, the residence shall obtain prescribed medication for residents and keep an adequate supply of resident medication on hand at all times.

**§ 2800.186. Prescription medications.**

(a) Each prescription medication must be prescribed in writing by an authorized prescriber. Prescription orders shall be kept current.

(b) Prescription medications shall be used only by the resident for whom the prescription was prescribed.

(c) Changes in medication may only be made in writing by the prescriber, or in the case of an emergency, an alternate prescriber, except for circumstances in which oral orders may be accepted by nurses in accordance with regulations of the Department of State. The resident's medication record shall be updated as soon as the residence receives written notice of the change.

**§ 2800.187. Medication records.**

(a) A medication record shall be kept to include the following for each resident for whom medications are administered:

- (1) Resident's name.
- (2) Drug allergies.
- (3) Name of medication.
- (4) Strength.
- (5) Dosage form.
- (6) Dose.
- (7) Route of administration.
- (8) Frequency of administration.
- (9) Administration times.
- (10) Duration of therapy, if applicable.
- (11) Special precautions, if applicable.
- (12) Diagnosis or purpose for the medication, including pro re nata (PRN).
- (13) Date and time of medication administration.
- (14) Name and initials of the staff person administering the medication.

(b) The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

(c) If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

(d) The residence shall follow the directions of the prescriber.

**§ 2800.188. Medication errors.**

(a) Medication errors include the following:

(1) Failure to administer a medication.

(2) Administration of the wrong medication.

(3) Administration of the wrong amount of medication.

(4) Failure to administer a medication at the prescribed time.

(5) Administration to the wrong resident.

(6) Administration through the wrong route.

(b) A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

(c) Documentation of medication errors and the prescriber's response shall be kept in the resident's record.

(d) There shall be a system in place to identify and document medication errors and the residence's pattern of error.

(e) There shall be documentation of the follow-up action that was taken to prevent future medication errors.

**§ 2800.189. Adverse reaction.**

(a) If a resident has a suspected adverse reaction to a medication, the residence shall immediately consult a physician or seek emergency medical treatment. The resident's designated person shall be notified, if applicable.

(b) The residence shall document adverse reactions, the prescriber's response and any action taken in the resident's record.

**§ 2800.190. Medication administration training.**

(a) A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

(b) A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

(c) A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

#### **§ 2800.191. Resident education.**

The residence shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error.

Documentation of this resident education shall be kept.

### **SAFE MANAGEMENT TECHNIQUES**

#### **§ 2800.201. Safe management techniques.**

The residence shall use positive interventions to modify or eliminate a behavior that endangers the resident himself or others. Positive interventions include improving communications, reinforcing appropriate behavior, redirection, conflict resolution, violence prevention, praise, deescalation techniques and alternative techniques or methods to identify and defuse potential emergency situations.

#### **§ 2800.202. Prohibitions.**

The following procedures are prohibited:

(1) Seclusion, defined as involuntary confinement of a resident in a room or living unit from which the resident is physically prevented from leaving, is prohibited. This does not include the admission of a resident in a secured dementia care unit in accordance with § 2800.231 (relating to admission).

(2) Aversive conditioning, defined as the application of startling, painful or noxious stimuli, is prohibited.

(3) Pressure point techniques, defined as the application of pain for the purpose of achieving compliance, is prohibited.

(4) A chemical restraint, defined as use of drugs or chemicals for the specific and exclusive purpose of controlling acute or episodic aggressive behavior, is prohibited. A chemical restraint does not include a drug ordered by a physician or dentist to treat the symptoms of a specific mental, emotional or behavioral condition, or as pretreatment prior to a medical or dental examination or treatment.

(5) A mechanical restraint, defined as a device that restricts the movement or function of a resident or portion of a resident's body, is prohibited. Mechanical restraints include geriatric chairs, handcuffs, anklets, wristlets, camisoles, helmet with fasteners, muffs and mitts with fasteners, poseys, waist straps, head straps, papoose boards, restraining sheets, chest restraints and other types of locked restraints. A mechanical restraint does not include a device used to provide

support for the achievement of functional body position or proper balance that has been prescribed by a medical professional as long as the resident can easily remove the device or the resident or his designee understands the need for the device and consents to its use.

(6) A manual restraint, defined as a hands-on physical means that restricts, immobilizes or reduces a resident's ability to move his arms, legs, head or other body parts freely, is prohibited. A manual restraint does not include prompting, escorting or guiding a resident to assist in the ADLs or IADLs.

**§ 2800.203. Bedside rails.**

(a) Bedside rails may not be used unless the resident can raise and lower the rails on his own. Bedside rails may not be used to keep a resident in bed. Use of any length rail longer than half the length of the bed is considered a restraint and is prohibited. Use of more than one rail on the same side of the bed is not permitted.

(b) Half-length rails are permitted only if the following conditions are met:

(1) The resident's assessment or support plan, or both, addresses the medical symptoms necessitating the use of half-length rails and the health and safety protection necessary in order to safely use half-length rails.

(2) The residence has attempted to use less restrictive alternatives.

(3) The resident or legal representative consented to the use of half-length rails after the risk, benefits and alternatives were explained.

## SERVICES

### § 2800.220. [Assisted living residence services] Service provision.

(a) *Services.* The residence shall provide [core] assisted living services as specified in subsection (b). The residence shall offer and provide the core service packages specified in subsection (c). The residence shall provide or arrange for the provision of supplemental health care services as specified in subsection (e). Other individuals or agencies may furnish services directly or under arrangements with the residence in accordance with a mutually agreed upon charge or fee between the residence, resident and other individual or agency. These other services shall be supplemental to the [core] assisted living services provided by the residence and shall not supplant them.

(b) [*Core services*] Assisted living services. The residence shall, at a minimum, provide the following services:

(1) Nutritious meals and snacks in accordance with §§ 2800.161 and 2800.162 (relating to nutritional adequacy; and meals).

(2) Laundry services in accordance with § 2800.105 (relating to laundry).

(3) A daily program of social and recreational activities in accordance with § 2800.221 (relating to activities program).

(4) Assistance with performing ADLs and IADLs [as indicated in the resident's assessment and support plan] in accordance with §§ 2800.23 and 2800.24 (relating to activities; and personal hygiene).

(5) Assistance with self-administration of medication or medication administration as indicated in the resident's assessment and support plan in accordance with §§ 2800.181 and 2800.182 (relating to self-administration; and medication administration).

(6) [Household] Housekeeping services essential for the health, safety and comfort of the resident based upon the resident's needs and preferences.

(7) Transportation in accordance with § 2800.171 (relating to transportation).

(8) Financial Management in accordance with § 2800.20 (relating to financial management).

(9) 24-hour supervision, monitoring and emergency response.

(10) Activities and socialization.

(11) Basic cognitive support services as defined in § 2800.4 (relating to definitions).

(c) Core service packages. The residence shall, at a minimum, provide the following core service packages:

(1) Independent Core Package. This core package shall be provided to residents who do not require assistance with ADLs. The services shall include the following:

(i) 24-hour supervision, monitoring and emergency response.

(ii) Nutritious meals and snacks in accordance with §§ 2800.161 and 2800.162 (relating to nutritional adequacy; and meals).

(iii) Housekeeping services essential for the health, safety and comfort of the resident based upon the resident's needs and preferences.

(iv) Laundry services in accordance with § 2800.105 (relating to laundry).

(v) Assistance with unanticipated ADLs for a defined recovery period.

(vi) A daily program of social and recreational activities in accordance with § 2800.221 (relating to activities program).

(vii) Basic cognitive support services as defined in § 2800.4 (relating to definitions).

(2) Enhanced Core Package. This core package shall be available to residents who require assistance with ADLs. The services shall include the following:

(i) The services provided in the basic core package under subsection (c)(1)(i) through (vii).

(ii) Assistance with ADLs and unanticipated ADLs for an undefined period of time.

(iii) Transportation in accordance with § 2800.171 (relating to transportation).

(iv) Assistance with self-administration of medication or medication administration as indicated in the resident's assessment and support plan in accordance with §§ 2800.181 and 2800.182 (relating to self-administration; and medication administration).

(d) Opt-out. If a resident wishes not to have the residence provide a service under subsection (c)(1)(ii)-(iv), the resident-residence contract must state the following:

(1) The service not being provided.

(2) The corresponding fee schedule charge adjustment that takes into account the reduction in service.

[(c)] (e) Supplemental health care services. The residence shall provide or arrange for the provision of supplemental health care services, including, but not limited to, the following:

(1) Hospice services.

(2) Occupational therapy.

(3) Skilled nursing services.

(4) Physical therapy.

(5) Behavioral health services.

(6) Home health services.

(7) Escort service if indicated in the resident's support plan or requested by the resident to and from medical appointments [if transportation is coordinated by the residence].

(8) Specialized cognitive support services as defined in § 2800.4 (relating to definitions).

[(d) *Cognitive support services.* The residence shall provide cognitive support services to residents who require such services, whether in a special care unit or elsewhere in the residence.]

**§ 2800.221. Activities program.**

(a) The residence shall develop a program of daily activities designed to promote each resident's active involvement with other residents, the resident's family and the community and provide the necessary space and equipment for the activities in accordance with §§ 2800.98 and 2800.99 (relating to indoor activity space; and recreation space). The residence shall [encourage] offer the opportunity for the residents' active participation in the development of the daily activities calendar.

(b) The program must be based upon individual and group interests and provide social, physical, intellectual and recreational activities in a planned, coordinated and structured manner and shall encourage active participation in the community at large.

(c) The week's daily activity calendar shall be posted in advance in a conspicuous and public place in the residence. The residence shall provide verbal cueing and reminders of activities, their start times and locations within the residence.

**§ 2800.222. Community social services.**

Residents shall be encouraged and assisted in the access to and use of social services in the community 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.

**§ 2800.223. Description of services.**

(a) The residence shall have a current written description of services and activities that the residence provides including the following:

(1) The scope and general description of the services and activities that the residence provides.

(2) The criteria for admission and discharge.

(3) Specific services that the residence does not provide, but will arrange or coordinate.

(b) The residence shall develop written procedures for the delivery and management of services from admission to discharge.

**§ 2800.224. [Preadmission screening.] Initial assessment and preliminary support plan.**

[(a) A determination shall be made by the administrator or designee within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the potential resident can be met by the services provided by the residence.

(b) A potential resident whose needs cannot be met by the residence shall be provided with a written decision denying their admission and provide a basis for their denial. The potential resident shall then be referred to a local appropriate assessment agency.

(c) The preadmission screening shall be completed by the administrator or designee. If the potential resident is referred by a State-operated facility, a county mental health and mental retardation program, a drug and alcohol program or an area agency on aging, a representative of the referral agent may complete the preadmission screening.

(d) A potential resident who requires assisted living services but does not currently require assistance in obtaining supplemental health care services may be admitted to the residence, provided the resident is only provided assisted living services required or requested by the resident. When services are required, the residence shall develop a support plan as required in § 2800.227 (relating to development of the support plan). This subsection applies to residents under any of the following circumstances:

(1) A resident who may require supplemental health care services in the future.

(2) A resident who wishes to obtain assistance in obtaining the services.

(3) A resident who resides in a facility in which the services are available.]

(a) Initial Assessment.

(1) The administrator, administrator designee, or licensed practical nurse, under the supervision of a registered nurse, or a registered nurse shall complete the initial assessment.

(2) An individual shall have a written initial assessment that is documented on the Department's assessment form within 30 days prior to admission unless one of the conditions contained in paragraph (3) apply.

(3) A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days after admission if one of the following conditions applies:

(i) The resident is being admitted directly to the residence from an acute care hospital.

(ii) The resident is being admitted to escape from an abusive situation.

(iii) The resident has no alternative living arrangement.

(4) A residence may use its own assessment form if it includes the same information as the Department's assessment form.

(5) The written initial assessment shall, at a minimum include the following:

(i) The individual's need for assistance with ADLs and IADLs.

(ii) The mobility needs of the individual.

(iii) The ability of the individual to self-administer medication.

(iv) The individual's medical history, medical conditions, and current medical status and how they impact or interact with the individual's service needs.

(v) The individual's need for supplemental health care services.

(vi) The individual's need for special diet or meal requirements.

(vii) The individual's ability to safely operate key-locking devices.

(viii) The individual's ability to evacuate from the residence.

[(e)] (b) An initial [screening] assessment will not be required to commence supplemental health care services to a resident of a residence under any of the following circumstances:

- (1) If the resident was not receiving the services at the time of the resident's admission.
- (2) To transfer a resident from a portion of a residence that does not provide supplemental health care services to a portion of the residence that provides such service.
- (3) To transfer a resident from a personal care home to a residence licensed by the same operator.

[(f)] Each residence shall demonstrate the ability to provide or arrange for the provision of supplemental health care services in a manner protective of the health, safety and well-being of its residents utilizing employees, independent contractors or contractual arrangements with other health care facilities or practitioners licensed, registered or certified to the extent required by law to provide the service.

(g) Persons requiring the services of a licensed long-term care nursing facility, may reside in a residence, provided that appropriate supplemental health care

services are provided and the design, construction, staffing and operation of the residence allows for safe emergency evacuation.]

(c) Preliminary Support Plan.

(1) An individual requiring services shall have a written preliminary support plan developed within 30 days prior to admission to the residence unless one of the conditions contained in paragraph (2) applies.

(2) A resident requiring services shall have a written preliminary support plan developed within 15 days after admission if one of the following conditions applies:

(i) The resident is being admitted directly to the residence from an acute care hospital.

(ii) The resident is being admitted to escape from an abusive situation.

(iii) Any other situation where the resident has no alternative living arrangement.

(3) The written preliminary support plan shall document the dietary, medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the individual, or referrals for the individual to outside services if the individual's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a residence to pay for the cost of these medical and behavioral

care services. The preliminary support plan shall document the assisted living services and supplemental health care services, if applicable, that will be provided to the individual.

(4) The preliminary support plan shall be documented on the Department's support plan form.

(5) A residence may use its own support plan form if it includes the same information as the Department's support plan form. A licensed practical nurse, under the supervision of a registered nurse, or a registered nurse shall review and approve the preliminary support plan.

(6) An individual's preliminary support plan must document the ability of the individual to self-administer medications or the need for medication reminders or medication administration and the ability of the resident to safely operate key-locking devices.

(7) An individual shall be encouraged to participate in the development of the preliminary support plan. An individual may include a designated person or family member in making decisions about services.

(8) Individuals who participate in the development of the preliminary support plan shall sign and date the preliminary support plan.

(9) If an individual or designated person is unable or chooses not to sign the preliminary support plan, a notation of inability or refusal to sign shall be documented.

(10) The residence shall give a copy of the preliminary support plan to the resident and the resident's designated person.

**§ 2800.225. [Initial and annual assessments] Additional assessments.**

(a) [A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or licensed practical nurse, under the supervision of a registered nurse, may complete the initial assessment.

(b) A residence may use its own assessment form if it includes the same information as the Department's assessment form.

(c) The administrator or administrator designee, or licensed practical nurse, under the supervision of a registered nurse, or a registered nurse shall complete [The resident shall have] additional written assessments for each resident. A residence may use its own assessment form if it includes the same information as the Department's assessment form. Additional written assessments shall be completed as follows:

(1) Annually.

(2) If the condition of the resident significantly changes prior to the annual assessment.

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

(b) The assessment shall, at a minimum include the following:

(1) The resident's need for assistance with ADLs and IADLs.

(2) The mobility needs of the resident.

(3) The ability of the resident to self-administer medication.

(4) The resident's medical history, medical conditions, and current medical status and how these impact or interact with the individual's service needs.

(5) The resident's need for supplemental health care services.

(6) The resident's need for special diet or meal requirements.

(7) The resident's ability to safely operate key-locking devices.

**§ 2800.226. Mobility criteria.**

(a) The resident shall be assessed for mobility needs as part of the resident's assessment.

(b) If a resident is determined to have mobility needs as part of the resident's initial or annual assessment, specific requirements relating to the care, health and safety of the resident shall be met immediately.

(c) The administrator or the administrator designee shall notify the Department within 30 days after a resident with mobility needs is admitted to the residence [or the date] and compile a monthly list of when a resident develops mobility needs.

**§ 2800.227. Development of the final support plan.**

(a) Each resident requiring services shall have a written final support plan developed and implemented within 30 days [of] after admission to the residence. The final support plan shall be documented on the Department's support plan form.

(b) A residence may use its own support plan form if it includes the same information as the Department's support plan form. A licensed practical nurse, under the supervision of a registered nurse, shall review and approve the final support plan.

(c) The final support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment. The residence shall review each resident's final support plan on a quarterly basis and modify as necessary to meet the resident's needs.

(d) Each residence shall document in the resident's final support plan the dietary, medical, 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 the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a residence to pay for the cost of these medical and behavioral care services. The final support plan shall document the assisted living services and supplemental health care services, if applicable, that will be provided to the resident.

(e) The resident's final support plan must document the ability of the resident to self-administer medications or the need for medication reminders or medication administration and the ability of the resident to safely operate key-locking devices. Strategies that promote interactive communication on the part of and between direct care staff and individual residents shall also be included in the final support plan.

(f) A resident shall be encouraged to participate in the development and implementation of the final support plan. A resident may include a designated person or family member in making decisions about services.

(g) Individuals who participate in the development of the final support plan shall sign and date the support plan.

(h) If a resident or designated person is unable or chooses not to sign the final support plan, a notation of inability or refusal to sign shall be documented.

(i) The final support plan shall be accessible by direct care staff persons at all times.

(j) A resident or a designated person has a right to request the review and modification of his support plan.

(k) The residence shall give a copy of the final support plan to the resident and the resident's designated person. The final support plan shall be attached to or incorporated into and serve as part of the resident-residence contract.

**§ 2800.228. Transfer and discharge.**

(a) The facility shall ensure that a transfer or discharge is safe and orderly and that the transfer or discharge is appropriate to meet the resident's needs. This includes ensuring that a resident is transferred or discharged with all his medications, durable medical equipment and personal property. The residence shall permit the resident to participate in the decision relating to the relocation.

(b) If the residence initiates a transfer or discharge of a resident, or if the legal entity chooses to close the residence, the residence shall provide a 30-day advance written notice to the resident, the resident's family or designated person and the referral agent citing the reasons for the transfer or discharge. This shall be stipulated in the resident-residence contract.

(1) The 30-day advance written notice must be written in language in which the resident understands, or performed in American Sign Language or presented orally in a language the resident understands if the resident does not speak standard English. The notice must include the following:

(i) The specific reason for the transfer or discharge.

(ii) The effective date of the transfer or discharge.

(iii) The location to which the resident will be transferred or discharged.

(iv) An explanation of the measures the resident or the resident's designated person can take if they disagree with the residence decision to transfer or discharge which includes the name, mailing address, and telephone number of the State and local long-term care ombudsman.

(v) The resident's transfer or discharge rights, as applicable.

(2) Prior to initiating a transfer or discharge of a resident, the residence shall make reasonable accommodation for aging in place that may include services from outside providers. The residence shall demonstrate through support plan modification and documentation the attempts to resolve the reason for the transfer or discharge. [The residence may not transfer or discharge a resident if the resident or his designated person arranges for the needed services.]

Supplemental services may be provided by the resident's family, residence staff

or private duty staff as agreed to by the resident and the residence. This shall be stipulated in the resident-residence contract.

(3) Practicable notice, rather than a 30-day advance written notice is required if a delay in transfer or discharge would jeopardize the health, safety or well-being of the resident or others in the residence, as certified by a physician or the Department. This may occur when the resident needs psychiatric services or is abused in the residence, or the Department initiates closure of the residence.

(c) A residence shall give the Department written notice of its intent to close the residence, at least 60 days prior to the anticipated date of closing.

(d) A residence may not require a resident to leave the residence prior to 30 days following the resident's receipt of a written notice from the residence regarding the intended closure of the residence, except when the Department determines that removal of the resident at an earlier time is necessary for the protection of the health, safety and well-being of the resident.

(e) The date and reason for the transfer or discharge, and the destination of the resident, if known, shall be recorded in the resident record and tracked in a transfer and discharge tracking chart that the residence shall maintain and make available to the Department.

(f) If the legal entity chooses to voluntarily close the residence or if the Department has initiated legal action to close the residence, the Department working in conjunction with appropriate local authorities, will offer relocation

assistance to the residents. Except in the case of an emergency, each resident may participate in planning the transfer, and shall have the right to choose among the available alternatives after an opportunity to visit the alternative residences. These procedures apply even if the resident is placed in a temporary living situation.

(g) Within 30 days of the residence's closure, the legal entity shall return the license to the Department.

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

(1) If a resident is a danger to himself or others and the behavior cannot be managed through interventions, services planning or informed consent agreements.

(2) If the legal entity chooses to voluntarily close the residence, or a portion of the residence.

(3) If a residence determines that a resident's functional level has advanced or declined so that the resident's needs cannot be met in the residence under § 2800.229 (relating to excludable conditions; exceptions) or within the scope of licensure for a residence. In that case, the residence shall notify the resident[,]  
and the resident's designated person [and the local ombudsman]. The residence shall provide justification for the residence's determination that the needs of the resident cannot be met. [If a resident or the resident's designated person

disagrees with the residence's decision to transfer or discharge, the residence shall contact the local ombudsman. If the residence decides to proceed with the transfer or discharge, the ombudsman shall notify the Department. The Department may take any appropriate licensure action it deems necessary based upon the report of the ombudsman.] In the event that there is no disagreement related to the transfer or discharge, a plan for other placement shall be made as soon as possible by the administrator in conjunction with the resident and the resident's designated person, if any. 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 Department.

(4) If meeting the resident's needs would require a fundamental alteration in the residence's program or building site, or would create an undue financial or programmatic burden on the residence.

(5) If the resident has failed to pay after reasonable documented efforts by the residence to obtain payment.

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

(7) Documented, repeated violation of the residence rules.

(8) A court has ordered the transfer or discharge.

(i) If grounds for transfer or discharge is based upon subsection (h)(1) or (3), a certification from one of the following individuals shall be required to certify in writing that the resident can no longer be retained in the residence:

(1) The administrator acting in consultation with supplemental health care providers.

(2) The resident's physician or certified registered nurse practitioner.

(3) The medical director of the residence.

**§ 2800.229. Excludable conditions; exceptions.**

(a) *Excludable conditions.* Except as provided in subsection (b), a residence may not admit, retain or serve an individual with any of the following conditions or health care needs:

(1) Ventilator dependency.

(2) Stage III and IV decubiti and vascular ulcers that are not in a healing stage.

(3) Continuous intravenous fluids.

(4) Reportable infectious diseases, such as tuberculosis, in a communicable state that requires isolation of the individual or requires special precautions by a

caretaker to prevent transmission of the disease unless the Department of Health directs that isolation be established within the residence.

(5) Nasogastric tubes.

(6) Physical restraints.

(7) Continuous skilled nursing care 24 hours a day.

(b) *Exception.* The residence may submit a written request to the Department on a form provided by the Department for an exception related to any of the conditions or health care needs listed in subsection (a) or (e) to allow the residence to admit, retain or serve an individual with one of those conditions or health care needs, unless a determination is unnecessary as set forth in subsection (e).

(c) *Submission, review and determination of an exception request.*

(1) The administrator of the residence shall submit the exception request. The exception request must be signed and affirmed by an individual listed in subsection (d) and accompanied by a support plan which includes the residence accommodations for treating the excludable condition requiring the exception request. Proposed accommodations must conform with the provisions contained within the resident-residence contract.

(2) The Department will review the exception request in consultation with a certified registered nurse practitioner or a physician, with experience caring for the elderly and disabled in long-term living settings.

(3) The Department will respond to the exception request in writing within 5 business days of receipt.

(4) The Department may approve the exception request if the following conditions are met:

(i) The exception request is desired by the resident or applicant.

(ii) The resident or applicant will benefit from the approval of the exception request.

(iii) The residence demonstrates to the Department's satisfaction that the residence has the staff, skills and expertise necessary to care for the resident's needs related to the excludable condition.

(iv) The residence demonstrates to the Department's satisfaction that any necessary supplemental health care provider has the staff, skills and expertise necessary to care for the resident's needs related to the excludable condition.

(v) The residence provides a written alternate care plan that ensures the availability of staff with the skills and expertise necessary to care for the resident's needs related to the excludable condition in the event the supplemental health care provider is unavailable.

(5) The Department will render decisions on exception requests on a case-by-case basis and not provide for facility-wide exceptions.

(d) *Certification providers.* The following persons may certify that an individual with an excludable condition may not be admitted or retained in a residence:

(1) The administrator acting in consultation with supplemental health care providers.

(2) The individual's physician or certified registered nurse practitioner.

(3) The medical director of the residence.

(e) *Departmental exceptions.* A residence may admit, retain or serve an individual for whom a determination is made by the Department, upon the written request of the residence, that the individual's specific health care needs can be met by a provider of assisted living services or within a residence, including an individual requiring:

(1) Gastric tubes, except that a determination will not be required if the individual is capable of self-care of the gastric tube or a licensed health care professional or other qualified individual cares for the gastric tube.

(2) Tracheostomy, except that a determination will not be required if the individual is independently capable of self-care of the tracheostomy.

(3) Skilled nursing care 24 hours a day, except that a determination will not be required if the skilled nursing care is provided on a temporary or intermittent basis.

(4) A sliding scale insulin administration, except that a determination will not be required if the individual is capable of self-administration or a licensed health care professional or other qualified individual administers the insulin.

(5) Intermittent intravenous therapy, except that a determination will not be required if a licensed health care professional manages the therapy.

(6) Insertions, sterile irrigation and replacement of a catheter, except that a determination will not be required for routine maintenance of a urinary catheter, if the individual is capable of self-administration or a licensed health care professional administers the catheter.

(7) Oxygen, except that a determination will not be required if the individual is capable of self-administration or a licensed health care professional or other qualified individual administers the oxygen.

(8) Inhalation therapy, except that a determination will not be required if the individual is capable of self-administration or a licensed health care professional or other qualified individual administers the therapy.

(9) Other types of supplemental health care services that the administrator,

acting in consultation with supplemental health care providers, determines can be provided in a safe and effective manner by the residence.

(10) For purposes of paragraphs (e)(1), (4), (7) and (8), a "qualified individual" means an individual who has been determined by a certification provider listed under subsection (d) to be capable of care or administration under paragraphs (1), (4), (7) and (8).

(f) *Request for exception by resident.* Nothing herein prevents an individual seeking admission to a residence or a resident from requesting that the residence apply for an exception from the Department for a condition listed in this section for which an exception must be granted by the Department. The residence's determination on whether or not to seek such an exception shall be documented on a form supplied by the Department.

(g) *Record.* A written record of the exception request, the supporting documentation to justify the exception request and the determination related to the exception request shall be kept in the records of the residence. The information required by this subsection shall also be kept in the resident's record.

(h) *Decisions.* The residence shall record the following decisions made on the basis of this section.

(1) Admission denials.

(2) Transfer or discharge decisions that are made on the basis of this section.

## SPECIAL CARE UNITS

### § 2800.231. Admission.

(a) This section and §§ 2800.232--2800.239 apply to special care units. These provisions are in addition to the other provisions of this chapter. A special care unit is a residence or portion of a residence that provides one or both of the following: [specialized care and services for residents with Alzheimer's disease or other dementia in the least restrictive manner consistent with the resident's support plan to ensure the safety of the resident and others in the residence while maintaining the resident's ability to age in place. Admission of a resident to a special care unit shall be in consultation with the resident's family or designated person. Prior to admission into a special care unit, other service options that may be available to a resident shall be considered.]

(1) Specialized care and services for residents with Alzheimer's disease or dementia in the least restrictive manner consistent with the resident's support plan to ensure the safety of the resident and others in the residence while maintaining the resident's ability to age in place.

(i) Admission of a resident shall be in consultation with the resident's family or designated person.

(ii) Prior to admission other service options that may be available to a resident shall be considered.

(2) Intense neurobehavioral rehabilitation for residents with severely disruptive and potentially dangerous behaviors as a result of brain injury in the least restrictive manner consistent with the resident's rehabilitation and support plan to ensure the safety of the resident and others in the residence.

(i) Each resident of a special care unit for INRBI shall have a rehabilitation and support plan that supports independence and promotes recovery and thereby discharge to a less restrictive setting.

(ii) Special care units for INRBI shall provide for each resident to age in place.

(iii) Admission of a resident shall be in consultation with the resident or potential resident and, when appropriate, the resident's designated person or the resident's family, or both.

(iv) Prior to admission other less restrictive service options that may be available to a resident or potential resident shall be considered.

(b) A resident or potential resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. [Documentation must include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a special care unit.]

(1) Documentation for a special care unit for residents with Alzheimer's disease or dementia must include the resident's diagnosis of Alzheimer's disease or dementia and the need for the resident to be served in a special care unit.

(2) Documentation for a special care unit for INRBI must include the resident's or potential resident's diagnosis of brain injury and need for residential services to be provided in a special care unit for INRBI. The evaluation shall include visual function, hearing, swallowing, mobility and hand function.

[(c) A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a special care unit.

(d) A geriatric assessment team is a group of multidisciplinary specialists in the care of adults who are older that conducts a multidimensional evaluation of a resident and assists in developing a support plan by working with the resident's physician, designated person and family to coordinate the resident's care.]

(c) Preadmission Screening.

(1) Special care unit for residents with Alzheimer's disease or dementia.

(i) A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's

cognitive preadmission screening form shall be completed for each resident within 72 hours prior to admission to a special care unit.

(ii) A geriatric assessment team is a group of multidisciplinary specialists in the care of adults who are older that conducts a multidimensional evaluation of a resident and assists in developing a support plan by working with the resident's physician, designated person and the resident's family to coordinate the resident's care.

(2) Special care unit for INRBI.

(i) A written cognitive, physical, behavioral (CPB) preadmission screening completed in collaboration with a physician, neuropsychologist or cognitive, physical, behavioral assessment team and documented on the Department's CPB preadmission screening form shall be completed for each resident or potential resident within 72 hours prior to admission to a special care unit for INRBI.

(ii) A cognitive, physical, behavioral specialist with brain injury experience shall assist in developing a rehabilitation and support plan by working with the resident's physician, neuropsychologist, and, when appropriate, the resident's designated person or the resident's family, or both to develop the resident's rehabilitation and support plan. This plan shall include a high level of nursing and behavioral supervision, medication management, occupational therapy,

cognitive therapy, behavioral therapy, vocational services, support for social re-entry, and a personalized treatment plan.

[(e)] (d) Each resident record must have documentation that the resident or potential resident and, when appropriate, the resident's designated person or the resident's family have agreed to the resident's admission or transfer to the special care unit.

(f) [In addition to the requirements in § 2800.225 (relating to initial and annual assessment), the resident shall also be assessed quarterly for the continuing need for the special care unit.] Additional assessments.

(1) In addition to the requirements in § 2800.225 (relating to additional assessments), residents of a special care unit for Alzheimer's disease or dementia shall also be assessed quarterly for the continuing need for the special care unit for Alzheimer's disease or dementia.

(2) In addition to the requirements in § 2800.225 (relating to additional assessments), residents of a special care unit for INRBI shall also be assessed at least semi-annually or more frequently as necessary to assure the continuing need for residence in the special care unit for INRBI.

(g) [An individual] A spouse, friend or family member who does not have a primary diagnosis of Alzheimer's disease or [other] dementia or brain injury may reside in the special care unit if desired by the resident or his designated person.

(1) The [individual] spouse, friend or family member shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department within 60 days prior to residence or 15 days after residence.

(2) The [individual] spouse, friend or family member shall have access to and be able to follow directions for the operation of the key pads or other lock-releasing devices to exit the special care unit.

(h) The resident-residence contract specified in § 2800.25 (relating to resident-residence contract) must also include a disclosure of services, admission and discharge criteria, change in condition policies, special programming and costs and fees.

(i) [For individuals with Alzheimer's disease or dementia, or when] When the residence holds itself out to the public as providing services or housing for individuals with [cognitive impairments] Alzheimer's disease or dementia, the residence shall disclose to individuals and provide materials that include the following:

(1) The residence's written statement of its philosophy and mission which reflects the needs of individuals with [cognitive impairments] Alzheimer's disease or dementia.

(2) A description of the residence's physical environment and design features to support the functioning of individuals with [cognitive impairments] Alzheimer's disease or dementia.

(3) A description of the frequency and types of individual and group activities designed specifically to meet the needs of individuals with [cognitive impairments] Alzheimer's disease or dementia.

(4) A description of the security measures provided by the residence.

(5) A description of the training provided to staff regarding provision of care to individuals with [cognitive impairments] Alzheimer's disease or dementia.

(6) A description of availability of family support programs and family involvement.

(7) The process used for assessment and establishment of a plan of services for the individual, including methods by which the plan of services will remain responsive to changes in the individual's condition.

(j) When an assisted living residence holds itself out to the public as a special care unit for INRBI, the residence shall disclose and provide materials to individuals and, when appropriate, the individual's designated person or the individual's family, or both that include the following information:

(1) The residence's written statement of its philosophy and mission which reflects the needs of individuals with brain injury for intense neurobehavioral rehabilitation and support.

(2) A description of the residence's physical environment and design features that support and promote the functioning and rehabilitation of individuals who need INRBI.

(3) A description of the types of individual and group activities that have been designed specifically to meet the requirements of the rehabilitation and support plans of specific residents with brain injury.

(4) A description of the security measures provided by the residence.

(5) A description of the credentials and experience required and the training provided to staff regarding the provision of rehabilitation and support for individuals who require INRBI.

(6) A description of availability of family support programs, family education programs, and family involvement.

(7) The process used for assessment and establishment of a plan of services for the resident, including methods by which the plan of services will remain responsive to progress in the resident's recovery.

(k) The residence shall identify measures to address individuals with [cognitive impairments] Alzheimer's disease or dementia or with INRBI who have tendencies to wander.

(l) The residence with a special care unit for INRBI shall identify measures to address individuals who require INRBI who have problems that may actually impede rehabilitation such as:

(1) Anger.

(2) Self-control.

(3) Aggression toward others.

(4) Self-injury.

(5) Deficient judgment and problem solving due to cognitive deficits.

(6) Frequent agitation.

(7) Prolonged confusional state.

(8) Seizure disorders and related behavioral problems.

(9) Significant memory and learning problems.

(10) Disruption of sleep and wake cycles.

(11) Problems with attention.

(12) Filtering and focusing.

(13) Emergence of mental health problems or exacerbation of pre-existing mental health issues.

(14) Emergence of substance abuse problems or exacerbation of pre-existing substance abuse issues.

(15) Other cognitive and behavioral problems which have or would prevent successful completion of traditional rehabilitation programs.

(m) The residence with a special care unit for INRBI shall identify at a minimum the following professionals with expertise in providing care for individuals requiring INRBI.

(1) On-site behavioral specialist.

(2) On-site cognitive rehabilitation therapist.

(3) A consulting psychiatrist; a consulting neuropsychologist.

(4) A consulting neuropsychiatrist or psychiatrist for prescribing and monitoring the psychiatric medications that may be needed for residents with behavioral health issues.

**§ 2800.232. Environmental protection.**

(a) The residence shall provide exercise space, both indoor and outdoor.

(b) No more than two residents may occupy a living unit regardless of its size. A living unit shall meet the requirement in § 2800.101 (relating to resident living units), as applicable. A living unit located in a special care unit for INRBI shall not include kitchen facilities.

(c) The residence shall provide space for dining, group and individual activities and visits.

(d) The residence shall provide a full description of the measures [taken] implemented to enhance environmental awareness, minimize environmental stimulation and maximize independence of the residents in public and private spaces based on the needs of the individuals being served. [The measures to enhance environmental awareness and maximize independence of the residents shall be implemented.]

(e) The residence with a special care unit for INRBI shall identify the process used to assure conformity of the individual resident's living unit to the ongoing rehabilitation recommendations of the neuropsychologist and the cognitive physical, emotional behavioral assessment team as expressed in the current rehabilitation and support plan.

### **§ 2800.233. Doors, locks and alarms.**

(a) Doors equipped with key-locking devices, electronic card operated systems or other devices that prevent immediate egress are permitted only if there is written approval from the Department of Labor and Industry, Department of

Health or appropriate local building authority permitting the use of the specific locking system.

(b) A residence shall have a statement from the manufacturer, specific to that residence, verifying that the electronic or magnetic locking system will shut down, and that all doors will open easily and immediately when one or more of the following occurs:

(1) Upon a signal from an activated fire alarm system, heat or smoke detector.

(2) Power failure to the residence.

(3) Overriding the electronic or magnetic locking system by use of a key pad or other lock-releasing device.

(c) If key-locking devices, electronic card systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

(d) Doors that open onto areas such as parking lots, or other potentially unsafe areas, shall be locked by an electronic or magnetic system.

(e) Fire alarm systems must be interconnected to the local fire department, when available, or a 24-hour monitoring service approved by the local fire department.

**§ 2800.234. Resident care.**

(a)(1) Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the special care unit, a support plan shall be developed, implemented and documented in [the resident] each resident's record.

(a)(2) For individuals being admitted into a special care unit for INRBI, a rehabilitation plan shall be developed, implemented and documented in the resident record. This rehabilitation plan and the individual's support plan shall be based on the CPB preadmission assessment and other available records and information.

(b)(1) The support plan and if applicable, the rehabilitation plan must identify the resident's physical, medical, social, cognitive and safety needs.

(b)(2) The rehabilitation and support plan for residents of a special care unit for INRBI must identify the residents' emotional and behavioral needs.

(c) The support plan and if applicable, the rehabilitation plan must identify the individual responsible to address the resident's needs.

(d)(1) The support plan for a resident of a special care unit for residents with Alzheimer's disease or dementia shall be reviewed, and if necessary, revised at least quarterly and as the resident's condition changes.

(d)(2) The support plan and rehabilitation plan for a resident of a special care unit for INRBI shall be reviewed, and if necessary, revised at least monthly and as the resident's condition changes.

(e) The resident, [or] the resident's designated person or the resident's family shall be involved in the development and the revisions of the support plan and if applicable, the rehabilitation plan.

**§ 2800.235. Discharge.**

(a) If the residence initiates a discharge or transfer of a resident, or the legal entity chooses to close the residence, the administrator shall give a 30-day advance written notice to the resident, the resident's designated person and the referral agent citing the reasons for the discharge or transfer. This requirement shall be stipulated in the resident-residence contract signed prior to admission to the special care unit.

(b) If a resident of a special care unit for INRBI, or when appropriate, the resident's designated person or the resident's family, request discharge to another facility, another assisted living residence or an independent living arrangement, transition services shall be provided by the special care unit.

**§ 2800.236. Training.**

(a) Each direct care staff person working in a special care unit for residents with Alzheimer's disease or dementia shall have 8 hours of initial training within the first 30 days of the date of hire and a minimum of 8 hours of annual training related to dementia care and services, in addition to the [12] 16 hours of annual training specified in § 2800.65 (relating to staff orientation and direct care staff person training and orientation).

(b) The training for each direct care staff person working in a special care unit for residents with Alzheimer's disease or dementia at a minimum must include the following topics:

- (1) An overview of Alzheimer's disease and related dementias.
- (2) Managing challenging behaviors.
- (3) Effective communications.
- (4) Assistance with ADLs.
- (5) Creating a safe environment.

(c) Each direct care staff person working in a special care unit for INRBI shall have 8 hours of initial training within the first 30 days of the date of hire and a minimum of 8 hours of annual training related to brain injury, in addition to the 16 hours of annual training specified in § 2800.65 (relating to staff orientation and direct care staff person training and orientation) and any continuing education required for professional licensing.

(d) The training for each direct care staff person working in a special care unit for INRBI in addition to paragraphs (b)(3), (4) and (5), must at a minimum include the following topics:

- (1) An overview of brain injury including the common cognitive, physical and behavioral effects.

(2) Understanding and managing challenging behaviors which follow from the cognitive, physical and behavioral effects of brain injury.

(3) Tailoring activities and interactions to provide individualized rehabilitation and support in accordance with the resident's rehabilitation and support plan.

(4) Coaching and cueing, interactive problem solving, promoting the initiation of self-soothing activities, and timing the fading of supports.

**§ 2800.237. Program.**

(a) The following types of activities shall be offered at least weekly to residents of a special care unit for residents with Alzheimer's disease or dementia:

(1) Gross motor activities, such as dancing, stretching and other exercise.

(2) Self-care activities, such as personal hygiene.

(3) Social activities, such as games, music and holiday and seasonal celebrations.

(4) Crafts, such as sewing, decorations and pictures.

(5) Sensory and memory enhancement activities, such as review of current events, movies, story telling, picture albums, cooking, pet therapy and reminiscing.

(6) Outdoor activities, as weather permits, such as walking, gardening and field trips.

(b) Resident participation for residents of a special care unit for residents with Alzheimer's disease or dementia in general activity programming shall:

- (1) Be voluntary.
- (2) Respect the resident's age and cognitive abilities.
- (3) Support the retention of the resident's abilities.

(c) The rehabilitation and support plans of the residents in a special care unit for INRBI will determine the types and frequency of the individual and group activities to be offered.

**§ 2800.238. Staffing.**

Each resident in a special care unit shall be considered to be a resident with mobility needs under § 2800.57(c) (relating to direct care staffing).

**§ 2800.239. Application to Department.**

(a) The legal entity shall submit [a written request] an application to the Department at least 60 days prior to the following:

- (1) Opening a special care unit.
- (2) Adding a special care unit to an existing residence.

(3) Increasing the maximum capacity in an existing unit.

(4) Changing the locking system, exit doors or floor plan of an existing unit.

(b) The Department will inspect and approve the special care unit prior to operation or change. The requirements of this chapter shall be met prior to operation.

(c) The following documents shall be included in the [written request] application specified in subsection (a):

(1) The name, address and legal entity of the residence.

(2) The name of the administrator of the residence.

(3) The maximum capacity of the residence.

(4) The requested resident population of the special care unit.

(5) A building description.

(6) A unit description.

(7) The type of locking system.

(8) Policy and procedures to be implemented for emergency egress and resident elopement.

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

- (10) Verification of completion of additional training requirements.
- (11) The operational description of the special care unit locking system of the doors.
- (12) The manufacturer's statement regarding the special care unit locking system.
- (13) A written approval or a variance permitting locked exit doors from the Department of Labor and Industry, the Department of Health or the appropriate local building authority.
- (14) The name of the municipality or 24-hour monitoring service maintaining the interconnection with the residence's fire alarm system.
- (15) A sample plan of care and service for the resident addressing the resident's physical, medical, social, cognitive and safety needs for the residents.
- (16) The activity standards.
- (17) The complete medical and cognitive preadmission assessment that is completed upon admission and reviewed and updated annually.
- (18) A consent form agreeing to the resident's placement in the special care unit, to be signed by the resident or the resident's designated person.

(19) A written agreement containing full disclosure of services, admission and discharge criteria, change in condition policies, services, special programming, costs and fees.

(20) A description of environmental cues being utilized.

(21) A general floor plan of the entire residence.

(22) A specific floor plan of the special care unit, outside enclosed area and exercise space.

## **RESIDENT RECORDS**

### **§ 2800.251. Resident records.**

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

(b) The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

(c) The residence shall use standardized forms to record information in the resident's record.

(d) Separate resident records shall be kept on the premises where the resident lives.

(e) Resident records shall be made available to the resident and the resident's designated person during normal working hours. Resident records shall be made

available upon request to the resident and the [family members] resident's designated person.

**§ 2800.252. Content of resident records.**

Each resident's record must include the following information:

- (1) Name, gender, admission date, birth date and Social Security number.
- (2) Race, height, weight at time of admission, color of hair, color of eyes, religious affiliation, if any, and identifying marks.
- (3) A photograph of the resident that is no more than 2 years old.
- (4) [Language or means of communication spoken or used by the resident] A language, speech, hearing or vision need which requires accommodation or awareness of during oral or written communication.
- (5) The name, address, telephone number and relationship of a designated person to be contacted in case of an emergency.
- (6) The name, address and telephone number of the resident's physician or source of health care.
- (7) The current and previous 2 years' physician's examination reports, including copies of the medical evaluation forms.
- (8) A list of prescribed medications, OTC medications and CAM.

- (9) Dietary restrictions.
- (10) A record of incident reports for the individual resident.
- (11) A list of allergies.
- (12) The documentation of health care services and orders, including orders for the services of visiting nurse or home health agencies.
- (13) The [preadmission screening,] initial [intake] assessment, the preliminary support plan and the most current version of the annual assessment.
- (14) A final support plan.
- (15) Applicable court order, if any.
- (16) The resident's medical insurance information.
- (17) The date of entrance into the residence, relocations and discharges, including the transfer of the resident to other residences owned by the same legal entity.
- (18) An inventory of the resident's personal property as voluntarily declared by the resident upon admission and voluntarily updated.
- (19) An inventory of the resident's property entrusted to the administrator for safekeeping.

(20) The financial records of residents receiving assistance with financial management.

(21) The reason for termination of services or transfer of the resident, the date of transfer and the destination.

(22) Copies of transfer and discharge summaries from hospitals, if available.

(23) If the resident dies in the residence, a copy of the official death certificate.

(24) Signed notification of rights, grievance procedures and applicable consent to treatment protections specified in § 2800.41 (relating to notification of rights and complaint procedures).

(25) A copy of the resident-residence contract.

(26) A termination notice, if any.

(27) A record relating to any exception request under § 2800.229 (relating to excludable conditions; exceptions).

(28) Ongoing resident progress notes.

**§ 2800.253. Record retention and disposal.**

(a) The resident's entire record shall be maintained for a minimum of 3 years following the resident's death, discharge from the residence or until any audit or litigation is resolved.

(b) Records shall be destroyed in a manner that protects confidentiality.

(c) The residence shall keep a log of resident records destroyed on or after \_\_\_\_\_ (*Editor's Note: The blank refers to the effective date of adoption of this proposed rulemaking.*). This log must include the resident's name, record number, birth date, admission date and discharge date.

(d) Records required under this chapter that are not part of the resident records shall be kept for a minimum of 3 years or until any audit or litigation is resolved.

**§ 2800.254. Record access and security.**

(a) Records of active and discharged residents shall be maintained in a confidential manner, which prevents unauthorized access.

(b) Each residence shall develop and implement policy and procedures addressing record accessibility, security, storage, authorized use and release and who is responsible for the records.

(c) Resident records shall be stored in locked containers or a secured, enclosed area used solely for record storage and be accessible at all times to the administrator, the administrator's designee, or the nurse involved in assessment and support plan development and upon request, to the Department or representatives of the area agency on aging.

**ENFORCEMENT**

**§ 2800.261. Classification of violations.**

(a) The Department will classify each violation of this chapter 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 resulted in or 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 guidelines for determining the classification of violations are available from the Department.

**§ 2800.262. Penalties and corrective action.**

(a) The Department will assess a penalty for each violation of this chapter.

(b) Penalties will be assessed on a daily basis from the date on which the citation was issued until the date the violation is corrected, except in the case of Class II and Class III violations.

(c) In the case of a Class II violation, assessment of the penalty will be suspended for 5 days from the date of citation to permit sufficient time for the residence to correct the violation. If the residence fails to provide proof of correction of the violation to the Department within the 5-day period, the fine will be retroactive to the date of citation. The Department may extend the time period for good cause.

(d) The Department will assess a penalty of \$20 per resident per day for each Class I violation. Each Class I violation shall be corrected within 24 hours.

(e) The Department will assess a minimum penalty of \$5 per resident per day, up to a maximum penalty of \$15 per resident per day, for each Class II violation.

(f) There is no monetary penalty for Class III violations unless the residence fails to correct the violation within 15 days. Failure to correct a Class III violation within the 15-day period may result in a penalty assessment of up to \$3 per resident per day for each Class III violation retroactive to the date of the citation.

(g) If a residence is found to be operating without a license, a penalty of \$500 will be assessed. After 14 days, if the residence operator cited for operating without a license fails to file an application for a license, the Department will assess an additional \$20 for each resident for each day during which the residence operator fails to apply.

(h) A residence charged with a violation of this chapter or Chapter 20 (relating to licensure or approval of facilities and agencies) has 30 days to pay the assessed penalty in full.

**§ 2800.263. Appeals of penalty.**

(a) If the residence that is fined intends to appeal the amount of the penalty or the fact of the violation, the residence shall forward the assessed penalty, not to exceed \$500, to the Secretary for placement in an escrow account with the State Treasurer. A letter appealing the penalty shall be submitted with the assessed penalty. This process constitutes an appeal.

(b) 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 legal entity together with interest accumulated on these funds in the escrow deposit.

(c) Failure to forward payment of the assessed penalty to the Secretary within 30 days will result in a waiver of the right to contest the fact of the violation or the amount of the penalty.

(d) After an administrative hearing decision that is adverse to the legal entity, or a waiver of the administrative hearing, the assessed penalty amount will be made payable to the "Commonwealth of Pennsylvania." It will be collectible in a manner provided by law for the collection of debts.

(e) If a residence liable to pay the penalty neglects or refuses to pay the penalty upon demand, the failure to pay will constitute a judgment in favor of the Commonwealth in the amount of the penalty, together with the interest and costs that may accrue on these funds.

**§ 2800.264. Use of fines.**

(a) Money collected by the Department under this section will be placed in a special restricted receipt account.

(b) Money collected will be used first to defray the expenses incurred by residents relocated under this chapter.

(c) The Department will use money remaining in this account to assist with paying for enforcement of this chapter. Fines collected will not be subject to 42 Pa.C.S. § 3733 (relating to deposits into account).

**§ 2800.265. Review of classifications.**

Semiannually, the Department will review the standard guidelines for the classification of violations and evaluate the use of these guidelines. This review is to ensure the uniformity and consistency of the classification process.

**§ 2800.266. Revocation or nonrenewal of licenses.**

(a) The Department will temporarily revoke the license of a residence if, without good cause, one or more Class I violations remain uncorrected 24 hours after the residence has been cited for the violation.

(b) The Department will temporarily revoke the license of a residence if, without good cause, one or more Class II violations remain uncorrected 15 days after the citation.

(c) Upon the revocation of a license in the instances described in subsections (a) and (b), or if the residence continues to operate without applying for a license as described in § 2800.262(h) (relating to penalties), residents shall be relocated.

(d) The revocation of a license may terminate upon the Department's determination that its violation is corrected.

(e) If, after 3 months, the Department does not issue a new license for a residence, the prior license is revoked under section 1087 of the Public Welfare Code (62 P. S. § 1087).

(1) Revocation or nonrenewal under this section will be for a minimum of 5 years.

(2) A residence, which has had a license revoked or not renewed under this section, will not be allowed to operate, staff or hold an interest in a residence which applies for a license for 5 years after the revocation or nonrenewal.

(f) If a residence has been found to have Class I violations on two or more separate occasions during a 2-year period without justification, the Department will revoke or refuse to renew the license of the residence.

(g) The power of the Department to revoke or refuse to renew or issue a license under this section is in addition to the powers and duties of the Department under section 1026 of the Public Welfare Code (62 P. S. § 1026).

**§ 2800.267. Relocation of residents.**

(a) If the relocation of residents is due to the failure of the residence to apply for a license, the Department will offer relocation assistance to the residents. This assistance will include each resident's involvement in planning the relocation, except in the case of an emergency. Each resident shall have the right to choose among the available alternatives after an opportunity to visit the alternative residences. These procedures will occur even if the residents are placed in a temporary living situation.

(b) A resident will not be relocated if the Secretary determines in writing that the relocation is not in the best interest of the resident.

**§ 2800.268. Notice of violations.**

(a) The administrator shall give each resident and the resident's designated person written notification of a Class I violation within 24 hours of the citation.

(b) The administrator shall give each resident and the resident's designated person oral or written notification of a Class I or Class II violation, as defined in § 2800.261 (relating to classification of violations), which remains uncorrected for 5 days after the date of citation.

(c) If a Class II violation remains uncorrected within 5 days following the citation, the administrator shall give written notice of the violation to each resident and the resident's designated person on the 6th day from the date of the citation.

(d) The Department will provide immediate written notification to the appropriate long-term care ombudsman of Class I violations, and notification of Class II violations which remain uncorrected 5 days after the date of citation.

**§ 2800.269. Ban on admissions.**

(a) The Department will ban new admissions to a residence:

(1) That has been found to have a Class I violation.

(2) That has been found to have a Class II violation that remains uncorrected without good cause 5 days after being cited for the violation.

(3) Whose license has been revoked or nonrenewed.

(b) The Department may ban new admissions to a residence that has been found to have a repeated Class II violation within the past 2 years.

(c) A ban on admissions will remain in effect until the Department determines that the residence has corrected the violation, and after the correction has been made, has maintained regulatory compliance for a period of time sufficient to permit a conclusion that the compliance will be maintained for a prolonged period.

**§ 2800.270. Correction of violations.**

The correction of a violation cited under section 1086 of the Public Welfare Code (62 P. S. § 1086) does not preclude the Department from issuing a provisional license based upon the same violation.

**Appendix A**  
**Assisted Living Resident Rights:**  
**During Residency and During Discharge or Termination of Residency**

*The following are assisted living resident rights, including the notification of a resident's designated person:*

**General Requirements**

1	The resident, or a designated person, has the right to rescind the contract for up to 72 hours after the initial dated signature of the contract.	§2800.25(h) Resident-residence contract
2	Either party has a right to rescind the informed consent agreement within 30 days of execution of the agreement.	§2800.30(k) Informed consent process

**Resident Rights**

3	Upon admission, each resident and, if applicable, the resident's designated person, shall be informed of resident rights and the right to lodge complaints without intimidation, retaliation or threats of retaliation by the residence or its staff persons against the reporter. Retaliation includes transfer or discharge from the residence.	§2800.41(a) Notification of rights and complaint procedures
4	Notification of rights and complaint procedures shall be communicated in an easily understood manner and in a language understood by or mode of communication used by the resident, and if applicable, the resident's designated person.	§2800.41(b) Notification of rights and complaint procedures
5	The Department's poster of the list of resident's rights shall be posted in a conspicuous and public place in the residence.	§2800.41(c) Notification of rights and complaint procedures
6	A copy of the resident's rights and complaint procedures shall be given to the resident and, if applicable, the resident's designated person upon admission.	§2800.41(d) Notification of rights and complaint procedures
7	A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.	§2800.41(e) Notification of rights and complaint procedures
8	A resident may not be discriminated against because of race, color, religious creed, disability, ancestry, sexual orientation, national origin, age or sex.	§2800.42(a) Specific rights
9	A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way. A resident must be free from mental, physical, and sexual abuse and exploitation, neglect, financial exploitation and involuntary seclusion.	§2800.42(b) Specific rights
10	A resident shall be treated with dignity and respect.	§2800.42(c) Specific rights
11	A resident shall be informed of the rules of the residence and given 30 days' written notice prior to the effective date of a new residence rule.	§2800.42(d) Specific rights
12	A resident shall have access to a telephone in the residence to make calls in privacy. Nontoll calls must be without charge to the resident.	§2800.42 (e) Specific rights

13	A resident has the right to receive and send mail. 1. Outgoing mail may not be opened or read by staff persons unless the resident requests. 2. Incoming mail may not be opened or read by staff persons unless the resident requests.	§2800.42 (f)(1) & (2) Specific rights
14	A resident has the right to communicate privately with and access the local ombudsman.	§2800.42(g) Specific rights
15	A resident has the right to practice the religion or faith of the resident's choice, or not to practice any religion or faith.	§2800.42(h) Specific rights
16	A resident shall receive assistance in accessing health care services, including supplemental health care services.	§2800.42(i) Specific rights
17	A resident shall receive assistance in obtaining and keeping clean, seasonal clothing. A resident's clothing may not be shared with other residents.	§2800.42(j) Specific rights
18	A resident and the resident's designated person, and other individuals upon the resident's written approval shall have the right to access, review and request corrections to the resident's record.	§2800.42(k) Specific rights
19	A resident has the right to furnish his living unit and purchase, receive, use and retain personal clothing and possessions.	§2800.42(l) Specific rights
20	A resident has the right to leave and return to the residence at times consistent with the residence rules and the resident's support plan.	§2800.42(m) Specific rights
21	A resident has the right to relocate and to request and receive assistance, from the residence, in relocating to another facility. The assistance must include helping the resident get information about living arrangements, making telephone calls and transferring records.	§2800.42(n) Specific rights
22	A resident has the right to freely associate, organize and communicate privately with his friends, family, physician, attorney and other persons.	§2800.42(o) Specific rights
23	A resident shall be free from restraints.	§2800.42(p) Specific rights
24	A resident shall be compensated in accordance with State and Federal labor laws for labor performed on behalf of the residence. Residents may voluntarily and without coercion perform tasks related directly to the resident's personal space or common areas of the residence.	§2800.42(q) Specific rights
25	A resident has the right to receive visitors at any time provided that the visits do not adversely affect other residents. A residence may adopt reasonable policies and procedures related to visits and access. If the residence adopts those policies and procedures, they will be binding on the residence.	§2800.42(r) Specific rights
26	A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.	§2800.42(s) Specific rights
27	A resident has the right to file complaints, grievances or appeals with any individual or agency and recommend changes in policies, residence rules and services of the residence without intimidation, retaliation or threat of discharge.	§2800.42(t) Specific rights
28	A resident has the right to remain in the residence, as long as it is operating with a license, except as specified in § 2800.228 (relating to transfer and discharge).	§2800.42(u) Specific rights
29	A resident has the right to receive services contracted for in the resident-residence contract.	§2800.42(v) Specific rights
30	A resident has the right to use both the residence's procedures and external procedures to appeal involuntary discharge.	§2800.42(w) Specific rights
31	A resident has the right to a system to safeguard a resident's money and property.	§2800.42 (x) Specific rights
32	To the extent prominently displayed in the written resident-residence contract, a residence may require residents to use providers of supplemental health care services as provided in § 2800.142 (relating to assistance with medical care and supplemental health care services). When the residence does not designate, the resident may choose the supplemental health care services provider. The actions and procedures utilized by a supplemental health care service provider	§2800.42(y) Specific rights

	chosen by a resident must be consistent with the residence's systems for caring for residents. This includes the handling and assisting with the administration of resident's medications, and shall not conflict with Federal laws governing residents.	
33	The resident has the right to choose his primary care physician.	§2800.42(z) Specific rights
34	A resident may not be deprived of his rights.	§2800.43(a) Prohibition against deprivation of rights.
35	A resident's rights may not be used as a reward or sanction.	§2800.43(b) Prohibition against deprivation of rights
36	Waiver of any resident right shall be void.	§2800.43(c) Prohibition against deprivation of rights
37	Prior to admission, the residence shall inform the resident and the resident's designated person of the right to file and the procedure for filing a complaint with the Department's Assisted Living Residence Licensing Office, local ombudsman or protective services unit in the area agency on aging, the Disability Rights Network or law enforcement agency.	§2800.44(a) Complaint procedures
38	The residence shall permit and respond to oral and written complaints from any source regarding an alleged violation of resident rights, quality of care or other matter without retaliation or the threat of retaliation.	§2800.44(b) Complaint procedures
39	If a resident indicates that he wishes to make a written complaint, but needs assistance in reducing the complaint to writing, the residence shall assist the resident in writing the complaint.	§2800.44(c) Complaint procedures
40	The residence shall ensure investigation and resolution of complaints. The residence shall designate the staff person responsible for receiving complaints and determining the outcome of the complaint. The residence shall keep a log of all complaints and the outcomes of the complaints.	§2800.44(d) Complaint procedures
41	Within 2 business days after the submission of a written complaint, a status report shall be provided by the residence to the complainant. If the resident is not the complainant, the resident and the resident's designated person shall receive the status report unless contraindicated by the support plan. The status report must indicate the steps that the residence is taking to investigate and address the complaint.	§2800.44(e) Complaint procedures
42	Within 7 days after the submission of a written complaint, the residence shall give the complainant and, if applicable, the designated person, a written decision explaining the residence's investigation findings and the action the residence plans to take to resolve the complaint. If the resident is not the complainant, the affected resident shall receive a copy of the decision unless contraindicated by the support plan. If the residence's investigation validates the complaint allegations, a resident who could potentially be harmed or his designated person shall receive a copy of the decision, with the name of the affected resident removed, unless contraindicated by the support plan.	§2800.44(f) Complaint procedures
43	The telephone number of the Department's Assisted Living Residence Licensing Office, the local ombudsman or protective services unit in the area agency on aging, the Disability Rights Network, the local law enforcement agency, the Commonwealth Information Center and the assisted living residence complaint hotline shall be posted in large print in a conspicuous and public place in the residence.	§2800.44(g) Complaint procedures
44	Nothing in this § 2800.44 (relating to complaint procedures) shall affect in any way the right of the resident to file suit or claim for damages.	§2800.44(h) Complaint

procedures

**Nutrition**

45	Residents have the right to purchase groceries and prepare their own food in addition to the three meal plan required in § 2800.220 (b) (relating to service provision) in their living units unless it would be unsafe for them to do so consistent with their support plan.	§2800.161 (h) Nutritional adequacy
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**Medications**

46	The residence shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.	§2800.191 Resident Education
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**Services**

47	A resident or a designated person has a right to request the review and modification of his support plan.	§2800.227 (j) Development of the final support plan
48	If the legal entity chooses to voluntarily close the residence or if the Department has initiated legal action to close the residence, the Department working in conjunction with appropriate local authorities, will offer relocation assistance to the residents. Except in the case of an emergency, each resident may participate in planning the transfer, and shall have the right to choose among the available alternatives after an opportunity to visit the alternative residences. These procedures apply even if the resident is placed in a temporary living situation.	§2800.228 (f) Transfer and discharge

**Enforcement**

49	If the relocation of residents is due to the failure of the residence to apply for a license, the Department will offer relocation assistance to the residents. This assistance will include each resident's involvement in planning the relocation, except in the case of an emergency. Each resident shall have the right to choose among the available alternatives after an opportunity to visit the alternative residences. These procedures will occur even if the residents are placed in a temporary living situation.	§2800.267 (a) Relocation of residents
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**Section 2800.1**  
**Purpose**

**A. Comment**

Two commentators noted while "aging in place" is a noble goal, a facility should have the ability to define limits which would be provided upon admission and through contract. One of the commentators recommended that a provision be added for defining when aging in place is not possible.

**Response**

An assisted living residence (ALR) is designed to allow a resident to age in place. The regulations and the Act of July 25, 2007, P.L. 402, No. 56 (Act 56) define "aging in place" as "receiving care and services at a licensed assisted living residence to accommodate changing needs and preferences in order *to remain* in the assisted living residence." 62 P.S. § 1001. In response to the commentator's recommendation that an ALR should have the ability to define limits which would be provided upon admission and through contract, the Department notes that Act 56 provides for such limits. For example, in order to ascertain that an ALR can meet the needs of a potential resident, a certification, along with a medical evaluation, initial assessment and preliminary support plan, are required prior to admission. See § 2800.22 (relating to application and admission). Act 56 also requires that the regulations for ALRs must "create standards for transfer and discharge that require the ALR to make *reasonable accommodations for aging in place* and that may include service from outside providers." 62 P.S. § 1026(a)(1)(viii). The standard of "reasonable accommodation" should satisfy the commentators' concerns since it does not unduly burden the ALR and, instead, recognizes that if a resident or potential resident's needs can no longer be met at the ALR, a transfer or discharge may be appropriate.

Furthermore, Act 56 recognizes that there are certain conditions or health care needs that may limit or prevent an ALR from admitting, serving or retaining specific individuals. These are defined as excludable conditions at § 2800.229 (relating to excludable conditions; exceptions). ALRs are prohibited from admitting, retaining or serving a consumer with an excludable condition unless an exception is granted by the Department of Public Welfare (Department).

**B. Comment**

Two commentators noted that the regulatory standard proposed, to "maintain maximum independence, self-determination and personal choice" exceeds the standard published in the legislation. The commentators questioned how "maximum independence" is determined, who makes that determination and what constitutes "maximum independence". The commentators alleged that the Department is creating a licensing standard that deviates from the plain text of the statute and suggested that it will be impossible to apply fairly, uniformly and consistently.

### **Response**

The Department amended the language in this section to provide that residents will receive the assistance they need to “age in place and develop and maintain maximum independence, *exercise decision-making* and personal choice”. The Department deleted the term “self-determination” and replaced it with “exercise decision-making”. Use of the words “exercise decision-making” is taken directly from the legislative findings and declarations in Act 56. Further, the language “maintain maximum independence” is the verbatim language taken from the personal care home (PCH) regulations at § 2600.1 (relating to purpose). Act 56 provides that the ALR regulations must “meet or exceed” the standards of the PCH regulations. 62 P.S. § 1021(a)(2)(i). As a result, the Department has not deleted that language.

### **C. Comment**

One commentator noted that many facilities whose objectives are to assist individuals to return to the community may fit some of the requirements of the general descriptions of ALRs, but not other significant requirements. The commentator suggested that the ALR regulations clearly establish that such programs are subject to PCH regulations and not subject to ALR regulations.

### **Response**

An existing licensed PCH is not required to seek licensure as an ALR and meet the new licensure requirements of Chapter 2800 (relating to assisted living residences). It is a business decision by a facility to decide if it wants to seek licensure as an ALR or remain a PCH.

### **D. Comment**

Sixteen commentators noted that the proposed regulations impose significant new costs for providers and ultimately those being cared for. The commentators stated that the regulations do not improve the quality of care, but in fact, may result in a decrease in resources available for care by forcing organizations to choose between physical plant changes and direct hands-on care. This increase in costs will result in higher fees to residents and potentially limit their ability to access services. One commentator questioned what impact the cost of these regulations will have on the availability of ALRs in rural areas of the state or to persons with limited ability to pay.

### **Response**

ALRs are another choice in the array of long-term care alternatives in this Commonwealth. Implementing the final-form regulations will fulfill the legislative intent to provide a “significant long-term care alternative” and to “ensure a balance of availability between institutional and home-based and community-based long-term care for adults who need such care.” Act 56 – Legislative Findings and Declarations (1) and (3). As a long-term care alternative, other options for long-term living will continue to be available. Further, these final-form regulations do not

force facilities to make changes and require licensure as an ALR. It is a business decision by a facility to decide if it wants to seek licensure as an ALR or remain a PCH.

In regards to cost, each facility will vary depending on structural enhancements required to meet licensure requirements. Costs are expected to be incurred by the regulated community beginning in Fiscal Year 2010-2011 ranging from \$0.006 million to \$0.403 million per ALR based on a 75-bed assisted living residence. At a minimum, all ALRs would be required to pay a licensure fee amounting to the \$0.006 million on average. This cost assumes a flat application or renewal fee of \$300 per home, an additional fee of \$75 per bed and for those facilities granted a special care designation, a third fee of \$150. It is assumed these fees will remain constant in the out years. Additional costs may be incurred, which when added to the licensing fee brings the total potential cost up to the maximum estimated average cost of \$0.403 million in the first year. These costs may or may not be incurred depending upon each facility's current status in relation to potential new costs imposed by the regulation. The majority of the costs relate to additional personnel expense in administering medication, enhanced reporting and additional administrative costs for resident care. It is assumed that those facilities that choose to apply for ALR licensure will already comply with the facility structural requirements of the proposed regulations, so no costs are assumed for structural modifications. It is assumed that 50 ALRs will incur these costs in FY 2010-2011.

Changes have been made in this final-form rulemaking that mitigate some of the provisions of the proposed regulations that were found to be most objectionable by industry stakeholders. For example, ALR licensure fees have been reduced from \$500 to \$300. Per bed fees have been reduced from \$105 to \$75. The proposed regulations required that all vehicles used to transport residents be accessible to resident wheelchair users and any other assistive equipment the resident may need, while this final-form rulemaking requires that they have a minimum of one such vehicle. The proposed regulations required that every vehicle used to transport residents have a first aid kit that included an automatic external defibrillation (AED) device, while this final-form rulemaking provides that the inclusion of an AED in a vehicle is optional. The proposed regulations required that first aid kits include AEDs, while the final-form rulemaking removes that requirement and instead requires that an AED be located in each building on the premises. The proposed regulations required a fire extinguisher in each living unit, while the final-form rulemaking requires one for each floor. The proposed regulations set the minimum square footage requirements for a living unit in the proposed regulations at 250 square feet for new construction and 175 square feet for existing facilities, while the final-form rulemaking for new construction sets the minimum square footage for living units at 225 square feet and 1 at 160 square feet for existing facilities. In the proposed regulations, facilities were required to provide microwaves and small refrigerators for every living unit, while in the final-form rulemaking, residents have the option of bringing their own small appliances with them.

In response to the commentators' concerns that the regulations will negatively impact the availability of ALRs in rural areas in the state, the Department submits that it cannot lower standards in some parts of the state and not in others, nor would it choose to do so when quality care, health and safety are involved. Should potential ALR licensees find particular requirements of these regulations to be too burdensome, § 2800.19 (relating to waivers) has been included to provide that waiver requests may be submitted by an ALR to the Department for consideration.

Regarding persons with a limited ability to pay, the Department submits that these regulations are licensing regulations. As such, funding issues are outside their scope.

#### **E. Comment**

Three commentators questioned what population will be served in the assisted living level of care and whether the progression of care is personal care, assisted living then a nursing facility. The commentators asked for clarification.

#### **Response**

This issue is addressed extensively in the Preamble. ALRs are a combination of housing and supportive services as needed. They provide for "aging in place" and are designed to cover the long-term living continuum of care.

#### **F. Comment**

Two commentators suggested that the regulation is overly stringent and would not result in qualitatively better care for residents. Instead, the regulation would make the expense of such ALRs prohibitive for many people of modest income. The commentators stated that the intent of Act 56 was to improve the quality of life for elderly citizens by guaranteeing safe alternatives for them as they age.

#### **Response**

The purpose of this regulation is to protect the health, safety and well-being of assisted living residents who may include not only older Pennsylvanians but also individuals living with disabilities. The commentator has not pointed out any specific areas in which the regulation for ALRs is "overly stringent". Without more specifics, it is difficult to respond to the commentator's concerns. As to resident costs, according to the National Clearinghouse for Long-Term Care Information ([http://www.longtermcare.gov/LTC/Main\\_Site/index.aspx](http://www.longtermcare.gov/LTC/Main_Site/index.aspx)), the average cost in Pennsylvania for a one-bedroom living unit in an ALR is \$ 3,186 a month. (This is based on facilities that currently refer to themselves as ALRs.) To put this into perspective, according to the National Clearinghouse the average daily rate for a private room in a nursing facility in Pennsylvania is \$248 a day, or \$7,543 a month. ALRs provide for a more affordable long-term living option and offer residents an opportunity to age in place and to develop and maintain maximum independence and personal choice.

#### **G. Comment**

Four commentators urged the Department to convene another workgroup with consumers, providers, PALA and other stakeholders to develop regulations for ALRs that specifically reflect the intent of Act 56. The current regulations do not improve upon the goal of Act 56. The commentators recommended that the issuance of the final regulation should be delayed until the workgroup is reconvened to further develop the regulation. These concerns were echoed by one legislator.

**Response**

As outlined in the Preamble of these regulations, the Department received 222 pieces of correspondence related to the publication of the initial notice of proposed rulemaking and an additional 79 in relation to the draft final-form rulemaking which was posted on June 24, 2009. The Department has also had close to twenty meetings with stakeholders since the publication of the notice of proposed rulemaking. As a result of this additional input from stakeholders, the Department finds that it has conducted a rulemaking process that has been very open, inclusive and responsive to the concerns of all interested parties.

**H. Comment**

Three commentators noted that the proposed regulations carry forward many of the disputes that were raised, debated and resolved by legislative enactment. The commentators suggested the Department appears to be re-opening issues rather than accepting the statutory platform.

**Response**

The Department does not concur with this characterization. The final-form regulation reflects the statutory language of Act 56.

**I. Comment**

One commentator recommended that a new section be added to the regulations that provides for the Department's allocation of project-based Medicaid waivers to ALRs that are selected through a competitive process and that serve a population that is at least 70 percent low-income. There should be a new section added regarding Funding ALRs with Medicaid Waivers stating that: (a) the Department may allocate Medicaid waivers to fund services for residents of ALRs who are low-income and who are living in subsidized ALRs, including but not limited to facilities subsidized with Federal housing subsidies. (b) The Secretary of the Department and the Secretary of Aging shall cooperate in assuring that waiver budgeting is secured on an annual basis and ongoing waiver reporting requirements are met. (c) Participating ALRs shall be selected through a competitive process administered by the agency in consultation with the Department of Aging. Priority in the award of demonstration program resources shall be given to ALRs in which a minimum of 70 percent of the units are restricted to low-income elderly households and which otherwise meet the requirements of this Chapter. (d) Medicaid waivers may be allocated on a project basis to participating ALRs.

### **Response**

These regulations are not intended to address funding or reimbursement issues. Additionally, the suggestions made by the commentator are more appropriate to a waiver application, rather than licensure regulations.

### **J. Comment**

One legislator commented that there is no assurance that future funding and regulatory changes will not be put in place that would jeopardize continuation of a facility. Given recent increases in food, energy and related expenses, facility losses for 2008 and 2009 are expected to worsen. The proposed regulations do little to meet the overwhelming financial crisis confronting the State's long-term care needs. The legislator commented that, under the proposed regulations there is little motivation for providers to want to continue providing excellent care to seniors as they are currently providing. The legislator added that Act 56 was intended toward allowing for resident independence, dignity and choice, not issues of physical structure and paperwork compliance as addressed in the proposed regulations.

### **Response**

The Department asserts that the regulations provide an additional option in the long-term continuum of care for individuals for whom ALRs are appropriate. Whether or not a provider pursues ALR licensing is a business decision. The Department maintains that residents who live in ALRs that meet the requirements of these regulations will receive the assistance they need to age in place, to develop and maintain maximum independence and to exercise decision making and personal choice. Also, these regulations are licensing regulations that are directed at ensuring the health and safety of ALR residents.

## **Section 2800.2 Scope**

### **A. Comment**

One commentator questioned whether the regulation refers to individuals with cognitive deficits other than dementia who are served efficiently by rehabilitation focused programs that provide education, training and skills improvement. The commentator noted that these facilities are currently licensed under PCH regulations and offer services under contract with State agencies. The commentator suggested that the ALR regulation clearly establish that such programs are not subject to the ALR regulation.

### **Response**

In response to stakeholder comments, § 2800.231(relating to admission) was created to address the needs of those with Intense Neurobehavioral Rehabilitation after Brain Injury (INRBI) by allowing for the creation of special care units for this population. It is not the intention of the Department that this final-form rulemaking

result in the displacement of PCH residents. Nor is it intended by the Department that the status quo of current operations of licensed PCHs and their programs be disrupted.

### **Section 2800.3 Inspections and Licenses**

#### **A. Comment**

Four commentators noted that the proposed regulations do not provide a standard establishing when the Department may or may not conduct an announced or unannounced inspection. The commentators further noted that the existence of a standard beyond "at random" decisions will establish clarity and consistency to the application of the regulation.

#### **Response**

The Department has elected to maintain this language, which is also required under the PCH regulations under §2600.3 (relating to inspections and licenses). By their very nature, unannounced inspections are meant to capture the environment of an ALR as it exists on a daily basis.

#### **B. Comment**

One commentator suggested that when the Department notifies the ombudsman to participate in inspection of exit proceedings, it take place in the same manner that the Department of Health (DOH) notifies the ombudsman for nursing home inspections. The commentator further suggested that this include pre-survey briefings and participation in exit conferences.

#### **Response**

This comment assumes that ombudsmen will be included in the inspection process as they are in nursing homes. However, ALRs are not health care facilities and are not governed by Federal nursing home law. Rather they are authorized under the Public Welfare Code which does not involve ombudsmen in the inspection process.

#### **C. Comment**

Six commentators questioned how extensive the abbreviated surveys will be. The commentators recommended that the ALR be required to post a copy of any waivers that have been approved, any complaints over the prior 18 months that have been founded, and provide copies of these documents at no cost.

#### **Response**

The Department has removed the reference for abbreviated annual licensure visit and the definition for "exemplary compliance". In the future, as the Department gains licensure experience and knowledge, the Department will publish, in consultation with stakeholders, regulations on this topic. The Department revised § 2800.19(b) (relating to waivers) to state the department will post waiver requests

on its website. Under § 2800.19(f), a copy of the waiver request and the Department's written decision shall be posted in a conspicuous and public place within the residence. The cost of requested document copies is up to the discretion of the ALR.

## **Section 2800.4 Definitions**

### Acquired Brain Injury

#### **A. Comment**

One commentator recommended that a definition for "acquired brain injury" be added to § 2800.4.

#### **Response**

In response to public comments, § 2800.231 (relating to admission) has been added to address the needs of residents with brain injury. In addition, in the definition section "INRBI- intense neurobehavioral rehabilitation after brain injury" has been added.

### Activities of Daily Living (ADLs)

#### **A. Comment**

Two commentators recommended that ADLs typically do not include "securing and managing health care and self-administration of medications." It is understood in the long-term care industry that ADLs encompass basic care needs: eating, drinking, transferring, grooming, toileting and ambulation.

#### **Response**

This definition was taken directly from the PCH regulations, which under Act 56, the Department must meet or exceed. Securing health care, managing health care, personal hygiene, self-administering medications and proper turning and positioning are included in the definition of "ADL" as critical self-care tasks of everyday life.

### Assistance

#### **A. Comment**

One commentator noted that the term "assistance" is used but not defined. The commentator proposed that the definition read as follows: "Actions or conduct required by this Chapter."

#### **Response**

The Department intends the usual and ordinary dictionary definition of "assistance," which according to the tenth edition of the Merriam Webster's Collegiate Dictionary, is "help." As a result, no regulatory definition is required.

Assisted Living Residence

**A. Comment**

One commentator questioned whether multiple buildings on the same premises are considered one residence covered by one license and whether the Department intends to have separate licenses for separate buildings on the same premises.

**Response**

The issue of multiple buildings is addressed in § 2800.11 (relating to procedural requirements for licensure or approval of assisted living residence; special care designation and dual licensure). This section states that multiple buildings located on the same premises may apply for a single ALR license.

**B. Comment**

One commentator stated that under the definition, it appears that currently-licensed PCHs that are the site of brain injury programs that are certified by the Commission on Accreditation of Rehabilitation Facility (CARF) and contracting state agencies are subject to these regulations. The commentator is requesting clarification of the definition.

**Response**

Currently-licensed PCHs are not subject to these regulations unless they choose to apply for ALR licensure. It is not the intention of the Department that this final-form rulemaking result in the displacement of PCH residents. Nor is it intended by the Department that the status quo of current operations of licensed PCHs and their programs be disrupted.

- C.** One commentator opposed naming ALRs as "residence" because of the confusing similar sound of "residents". The commentator recommended that an ALR should be renamed a "home" as it emphasizes that an ALR residence is not just a residence but rather it is a resident's home.

**Response**

The Department utilized statutory language throughout the rulemaking which refers to ALRs as residences, not as homes.

Assisted Living Residence Administrator

**A. Comment**

One commentator noted that the definition ended with the words "duties are shared with other individuals". The commentator questioned whether the language implies that the administrator can also function as the administrator of a licensed PCH section of a facility at the same time.

**Response**

This language is identical to that in the PCH regulations, which the Department is required to meet or exceed. The Department has provided in § 2800.11 (relating to procedural requirements for licensure or approval of assisted living residences; special care designation and dual licensure) for a waiver of the administrator hourly staffing requirements to allow for the sharing of administrators for dually licensed PCHs and ALRs.

### Assisted Living Services

#### **A. Comment**

Three commentators and one legislator noted that the definition should specifically include assistance with the following: Activity of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL), financial management, 24-hour supervision and monitoring, meals, housekeeping, laundry, activities and socialization, space and equipment for activities, medication administration, health care services, cognitive support services, supplemental health care services, hospice and transportation to medical and social appointments.

#### **Response**

Section 2800.220 (relating to service provision) was revised to list specific services offered by ALRs. The Department submits that this should address the commentator's concerns.

### Cognitive Support Services

#### **A. Comment**

One commentator requested that this definition be clarified. The commentator stated that in some cases the definition appears to refer to dementia and Alzheimer's and in other cases it appears that the definition could be referring to mental health, mental retardation, autism, traumatic brain injury or another disability. Another commentator noted that the term "cognitive impairment" is not defined but "dementia" is defined.

#### **Response**

Act 56 defines "cognitive support services" as "services are provided to an individual who has memory impairments and other cognitive problems which significantly interfere with their ability to carry out activities of daily living without assistance and who require that supervision, monitoring and programming be available to them 24 hours per day, seven days per week, in order for them to reside safely in the setting of their choice" (62 P.S. §1001). Since the definition of "cognitive support services" is statutorily defined, the Department cannot amend the definition. However, additional amendments were made at § 2800.231 (relating to admission) to address those in need of INRBI and to allow for special care units for residents who fall into this category.

#### **B. Comment**

One commentator questioned who determines the appropriate activities for a person with a diagnosis of dementia.

**Response**

The determination of appropriate activities for residents is established through a resident's assessment and corresponding support plan in § 2800.224 (relating to initial assessment and preliminary support plan), § 2800.225 (relating to additional assessments) and § 2800.227 (relating to development of the final support plan). In addition, resident activities are addressed in § 2800.23 (relating to activities), which directs ALRs to provide assistance to residents with ADLs and IADLs and to provide appropriate cueing for both. Additional provisions are located in § 2800.231 (relating to admission), which details the requirements of special care units for those with dementia and those in need of intense neurobehavioral rehabilitation as a result of brain injury.

**C. Comment**

Two commentators suggested that the definition read as follows: "Services provided to an individual who has memory impairments and/or other cognitive problems which significantly interfere with their ability to carry out ADLs without assistance and who requires the supervision, monitoring and programming be available 24 hours a day in order to reside safely in the setting of their choice." Another commentator suggested that the definition be clarified so that programs that are not related to dementia and degenerative neurological conditions are exempt.

**Response**

The definition of "cognitive impairment" is taken directly from Act 56. The Department cannot change statutory language through regulation.

**D. Comment**

One commentator asked how an ALR determines when a resident with cognitive weaknesses changes significantly. If "significantly" is left undefined the decision may vary from inspector to inspector or from one day to another. The commentator recommended that this decision be made by the ALR's clinical staff.

**Response**

The Department concurs that the decision of whether a change in condition is significant or not is a clinical decision, which is why any change in a resident's condition would trigger a medical evaluation under § 2800.141(b)(2) (relating to resident medical evaluation and health care).

*Community service organizations*

**A. Comment**

One commentator requested the term "community service organizations" be defined, as the term is too broad and could require residences to allow private organizations to enter the facility, thereby limiting the resident's protection.

**Response**

This language is taken from the PCH regulations, which the Department must meet or exceed. The Department has elected to retain this term because its elimination or narrowing could unnecessarily impact resident access to additional services and resources and thus affect their ability to choose service options.

Dementia

**A. Comment**

Two commentators noted that the definition was not correct. Dementia is a loss of intellectual capacity such as memory, judgment, language, visual-spatial skills and executive functioning. It does not have to be of "long" duration.

**Response**

The Department finds that this definition was taken from the PCH regulations and reads that "dementia" is "characterized by a decline of long duration in mental function in an alert individual."

**B. Comment**

One commentator suggested that the lack of a definition of "acquired brain injury" suggests that the regulations do not apply to brain injury rehabilitation programs currently operating as PCHs.

**Response**

Although no definition of "acquired brain injury" existed in the notice of proposed rulemaking, the Department added provisions for individuals with brain injury to reside in special care units. This is because Act 56 does not restrict an ALR which operates a special care unit to just those individuals with dementia and Alzheimer's disease, but includes residents with "severe cognitive impairments." See 62 P.S. §1001.

Designated Person

**A. Comment**

One commentator recommended that for clarification the definition of "designated person" should be amended to include the legal guardians of both the estate and the person.

**Response**

As provided in the definition of "designated person," a designated person may be the resident's legal representative. The final-form rulemaking defines "legal

representative as "an individual who holds a power of attorney, a court-appointed guardian or other person legally authorized to act for the resident." Since not every type of legal representation can be identified, this definition leaves open the possibility of other types of applicable legal authorization being included in the definition of "legal representative."

**B. Comment**

One commentator noted that a designated person, unless the designated person is a legal representative, does not have the authority to make decisions on behalf of the resident without express written consent from the resident and this consent must be included in the resident's record.

**Response**

The Department agrees with this comment and intentionally uses the distinct terms "designated person" and "legal representative" in the regulations as noted above.

**C. Comment**

One commentator suggested that the definition of "designated person" be defined in a manner that the resident, should he chose to, be permitted to allow them to legally act on their behalf on all matters related to the terms and conditions of the resident's residency as expressed in the contract. The commentator further suggested that the resident should be permitted to make this choice as part of the contractual agreement with the ALR and the ALR be required to honor that choice.

**Response**

A resident may choose a legal representative to legally act on his behalf. Section 2800.25 (relating to resident-residence contract) allows a resident to choose whether to have his designated person participate in the contracting process. The definition of "designated person" provides that a designated person may be the resident's legal representative. See § 2800.4. A "legal representative" is defined at § 2800.4 (relating to definitions) as "an individual who holds a power of attorney, a court-appointed guardian or other person legally authorized to act for the resident."

Designee

**A. Comment**

One commentator suggested the following wording be added: A staff person who has completed the administrator training and satisfies the direct care staff qualifications and who is authorized in writing to act in the administrator's absence.

**Response**

The substantive training and qualification requirements for an administrator designee are contained in § 2800.64 (relating to administrator training and orientation) and § 2800.53 (relating to qualifications and responsibilities of administrators) respectively. The Department has elected to not make the changes recommended by the commentator except to add in § 2800.56(b) (relating

to administrator staffing) that the administrator shall assign an administrator designee in writing to supervise the ALR during the administrator's temporary absence.

### Discharge

#### **A. Comment**

One commentator stated that the term "discharge" is commonly used to describe a health care facility's decision to release a patient from a medical environment. The commentator suggested that the regulation use terminology that embodies the intent of the law and extends choice and dignity to the resident. The commentator further suggested that for termination of a resident's residency, the regulation should refer to the action for what it is: "termination of residency."

#### **Response**

The Department has elected to retain the original wording since the term "discharge" is taken from Act 56 (62 P.S. § 1021(a)(2)(viii)), which requires that regulations for ALRs shall create standards for "transfer and discharge."

### Exemplary Compliance

#### **A. Comment**

Two commentators noted that this provision is designed to allow the Department to focus its resources on consistently poor performing providers. The commentators stated that it is important to note that not all deficiencies relate to poor quality of care. When defining exemplary compliance, the regulations should allow abbreviated inspections for facilities that are free of deficiencies that directly impact upon the health and welfare of the resident. The commentators suggested the following language: "Two consecutive years of inspections which are free of deficiencies that impact upon the health and welfare of the resident shall be considered exemplary compliance."

#### **Response**

Based on commentator input, the Department has removed the provision for abbreviated annual licensure visit and the definition for "exemplary compliance". The Department will consider this issue for a future rulemaking.

### Immobile Resident

#### **A. Comment**

One commentator stated that the definition is not meaningful and does not highlight the assistance that an individual requires.

#### **Response**

Although the term "immobile resident" is not used in these regulations, the language "resident with mobility needs" is defined in this section and used in

various sections of the regulation. The definition of "resident with mobility needs" is taken from the statutorily-defined term "immobile person" at 62 P.S. § 1001. In addition, the Department maintains that use of "resident with mobility needs" is an appropriate measure for determining resident staffing based on the level of resident need for assistance.

### Informed Consent Agreement

#### **A. Comment**

One commentator stated that no resident can sign such an agreement that puts another resident or residents at risk. The commentator recognized that although Senate Bill 704 and Act 56 included "another resident" he disagrees with the language. Another commentator suggested the language should mirror Act 56.

#### **Response**

The Department is obligated to follow Act 56 with respect to this term. The Department directs the commentators to the definition of "informed consent agreement" in 62 P.S. § 1001, which refers to "...choices" that "will place the resident or other residents at risk of harm."

#### **B. Comment**

One commentator suggested the definition clarify how the agreement should be crafted for individuals with brain injuries. Another commentator suggested that a person should be evaluated at the time of admission in order to determine their ability to make decisions.

#### **Response**

The Department finds that the definition section is not the appropriate place for substantive provisions. Instead, the substantive provisions related to informed consent agreements are found in § 2800.30 (relating to informed consent process).

### Instrumental Activities of Daily Living (IADLs)

#### **A. Comment**

One commentator noted that medication management, laundry, money management, bill paying and light household cleaning are not typically categorized as IADLs. Another suggested that "housekeeping" be added to the list of IADLs.

#### **Response**

Regarding IADLs, this definition is taken from the PCH regulations, which the Department is required to meet or exceed. Regarding housekeeping, although it was included in the notice of proposed rulemaking in the list of IADLs, it has been deleted from that list. Instead, based on further review, it has been added to the definition of "assisted living services" under § 2800.220(b)(6) (relating to service provision). Based on the comments received, housekeeping is one of those

services that the ALR resident may choose to opt out of receiving under § 2800.220(d).

License

**A. Comment**

One commentator recommended that the definition specify the permissible number of individuals who may receive assisted living services at any one time within the ALR and that the licenses apply to those living units being occupied by individuals receiving assisted living services.

**Response**

The Department asserts that it is not appropriate to place substantive provisions in the definition section.

Living Unit

**A. Comment**

One commentator recommended that the definition be amended as follows: "The resident living space cannot be shared with more than one person except upon request of the resident that includes no less than 250 square feet of useable space in the living unit, in addition to the space occupied by the bathroom, kitchen area closets and storage spaces. All living units must have lockable doors. And double occupancy units shall have separate bedrooms with lockable doors to the living space and a lockable bathroom door. All units must be accessible to potential residents who use wheelchairs."

**Response**

The Department elects not to include these substantive provisions in the definitions section and refers the commentator to § 2800.101 (relating to resident living unit) and § 2800.102 (relating to bathrooms) for the requirements related to living units and bathrooms.

Long-Term Care Ombudsman

**A. Comment**

Two commentators suggested that this definition be expanded to encompass greater responsibilities such as quality assurance, training and public education. Another suggested that the definition is not clear and could result in the ombudsman being placed in the position of acting as a facility and/or regulatory agent.

**Response**

This language is taken from the PCH regulations, which the Department is required to meet or exceed.

**B. Comment**

One commentator alleged that the inclusion of this definition and the protective services unit suggests that the scope of the regulation is limited to services for individuals defined by the need of care related to age, not to type of limitation/disability/handicap.

**Response**

This definition mirrors the definition in the PCH regulations, which the Department is required to meet or exceed. The definition is similar to the definition in 6 Pa. Code § 11.3 (relating to definitions) of the Department of Aging's regulation for older adult daily living centers. The Office of the State Long-Term Care Ombudsman, established by the Older Americans Act of 1965 (42 U.S.C.A. §§ 3001–3057g), is charged with the statewide reporting and investigative system for complaints made by or on behalf of adults who are age 60 years or older who are consumers of a long-term care service.

Mobile Resident

**A. Comment**

One commentator stated that the definition is not a clinical term and recommended that it be replaced with terms which are commonly used in the long-term care industry. The commentator added that the term is misleading, may affect the number of care hours that a resident receives and may not address a person's needs for personal care.

**Response**

This definition was taken directly from the PCH regulations, which the Department is required to meet or exceed.

Relative

**A. Comment**

One commentator suggested that cousins should be included, particularly for people who are unmarried and have no children, siblings or aunts or uncles. The commentator also believes there should be accommodations for gay partners.

**Response**

The authority for this definition is 62 P.S. § 1001, which defines "relative" as "parent, child, stepparent, stepchild, grandparent, grandchild, brother, sister, half brother, half sister, aunt, uncle, niece, nephew." Since the definition of "relative" is statutorily defined, the Department cannot amend this language through regulation.

Resident

**A. Comment**

One commentator questioned whether a relative not in need of services would be permitted to move into a residence with someone who is disabled and/or in need of assisted living services.

**Response**

As discussed in the Preamble, Act 56 envisions a broad range of individuals who may choose to reside in an ALR.

Special Care Designation

**A. Comment**

One commentator requested that "acquired brain injury" be added to Special Care Designation.

**Response**

Although the Department chose not to add this language to the definition, § 2800.231 (relating to admission) has been revised to allow for the establishment of special care units for individuals with brain injury.

**B. Comment**

One commentator questioned whether the inclusion of this definition implies that brain injury programs are subject to the special care designation requirements.

**Response**

It is not intended by the Department that the status quo of current operations of licensed PCHs and their programs be disrupted. Nor is it the intention of the Department that this final-form rulemaking result in the displacement of PCH residents.

**C. Comment**

One commentator alleged that the definition does not track the language in Act 56. The commentator does not object to the proposed language, however recommended that the definition be aligned with the language in Act 56.

**Response**

Under the Pennsylvania Code and Bulletin Style Manual, the word "including" is intended to mean "includes but is not limited to." As a result, the Department made no further change to the definition.

**D. Comment**

One commentator suggested that the proposed definition start from a premise that an ALR is either totally exclusive to a special population or has a distinct part where that population is segregated and assigned to live. The commentator raised concern that this stereotypes the special needs population, compromises their dignity and limits the type of resident's choice as to the resident's living alternatives. The commentator further noted that many residents with cognitive

support needs can succeed in living among all the residents of an ALR while receiving individualized support for their unique needs. The commentator recommended that the Department employ the principle that "special care designation" applies to the resident and not the residence.

### **Response**

The definition of "special care unit" is taken from Act 56. See 62 P.S. § 1001. The Department cannot through regulation amend statutory language.

### Support Plan

#### **A. Comment**

One commentator stated that the support plan should be based on a comprehensive pre-admission screening, such that the consumer is informed of how the residence will meet resident needs with regard to cognition, functionality/mobility, continence, medication administration, nutrition and medical care. The commentator strongly recommended that the support plan be developed before a contract is signed.

### **Response**

The Department has revised § 2800.224 (relating to initial assessment and preliminary support plan) to address this concern by requiring that a preliminary support plan be developed within 30 days prior to admission or within 15 days after admission in the limited circumstances detailed in § 2800.224(a)(3).

## **Section 2800.5**

### **Access**

#### **A. Comment**

One commentator recommended there should be a provision to ensure that a residence provides access to legal guardians. Additional commentators would expand this to include the resident's attorney, law enforcement, protective services or any state or local building code officials to enter the facility.

### **Response**

The Department agrees that legal guardians should be included and a change has been made to subsection (a)(5) to provide access to a designated person if so requested by the resident. Section 2800.4 (relating to definitions) provides that a designated person may be the resident's legal representative. Additional persons mentioned by commentators are already covered by other laws related to law enforcement officials, protective services under the Older Americans Protective Services Act, state laws enforced by the Department of Labor and Industry and local laws.

#### **B. Comment**

One commentator noted there is no mention of providing access to a community-based physician or nurse practitioner to make home visits.

**Response**

Under § 2800.42(o) (relating to specific rights) the regulations require that a resident has the right to freely associate, organize and communicate privately with his friends, family, physician, attorney and other persons.

**Section 2800.11  
Procedural Requirements for Licensure  
or Approval of Assisted Living Residences;  
Special Care Designation and Dual Licensure**

**A Comment**

One hundred and twenty commentators stated the proposed licensure fees are excessive and cost prohibitive. Others wrote to commend the Department for setting licensure fees that are sufficient to fund state oversight. Others supported the application and renewal fees but not the per bed fee.

**Response**

In response to public comments, the licensure fees have been lowered. The license application fee has been reduced to \$300 from \$500 and the per bed fee has been reduced to \$75 from \$105. The Department has responded more fully to this issue in the Preamble.

**B. Comment**

One commentator recommended that wording be added requiring an existing PCH or other licensed care facility seeking to transition to licensure as an ALR to (a) meet all requirements of the ALR regulations including those for staffing, staff training and physical site, (b) have full inspection, (c) at the time of application, be in complete compliance with the regulations governing the facility type they were/are, and (d) at the time of application, have an exemplary compliance history.

**Response**

Section 1007 of the Public Welfare Code sets forth the criteria for issuance of a license. See 62 P.S. § 1007. The Department has elected not to include the explicit provisions recommended by the commentator. The Department will only issue an ALR license if a facility is found to be in compliance with applicable laws and regulations, including this Chapter.

**C. Comment**

Two commentators questioned if a facility does not apply for an ALR license immediately will the facility be able to apply later without penalty. The commentator also questioned if the application for licensure as an ALR is voluntary or mandatory.

**Response**

Application for an ALR license can occur at any time and is not mandatory. There is no deadline for application.

**D. Comment**

Six commentators noted that the regulations are so ambiguous that the vast majority of current PCH providers who could qualify for the new ALR license will elect not to apply for licensure. As a result thousands of seniors could unnecessarily be forced into skilled nursing facilities costing the State and taxpayers millions of dollars in long-term care costs. They stated that the costs could be avoided with specific and appropriate ALR regulations.

**Response**

The Department does not agree with the commentator that the regulations are ambiguous. As to their impact on the availability of ALRs, the Department has made numerous changes to the regulations that address major concerns communicated by industry stakeholders. Each PCH will have a business decision to make regarding conversion to an ALR and none will be required to do so.

**E. Comment**

One commentator noted that ALRs cannot discriminate against individuals who receive public funding and that ALRs be prohibited from denying admission, transfer or discharge to an individual because of their payment source.

**Response**

The commentator has not provided any legal basis for this recommendation. The PCH regulations, which the Department is required to meet or exceed, contain no parallel provision.

**F. Comment**

Six commentators feel it is critical to remember that assisted living is a new licensure category and grandfathering of staff qualifications, physical site or other elements of the new regulation is not appropriate.

**Response**

The Department does not concur that the regulation omits standards by which PCHs will be judged as to their suitability as an ALR. Licensure applicants clearly must comply with all applicable laws and regulations and all of the provisions of Chapter 2800. While existing facilities have not been grandfathered, the Department has provided some relief in areas such as administrator qualifications and square footage requirements for living units.

**G. Comment**

Six commentators urged the Department to include a section on dual licensure and provide recommendations for when and how a facility could be dually licensed as an ALR or something else.

### **Response**

Based on comments received, the Department has amended the regulations in § 2800.11 (relating to procedural requirements for licensure or approval or assisted living residences: special care designation and dual licensure), to permit dual licensure. The regulations require that the facility must be inspected by the Department and found to be in compliance with applicable laws and regulations. Subsection (g) now provides that a licensed PCH may submit an application to the Department requesting dual licensure if the licensed PCH and the ALR are collocated in the same building and are each located in a distinct part of the building. If the Department determines that the licensed facility meets all of the requirements of this Chapter, the facility will be issued a dual license.

## **Section 2800.12 Appeals**

### **A. Comment**

One commentator stated there should be some assistance provided for persons with cognitive challenges in the appeal process.

### **Response**

Article X of the Public Welfare Code does not grant authority to the Department to adjudicate resident appeals of actions taken by an ALR. Instead, it is a matter of contract law between the home and the resident.

### **B. Comment**

One commentator noted that providers only have an opportunity to appeal as it relates to the status of their licensure as an ALR. Providers of assisted living services need to have an ability to appeal citations assigned to them as well. There is a high likelihood that citations will occur despite the best efforts of all parties to act consistent with the intent of Act 56. Of particular note also are the significant financial penalties and licensure risks imposed upon the provider based upon such citations. A provider needs a legal avenue of appeal in that regard as well.

### **Response**

Actions related to the licensure or approval of an ALR may be appealed under § 2800.12 (relating to appeals). In addition, an ALR that is fined may appeal the amount of the penalty or the fact of the violation under § 2800.263 (relating to appeals of penalty). For Class II and Class III violations, a provider has a period of time to correct the violation before a monetary penalty is imposed.

## **Section 2800.14**

## **Fire Safety Approval**

### **A. Comment**

One commentator requested clarification of who is responsible for the renewal approval and what needs to be documented.

#### **Response**

The Department finds that ALRs are responsible for attaining and documenting fire safety approval as set forth in subsection (e).

### **B. Comment**

One commentator questioned if anyone investigated whether the agencies responsible for fire safety approval have agreed to renew the approval at least every 3 years.

#### **Response**

These regulations establish the standards for licensure and the licensee is responsible for ensuring that those standards are met. In other long-term living community-based facilities, such as adult daily living centers and domiciliary care, fire safety inspections are completed by either fire safety experts, such as staff from local fire departments, or other fire safety authorities including private companies. In adult day facilities, these inspections are required annually.

### **C. Comment**

One commentator noted the regulation does not contain provisions relating to building codes and questioned what these requirements would be.

#### **Response**

The specific building code on the Certificate of Occupancy will be determined by the Department of Labor and Industry or the local building inspector based on the intended use of the building that is being inspected.

### **D. Comment**

One commentator recommended the section be revised to indicate the impact to the facility's license if fire safety approval is withdrawn by the appropriate fire safety agency. The commentator and six others further stated the facility should be put on a provisional license and be required to remedy fire safety problems immediately or residents should be relocated.

#### **Response**

Fire safety approval is a prerequisite to operating as an ALR. The Department will investigate and take appropriate action should fire safety approval be withdrawn. Lack of a valid and current fire safety inspection or a withdrawn Certification of Occupancy would result in a citation.

### **E. Comment**

Two commentators noted that the term "frequently" is undefined, making the regulation unclear and susceptible to inconsistent and arbitrary application. The commentators stated that a specific timeframe would establish consistency and clarity.

#### **Response**

The Department reserves the right to request a fire safety inspection at any time it observes conditions that appear to pose a risk for fire safety or other safety deficiencies. This could be as a result of a complaint investigation or based on conditions observed during a regular or unannounced inspection.

### **Section 2800.15 Abuse Reporting covered by Law**

#### **A. Comment**

Two commentators suggested that the definition of "immediately" be clarified. The commentator questioned if "immediately" meant following the event or within 24 hours of occurrence?

#### **Response**

This language mirrors the PCH regulations, which the Department is required to meet or exceed. As with PCHs, ALRs will be required to comply with the Older Adults Protective Services Law (OAPSA). Complete information on reporting requirements, including timeframes for reporting and methods of reporting, can be found on the PA Department of Aging web site at [www.aging.pa.state.us](http://www.aging.pa.state.us) - see Professional and Providers/Protective Services and Ombudsman/Online Training: Mandatory Abuse Training, Criminal History Background Checks.

### **Section 2800.16 Reportable Incidents and Conditions**

#### **A. Comment**

Twenty-eight commentators recommended that "illness" be removed from the list of reportable conditions. The commentators stated that residents will be susceptible to illness and mandating a report each time that illness occurs is time-consuming and distracts from resident care. In addition, the commentator stated it would be overwhelming for the Department. Another commentator stated that the use of "illness" is too vague. Another commentator asked if a cold would be defined as an illness and if so, would it be reportable at the time of admission or when it develops.

#### **Response**

The Department submits that the primary goal of an incident management system is to ensure that when an incident occurs, the investigation and corrective action will protect the health, safety and well-being of the resident. The intent of this provision of the regulations is to ensure that illnesses that require treatment at a

hospital or medical facility be reported. The language does not require admission to a hospital or medical facility. Incident reports serve as a mechanism for facilities to demonstrate how they properly respond to emergencies and that they report incidents as required to various agencies. Similar language exists for adult day facilities under 6 Pa. Code § 11.3 (relating to definition of unusual incident).

**B. Comment**

One commentator recommended having the provider conduct an investigation would not be in the resident's best interest, especially for a resident with cognitive issues.

**Response**

The Department submits that this language was taken from the PCH regulations, which the Department is required to meet or exceed.

**C. Comment**

One commentator questioned whether "an absence of staff or inadequate staff to supervise residents" requires a reportable incident for any staff absence.

**Response**

The Department has amended subsection (a)(20) to address this concern. It now reads that an absence of staff such that residents receive inadequate care as defined by the respective resident support plans is a reportable incident.

**D. Comment**

Seven commentators stated the regulations need to indicate the facility must write up a report on the facility's incident investigation findings and make the reports available at inspections. The commentators further stated the State should be compiling and publishing data on the nature and scope of reportable incidents.

**Response**

Section 2800.16(d) requires that an ALR submit a final report to the Department's ALR office immediately following the conclusion of an investigation. Further, subsection (f) requires an ALR to keep a copy of the report of the reportable incident or condition. Under § 2800.5(a)(1) (relating to access), the administrator, administrator designee or designated staff person must provide immediate access to resident records to agents of the Department. Since reports of reportable incidents and conditions are records that are required to be kept by the ARL, these reports are available to departmental inspectors at inspection visits. It is anticipated that the Department will be able to produce, upon request, a report of the number of reports by type of incident.

**E. Comment**

One commentator recommended changing the language such that reportable incidents include "errors or adverse drug reaction that cause serious injury" to

residents, rather than requiring that minor events, such as a missed prescription vitamin, be reported.

#### **Response**

The Department submits that this language mirrors the PCH regulations, which the Department is required to meet or exceed. Additionally, the Department points out that subsection (a)(13) includes as a reportable incident a prescription medication error as defined in § 2800.188 (relating to medication errors).

#### **F. Comment**

One commentator stated the proposed language does not adequately define "medical facility." The commentator further stated if a facility has a health care clinic, would all visits to this clinic need to be reported to the Department since the clinic is a medical facility.

#### **Response**

This language mirrors the PCH regulations, which the Department is required to meet or exceed. In the PCH regulations, the Department has interpreted "requiring treatment at a hospital or emergency facility" to include outpatient and emergency room care and treatment.

#### **G. Comment**

One commentator noted the absence of any reporting obligation to family, next-of-kin or responsible party in the event of an incident (slip, trip, fall out of a chair or bed). The commentator further stated this section should be divided into incidents and conditions which warrant reporting to the Department and those that warrant advising and notifying family, next-of-kin or responsible party.

#### **Response**

A list of reportable incidents is set forth in subsection (a) that mirrors the PCH regulations. Language has been added to subsection (c) that requires the family and the resident's designated persons to be notified of the incident or condition.

#### **H. Comment**

One commentator noted that the Mcare definition of "serious event" is absent and should be included. The commentator noted in subsection (a)(3) the section should define a "serious bodily injury" in a way that Mcare does: an occurrence or happening which is unanticipated by a reasonable patient and requires medical care. The commentator noted the definition in the regulations is "an injury, illness or trauma requiring treatment at a hospital or medical facility." The commentator further stated it would be useful if consistent definitions were used in differing pieces of legislation. Two commentators proposed revising subsection (a)(3) to read: "A serious bodily injury or trauma requiring treatment at a hospital or medical facility. This does not include minor injuries such as sprains or minor cuts."

#### **Response**

The term, "serious event" is defined in Section 302 of the Mcare act (Act 13 of 2002, the Medical Care Availability and Reduction of Error Act). The Department did not adopt this definition because the Mcare definition of "serious event" at 40 P.S. § 1303.302 applies to "medical facilities". The Mcare definition of "medical facility" is "an ambulatory surgical facility, birth center, hospital or abortion facility." ALRs do not fall under the definition of "medical facilities," and, as such, are not required to report "serious events" under the Mcare statute. Consistent definitions are not required since the Mcare statute and ALR regulations do not apply to the same type of facilities. A medical facility is distinguishable from an ALR, which is predicated on a "social model" of care rather than a "medical model."

Furthermore, a "reportable incident or condition" in the ALR regulation includes "an injury, illness, or trauma requiring treatment at a hospital or medical facility. This does not include minor injuries such as sprains or minor cuts." See § 2800.16(a)(3). A comparison of the definition of "serious event" that the commentator has requested, versus what the final-form regulation provides would appear to cover the same type of incident. Injuries and traumas are usually "unanticipated events" and both definitions meet the test of "an occurrence or happening which is unanticipated by a reasonable patient and requires medical care."

#### **I. Comment**

One commentator stated all third parties providing goods and services to residents should maintain incident reports and records. It was further stated that these reports and records shall be made available to residents, residents' physicians and families and to any family council. The commentator further stated all third parties should report any knowledge of reportable incidents or violations of regulations to the Department of Public Welfare Licensing Entity.

#### **Response**

The Department has not made the recommended change since its licensing authority does not extend to third parties.

### **Section 2800.17 Confidentiality of Records**

#### **A. Comment**

One commentator stated that legal guardians should have access to records.

#### **Response**

This language mirrors the PCH regulations, which the Department must meet or exceed. The degree of access will depend on the scope of authority granted to the designated person, depending on individual circumstances.

#### **B. Comment**

One commentator noted that privacy standards on health-related matters should be in compliance with Federal HIPAA guidelines. The commentator further stated

that no information, unless covered under another governmental policy, should be shared on a resident's personal file.

**Response**

As a condition of licensure, an ALR must comply with all applicable laws, including HIPAA. See § 2800.18 (relating to applicable laws). This regulation mirrors the PCH regulations on record confidentiality. The Department must meet or exceed the PCH regulations.

**C. Comment**

One commentator stated there is no mention of a visiting physician/nurse's ability to review the facility record.

**Response**

Resident records are confidential and private. The provisions of this section mirror the PCH regulations and require that an ALR may not release the resident's record to anyone other than the resident, the resident's designated person, the resident's power of attorney, staff persons for the purposes of providing services, agents of the Department and the long-term care ombudsman without the written consent of the resident, a power of attorney for health care or health proxy or a resident's designated person, or if a court orders disclosure.

**D. Comment**

One commentator stated records should be made available free of charge for the resident or the resident's representative where there has been a serious event. The commentator stated a residence must comply with applicable Federal, State and local laws, ordinances and regulations and this would presumably include State laws with respect to costs for records. The comment noted, however, a resident is typically in a different situation than a non-resident in terms of their ability to afford records and perhaps to even understand them. The commentator continued, perhaps the ombudsman would be in a position to request the records without cost for good cause.

**Response**

The Department has elected not to regulate on this issue. Section 2800.254(b) (relating to record access and security) provides that each ALR is responsible for the development and implementation of policies and procedures addressing record accessibility, security, storage, authorized use and release and who is responsible for the records. The decision whether or not to charge for such records is, therefore, a business decision for the ALR to make.

**Section 2800.18  
Applicable Laws**

**A. Comment**

Seven commentators recommended that all residences - including buildings that exist as of the day the regulations take effect - should be required to meet the best available standards or practices for accessibility (including residents using wheelchairs and/or scooters), fire safety, life safety and uniform construction codes. The commentators expressed that this would ensure the best practices for keeping residents safe. Another commentator recommended that the regulations explicitly refer to accessibility design requirements in the ADA Guidelines or other accessibility standards. In addition one commentator stated that residences should be required to admit service animals for residents.

**Response**

Fire and life safety standards in construction are set by the International Building Code. How these standards are utilized and enforced are determined by the Department of Labor and Industry. Other applicable Federal, State and local requirements such as Americans with Disabilities Act (ADA) would also apply.

The Department maintains that the issue of service animals is covered by the ADA, which provides detailed and comprehensive guidance on the issue. Section 2800.18 (relating to applicable laws) of this final-form rulemaking requires that an ALR comply with applicable Federal, State and local laws, ordinances and regulations. The Department thus defers to Federal law on the issue of service animals and direct ALRs to the following web site: <http://www.ada.gov/qasrvc.htm>.

**B. Comment**

Six commentators stated all applicants for ALR licensure must comply with all regulations and laws required for new construction.

**Response**

Compliance is addressed under § 2800.18 (relating to applicable laws), which requires that an ALR comply with applicable Federal, State and local laws, ordinances and regulations.

**C. Comment**

One commentator stated this section should clarify that, in the event of a conflict between the State regulations and Federal requirements, the Federal requirements of public and affordable housing admissions and continued occupancy would prevail. The commentator stated this requirement would ensure Federal subsidization of the housing.

**Response**

The Department finds that the commentator's recommendation is beyond the scope of this rulemaking since the rulemaking addresses ALR licensing, not funding issues.

**D. Comment**

One commentator recommended a thorough review of the regulations for any necessary changes to ensure that assisted living services may be provided in Low Income Housing Tax Credit (LIHTC) developments. For an ALR to be eligible for tax credits, it must be primarily residential in nature, rather than primarily a health care facility. The IRS has found that continual or frequent nursing, medical or psychiatric services will qualify a home as a health care facility rather than a residential property and additional supportive services, such as meals and housekeeping, are acceptable within the definition of a residential facility. As long as nursing care or medical care are optional, and not a condition of occupancy, a facility may be considered a residential rental facility by the IRS and eligible for tax credits. In order to ensure tax credits leverage private investment for service-enriched housing, it is important that the ALR make it clear that the supplemental services mentioned are not mandatory. It is recommended that the zoning of the residential units in the property not be institutional to avoid a conclusion by the IRS that the property is a health care facility.

**Response**

The Department finds that the commentator's recommendations regarding tax credits is beyond the scope of this rulemaking since the rulemaking addresses ALR licensure, not funding issues.

**E. Comment**

One commentator suggested that in order to provide assisted living services to low-income elderly it is essential that the ALR license and relevant regulations accommodate housing-related regulatory features and constraints. The regulations for the newly authorized assisted living services should be as flexible as possible to provide seniors the services they need, allowing them to age in place.

**Response**

The Department submits that this final-form rulemaking adequately provides ALR residents with an environment in which they can age in place. The Department furthermore finds that the commentator's recommendations concerning housing-related regulatory features and constraints are beyond the scope of this rulemaking.

**Section 2800.19  
Waivers**

**A. Comment**

One commentator suggested adding "legal guardian" to the list of those who get a copy of a completed, written waiver request.

**Response**

The Department notes that relettered subsection (f) requires that a copy of the waiver request and the Department's written decision be posted in a conspicuous and public place within the ALR. In addition, the Department added a new

subsection (b) to require the Department to post waiver requests on the Department's website, thereby making them available to the general public, including legal guardians. Also, under subsection (d), the ALR must provide a copy of the completed written waiver request to the resident and the designated person. A designated person may include a legal representative, such as a legal guardian, if so designated by the resident.

#### **B. Comment**

One commentator noted the regulations should state the waiver be initiated by the resident and there should be a period of rescission. The commentator also noted these provisions would prevent misuse by a residence.

#### **Response**

The Department submits that waiver requests are made by an ALR to the licensing authority, which is the Department of Public Welfare. Waiver requests are not made by residents. The Department does not have a direct relationship with residents under these regulations. Instead, the ALR is the entity that is subject to these licensure regulations. Therefore, the ALR is the entity that seeks a waiver of a regulatory requirement under licensing principles. A review of the Department's licensing regulations in other chapters in Title 55 Pa.Code governing residential facilities, including Personal Care Homes (Chapter 2600) and Child Residential Facilities (Chapter 3800), makes clear that it is the facility, not an individual, which seeks waiver of specific regulatory requirements. Thus, the Department declines to make the commentator's requested change.

Regarding a rescission period, subsection (g) provides for an annual review of waivers by the Department and provides that the Department may revoke a waiver if the conditions required by the waiver are not met.

#### **C. Comment**

One commentator stated that no training requirements should be waived for any position.

#### **Response**

Subsection (c) has been amended to require that no staff training requirements may be waived.

#### **D. Comment**

Numerous comments were received requesting that waivers should be automatically granted if conditions are met by an ALR and/or if similar waivers are already approved. These commentators usually also requested that an appeals process be included. Numerous comments were also received asking that no exceptions or waivers be provided when a PCH first seeks to become an ALR.

#### **Response**

As with the PCH regulations, which the Department is required to meet or exceed,

regulatory waivers are granted at the Secretary's discretion and will be carefully reviewed on an individual basis. Based on industry stakeholder comments, an appeals process related to revocation of a standing waiver was added in subsection (g) of this section.

As to comments seeking that no exceptions or waivers be provided when a PCH first seeks to become an ALR, the Department's intent is not to create rigid rules on waivers for existing PCHs but to weigh the merits of each on a case-by-case basis.

**E. Comment**

One commentator noted the form for the waiver request should not be left to the complete discretion of the Department, but rather should be part of a stakeholder process which includes the regulated community.

**Response**

This provision mirrors that of the PCH regulations, which the Department is required to meet or exceed. Using a departmental form ensures that all elements of a waiver request will be complete when the request is submitted.

**F. Comment**

One commentator stated additional language should be added to include the possibility of providing a waiver for the regulations for which the residence and resident have signed an informed consent agreement.

**Response**

The Department finds that ALRs and residents do not have the authority to agree to grant a Department waiver of the regulations. The informed consent process is addressed in § 2800.30 (relating to the informed consent process).

**G. Comment**

One commentator recommended grandfathering is inappropriate for a new classification of licensure. The commentator stated existing PCHs can continue to operate as a PCH but should be required to comply with all assisted living regulations if they intend to operate as ALRs. Another commentator had specific issues with any grandfathering for staff or administrator training, experience or requirements.

**Response**

The Department has not grandfathered existing PCHs as ALRs under this Chapter. However, it has elected to provide certain requirements that will recognize existing stock of PCHs. For example, new qualification requirements have been established for PCH administrators to become ALR administrators. Different square footage requirements have been established for living units in existing PCHs compared to newly constructed ALRs.

#### **H. Comment**

One commentator stated that the listing of items that may not be waived limits a residence's flexibility to make adaptations as circumstances require.

#### **Response**

The PCH regulations, which the Department is required to meet or exceed, lists four items that may not be waived: scope, definitions, applicability or residents' rights. The additional items listed in subsection (c) of this section are included as non-waivable because they directly impact the rights and safety of ALR residents and are based upon consumer comments.

### **Section 2800.20 Financial Management**

#### **A. Comment**

One commentator recommended adding "legal guardian of estate."

#### **Response**

Subsection (a) requires, "A resident may manage his personal finances unless he has a guardian of his estate." By definition, a "guardian" is "one who has the legal authority and duty to care for another's person or property." See Black's Law Dictionary 712 (7<sup>th</sup> ed. 1999). Therefore, the Department did not make the suggested change.

#### **B. Comment**

One commentator noted the regulation does not allow for consumer choice if the resident chooses to have more than \$200 in his account.

#### **Response**

This language mirrors the PCH regulations, which the Department is required to meet or exceed. Consumer choice is preserved since the regulation only requires that the ALR "notify" the resident and "offer assistance" in establishing an interest-bearing account. The resident may accept or reject such an option.

#### **C. Comment**

One commentator noted the current language does not provide for a power of attorney, nor does it address if the individual has dementia.

#### **Response**

The language of subsection (a) requires, "A resident may manage his personal finances unless he has a guardian of his estate." This language provides a resident with the autonomy to handle his own finances unless a court appoints a guardian of his estate. This language mirrors the provisions at § 2600.20 (relating to financial management) in the PCH regulations, which the Department is required to meet or exceed under Act 56.

#### **D. Comment**

One commentator stated the regulations should prohibit the administrator or any other employee of the facility from being required to be representative payee for any resident's Social Security payments.

#### **Response**

For SSI benefits, the Social Security Administration (SSA), not the Department, selects a representative payee under 20 CFR 416.620 (relating to information considered in selecting a representative payee) for payment of benefits. Federal regulations further provide the SSA's order of preference in selecting a representative payee. See 20 CFR 416.621 (relating to what is our order of preference in selecting a representative payee for you?) If the SSA's preferences for an individual to serve as a representative payee are not available, the SSA may select an institution under 20 CFR 416.621 to fulfill this role.

#### **E. Comment**

One commentator recommended that this provision should be fine-tuned to the situation of individuals with brain injury in waiver programs providing assistance for cognitive limitations related to brain injury.

#### **Response**

The Department finds that waiver programs are outside the scope of this final-form rulemaking.

#### **F. Comment**

One commentator had the following recommendations: prohibit residences from requesting or requiring the right to be, or from being, representative payee for residents; prohibit residences from requiring residents to give them authority to handle the residents' funds; prohibit residences from charging residents for handling residents' funds; require residences to give residents, or their estate, a full and complete accounting of any funds handled by the residence within 30 days of a resident's transfer, discharge or death.

#### **Response**

The provisions of this section mirror the PCH regulations, which the Department is required to meet or exceed. The Department's intent is to ensure accountability and tracking of resident funds and expenditures and to prevent theft and exploitation. This section applies only if the resident chooses to have the ALR hold the resident's funds. A resident may still choose to manage his own personal financial affairs. The Department finds that this is in line with the intent of Act 56 to provide residents with choice and decision-making ability.

#### **G. Comment**

Six commentators recommend the administrator not be appointed to serve as representative payee unless the resident, family and legal representatives are first given a standardized disclosure form provided by the Department which explains:

what a representative payee means; that other agencies may be available to provide representative payee service for little or no fee; the representative payee is voluntary; the resident can terminate the representative payee relationship at any time; and information is provided on how to terminate the relationship.

### **Response**

As stated above, for SSI benefits, the Social Security Administration (SSA), not the Department, selects a representative payee under 20 CFR 416.620 (relating to information considered in selecting a representative payee) for payment of benefits. Federal regulations specifically address various topics regarding the representative payee function, including the determination of when a representative payee is needed and the order of preference for a representative payee. See 20 CFR 601 – 665. For these reasons, the Department did not adopt the commentators' suggestions.

## **Section 2800.21 Offsite Services**

### **A. Comment**

One commentator noted the term "offsite services" is not defined in the definition section. The commentator stated that currently, PCH residents are transported to another location to secure meals and medications and this has caused problems for them. In addition, if assisted living facilities will be providing services to a more frail population, it wouldn't support the concept of aging in place if services are not onsite.

### **Response**

The Department has elected not to define "offsite services" and intends its usual and customary dictionary definition, which is "not located or occurring at the site of a particular activity" as found in the tenth edition of the Merriam Webster's Collegiate Dictionary.

### **B. Comment**

Six commentators recommended that personal assistants should be included in attending offsite activities and be permitted to travel on arranged transportation with the resident.

### **Response**

The Department submits that if the resident support plan requires staff support with offsite activities, then the ALR is required to include them. In addition, Section § 2800.171 (b)(7) (relating to transportation), requires that an assistant be provided, if necessary, to escort residents in and out of the ALR and provide assistance during trips.

## **Section 2800.22 Application and Admission**

**A. Comment**

Twenty-four commentators stated it is unreasonable and unnecessary for potential residents to receive copies of the facility rules and regulations. They noted this is cost prohibitive, wasteful of resources and could cause applicants to feel overwhelmed, as this information is explained at the time of admission. In addition, they stated the Department does not need to approve the information a facility chooses to cover in their handbook. Other commentators requested clarification on how the Department will approve the resident handbook, if it will require approval each time there is a change and how long approval will take.

**Response**

An ALR's rules and regulations contain health and safety information that is important to consider when choosing an ALR. The Department maintains that a potential resident and his family need materials they can review at their own pace in order to make informed decisions on which ALR to choose. Having this information is an important consumer protection. The Department must approve the resident handbook to identify any conflicts with Act 56 or these regulations. Review of the handbook will occur at the time of application for licensure and subsequently during the inspection process. The time the review will take will depend on any problems identified with its provisions.

**B. Comment**

What form is used and who completes the pre-admission screening, a physician or advanced nurse practitioner?

**Response**

The Department has changed the term "pre-admission screening" to "initial assessment." Initial assessments must be completed by the administrator, administrator designee, or licensed practical nurse, under the supervision of a registered nurse, or a registered nurse as specified under § 2800.224(a)(1) (relating to initial assessment and preliminary support plan). Section § 2800.224(a)(4) provides that an ALR may use its own assessment form if it includes the same information as the Department's assessment form.

**C. Comment**

One commentator stated that the Department should seek input from the medical community regarding the types of forms mandated by the Department.

**Response**

Forms developed by the Department for ALRs will be created in consultation with industry stakeholders, consumers and other interested parties, which may include the medical community.

**D. Comment**

One commentator stated a provision should be added to clarify that a resident who is capable of managing his own affairs may do so and, therefore, is not required to

name a responsible person at the time of admission. The commentator further stated consumers be encouraged and educated on the importance of identifying a responsible person, but again, this should not be a requirement.

**Response**

The Department concurs with the commentator. Naming of a designated person is at the discretion of the resident.

**E. Comment**

Four commentators recommended consumers have access to easy-to-understand materials to help them make an informed choice before they apply for residency.

**Response**

The Department agrees with this recommendation.

**F. Comment**

Nine commentators questioned the timeframe for medical evaluations stating that the regulations should allow medical evaluations to be performed after admission.

**Response**

The Department revised subsection (a)(1) to require that medical evaluations must be completed within 60 days prior to admission or 15 days after admission in certain circumstances as outlined in subsection (a)(2).

**G. Comment**

The Department received many comments, including a comment from one legislator, with respect to the timing of the initial assessment process and development of support plans, asserting that there were gaps in the timeline.

**Response**

The Department carefully considered these concerns and made appropriate amendments to subsections (a)(1) (a)(2), and (a)(3) to strengthen assessment and support plan provisions and to allow sufficient time for thorough assessments and the development of comprehensive support plans. These changes should allay the commentators' concerns.

**H. Comment**

One commentator stated the content of the pre-admission screening form has not been determined. The commentator questioned if this form seeks only to screen for "excludable conditions?" The commentator stated the form should be user-friendly so practitioners can help potential residents decide on the best long-term care option. In addition the commentator noted the proposed regulations do not specify whether the MA-51 will be used for the medical evaluation. The commentator stated this form does not promote the kind of adequate evaluation needed in this setting.

**Response**

Forms developed by the Department for ALRs will be created in consultation with industry stakeholders, consumers and other interested parties. The Department will strive to have forms that are user-friendly. Regarding the MA-51, this form is no longer used by PCHs and has been replaced by the Adult Residential Licensing Personal Care Home Assessment form.

**I. Comment**

One commentator stated all information about all eventualities cannot be communicated to residents and their families at the moment of admission. The commentator stated protocols, which involve the resident's health, that an ALR has established and follows, should be included in an orientation manual or packet of information that is provided to new residents and their families. In addition, the commentator noted formal orientation materials for residents and their families, agents and guardians should be required. The commentator further noted that where an ALR has a personnel policy manual it should include policies on resident ADLs, IADLs and other resident care issues, and the ALR should make that information available to residents during orientation.

**Response**

The Department requires in subsection (e) that upon application for residence and prior to admission to the ALR, the licensee must provide each potential resident or potential resident's designated person with written disclosures that include a list of the non-waivable resident rights, a copy of the contract the resident will be asked to sign, a copy of ALR rules and the resident handbook. The resident must be provided with specific information about the services and the core packages, the cost of those services and the cost of the core packages when a potential resident may require the services offered in a different core package, the contact information for the Department, the licensing status of the most recent inspection reports and instructions for access to the Department's website for information on the ALR's most recent inspection reports, the number of living units in the ALR that comply with the Americans with Disabilities Act and disclosure of any waivers that have been approved for the ALR and are still in effect. The Department maintains that these disclosures adequately protect the health and safety of residents.

The Department finds that information concerning ADLs and IADLs is highly individualized and is included in the preliminary and final support plan of each resident, copies of which are to be provided to the resident and their designated person. See § 2800.224(b)(3)(c)(10) (relating to initial assessment and preliminary support plan) and § 2800.227(k) (relating to development of final support plan).

**J. Comment**

One legislator stated that information regarding the discharge and transfer policies of the residence, including the resident's right to appeal a decision, as well as information on the appeal procedure and the reason for the discharge or transfer should be included in subsection (e).

**Response**

Regarding appeals, the Department does not have jurisdiction under Article X of the Public Welfare Code or Act 56 to adjudicate resident appeals. As addressed in the Preamble, a resident's transfer or discharge is a contract matter between the resident and the ALR and, as such, the Court of Common Pleas has jurisdiction unless other provisions are made in the contract for dispute resolution such as mediation or arbitration. Section 2800.228 (relating to transfer and discharge) outlines the conditions for which a resident can be transferred and discharged.

**K. Comments**

One commentator suggested disclosure should be provided to the potential resident's legal guardian(s).

**Response**

This is covered under subsection (e), which allows for the involvement of a resident's designated person. This may include a legal representative as provided in § 2800.4 (relating to definitions) to include an individual who holds a power of attorney, a court-appointed guardian or other person legally authorized to act for the resident.

**L. Comment**

One commentator questioned what ALRs must disclose in the marketing materials about products, policies and procedures. The commentator stated that the regulations stipulate that potential residents be provided with specific disclosures, but the list is limited and disclosures will only occur upon the resident's application for residency.

**Response**

The Department does not wish to dictate marketing content to ALRs and has elected not to incorporate this provision into the regulations.

**M. Comment**

Ten commentators support regulatory guidance on what is appropriate marketing. Marketing must follow state consumer protection laws against fraud and deceptive practices. It is recommended that a section be created that speaks to marketing of ALRs. That section should address such issues regarding how ALRs present the ability to age in place and how residents would be able to continue residency when care needs change or the resident's funds are spent down.

**Response**

The Department does not wish to dictate the marketing practices of ALRs. It furthermore submits that enforcement of consumer protection laws is provided for under § 2800.18 (relating to applicable laws).

**N. Comment**

One commentator recommended that a resident should have the right to a comprehensive needs assessment and to participate (along with others invited by the resident) in the assessment process prior to admission or within 72 hours of admission. They noted in the case of an urgent or emergent admission due to hospital discharge the resident should receive a copy of their current assessment without charge.

**Response**

The Department has elected not to make this change. Act 56 requires the Department to meet or exceed the PCH regulations, which this language accomplishes. The under § 2800.224 (relating to initial assessment and preliminary support plan) require that initial assessments occur within 30 days prior to admission except in instances where a resident is coming directly from a hospital, is escaping an abusive situation or has no alternative living arrangement. In those cases initial assessments are permitted to be conducted within 15 days after admission. The Department maintains that this provides sufficient flexibility to the ALR in performing assessments and developing preliminary support plans but takes into consideration extenuating circumstances. Section 2800.224(c)(7) provides that an individual shall be encouraged to participate in the development of the preliminary support plan and he may include a designated person or family member in making decisions about services.

The Department submits that this strikes a balance between providing a consumer-oriented process and addressing practical aspects facing ALRs. In regards to provision of a copy of the current assessment form being given to a resident in the case of emergent admission due to a hospital discharge, it is unclear to the Department how this could be achieved since the assessment is not done until after the individual enters the ALR.

**Section 2800.23  
Activities**

**A. Comment**

One commentator stated they were unsure how these provisions related to activities.

**Response**

As used in the section, "activities" relate to both ADLs and IADLs as outlined in § 2800.4 (relating to definitions). The final-form regulation also clarifies that the residence shall provide appropriate cueing for both ADLs and IADL as indicated in the resident's assessment and support plan.

**Section 2800.24  
Personal Hygiene**

**A. Comment**

One commentator stated there is no mention of incontinence care for persons with bowel or bladder incontinence and regarding foot care. Would the ALR have a contract for podiatry services?

**Response**

The Department submits that assistance with toileting is considered an ADL as defined in § 2800.4 (relating to definitions) and is one of the core services in § 2800.220(b) (relating to service provision). Personal hygiene covers foot care. See § 2800.24(7). The need for podiatry services would depend upon a resident's support plan.

**B. Comment**

One commentator noted that although it states the ALR is responsible for assisting in personal hygiene, it does not specify the frequency.

**Response**

The Department submits that a resident's support plan would provide details on the frequency of support a resident needs with personal hygiene. Under § 2800.57 (relating to direct care staffing) a direct care staff person must be available to provide at least one hour per day of assisted living services to a mobile resident and at least 2 hours per day to an immobile resident.

**Section 2800.25  
Resident-Residence Contract**

**A. Comment**

Ten commentators stated that the language regarding the fee schedule of services that will be available to the individual is unclear. The commentators stated clarification is needed regarding whether or not core services can or cannot be bundled or unbundled.

**Response**

The regulations have been amended under § 2800.220(c) (relating to service provision) to require that ALRs offer two core packages. Section 2800.25(c)(2) requires that contracts contain a fee schedule that lists the actual amount of charges for each of the services that are included in the resident's core package.

**B. Comment**

Twenty-seven commentators expressed concern over the notice requirements for terminating a contract. Commentators stated the two parties entering into the agreement should have equal contract termination rights. They also stated there is no basis for allowing the resident to terminate the contract with 14 days notice while binding the provider to 30 days notice. Additionally they stated receiving a 14-day notice from a resident would significantly impact budgetary operations and increase admission costs to residents. They stated that it is not adequate time to plan a discharge and ensure the departing resident has adequate services in place.

**Response**

The Department maintains that provision of the 14-day notice period is an enhanced consumer protection and has, therefore, not made the recommended change.

**C. Comment**

Twenty-eight commentators recommended the resident have the right to rescind the contract up to 72 hours after admission, but not up to 72 hours after the initial support plan is provided. They stated this is too long a time period to be able to rescind a contract when the ALR is not given the same timeframe. They further stated this is burdensome to providers and does not exist in either personal care or nursing homes.

**Response**

The Department has relettered subsection (h) by removing the provision allowing a contract to be rescinded up to 72 hours after receipt of the initial support plan.

**D. Comment**

One commentator requested "legal guardian" be added to subsections (a) and (b).

**Response**

The resident's "designated person" is referenced in these subsections. The Department submits that a designated person, as defined in § 2800.4 (relating to definitions) may be the resident's legal representative which includes a court-appointed guardian or other person legally authorized to act for the resident.

**E. Comment**

Two commentators requested further explanation on subsection (i): "Supplemental health care services must be packaged, contracted and priced separately."

**Response**

This language was taken directly from Act 56. See 62 P.S. §1021 (a)(2)(iii).

**F. Comment**

Eight commentators questioned subsection (d), which prohibits an ALR from seeking or accepting payments from any rent rebate funds received by non-SSI residents. They noted since these regulations are required by Act 56 to meet or exceed the PCH regulations, how can they exclude the poorest residents from this financial protection. They further stated a clause should be added allowing the use of SSI funds not to exceed half of the funds.

**Response**

Based on consensus achieved with industry stakeholders, consumers and other interested parties, the Department has changed the language in this subsection to

mirror the language of a statement of policy issued by the Department relating to PCHs at 39 Pa.B. 2346 (May 9, 2009).

**G. Comment**

Six commentators recommended an ALR should not require a cosigner on the agreement. They stated the Nursing Home Reform Law prohibits this in nursing homes and it is inappropriate for a family member to be forced to be responsible for the resident's cost of care.

**Response**

The Department submits that subsection (b) provides that it is a resident's decision whether or not to have a cosigner.

**H. Comment**

Two commentators recommended information on advanced directives be provided to the resident at the time of admission. They stated the completion of an advanced directive not be a condition of admission or retention. They noted that providing information is an important part of resident choice as is ensuring that resident's wishes are respected. They noted that a copy of the completed directive should be part of the resident's file and a copy provided to the resident's personal physician. They stated specific provisions need to be added to require contract language that is understandable to the resident and legal representative.

**Response**

The Department maintains that this is a matter of personal choice and declines to specify how ALRs address the issue except to require that, if a resident has an advance directive, it must be available at all times for each resident and shall accompany the resident when he needs emergency medical attention. See § 2800.143(b)(11) (relating to emergency medical plan).

**I. Comment**

Three commentators stated the term "resident-residence contract" is awkward and could lead to error or misunderstanding. The commentators noted this could be replaced with "consumer-facility", "resident-provider", "ALR-resident" or simply "resident contract."

**Response**

The Department finds the term "resident-residence contract" is sufficiently clear and is consistent with the language of Act 56, which refers to a "resident" and a "residence."

**J. Comment**

One commentator recommended the addition of the following language to subsection (c): "add a provision to address what happens if/when a resident runs out of money—safeguards available to residents." "Add the list of excludable

conditions detailed in 2800.229 and detail what will happen if the resident is diagnosed with an excludable condition while residing in the facility.”

**Response**

After careful consideration the Department declines to add the recommended language. Section 2800.228(h)(5) (relating to transfer and discharge) clearly provides that failure to pay after reasonable documented efforts by the ALR to obtain payment is grounds for discharge. Regarding excludable conditions, the Department finds it inappropriate to require that they be listed in resident-residence contracts. 62 P.S. § 1057.3(g) provides that, if an ALR is permitted to admit or retain a person with an excludable condition, the ALR must be able to meet the health care needs of that person. The Department submits that an ALR will not know at the time a contract is entered into if a resident will develop an excludable condition, what the excludable condition will be and whether the ALR will be able to safely treat a resident with that condition. The Department, therefore, declines to make the suggested change.

**K. Comment**

One commentator stated that all form contracts used by an ALR should be reviewed by the Department for conformity to Department regulations upon initial licensing and thereafter on a regular basis. The commentator noted review of these contracts will avoid consumer problems and violations of regulations since residents have limited resources to obtain legal opinions.

**Response**

As part of the initial and ongoing licensing inspections, the Department will review contracts used to determine licensee compliance with the provisions in the regulations.

**L. Comment**

Two commentators recommended the following: Require that ALRS give residents at least 60 days advance notice before increasing rates; require that ALRs waive the requirement that residents give 14 days advance notice upon their death; prohibit ALRs from charging admissions fees; prohibit contracts from waiving any statutory or common law rights of residents and to include waivers of liability; require a pre-admission needs and cost assessment to determine if the ALR can meet a consumer's specific needs prior to signing a contract.

**Response**

Subsection (c)(10) provides that a resident is entitled to at least 30 days' advance notice, in writing, of the ALR's request to change the contract. The Department finds this period of notice to be adequate. As to admission fees, the Department does not regulate private fees and maintains that this is a contract matter between the ALR and the resident. If a potential resident does not wish to pay an admission fee, he has the option of choosing another ALR. Concerning the waiving of rights,

it is unclear to the Department what the commentator's intent is with respect to the commentators' use of the phrase "any statutory or common laws."

The commentators' concerns about pre-admission needs determination have been addressed in § 2800.224 (relating to initial assessment and preliminary support plan). Cost assessments are outside the scope of this licensure rulemaking.

#### **M. Comment**

One commentator questioned whether supplemental health services will be billed to Medicare or billed to the consumer. The commentator wonders how it would be managed if a patient's primary care physician orders skilled nursing care or physical therapy.

#### **Response**

The Department finds that third-party billing issues are beyond the scope of this rulemaking.

#### **N. Comment**

One commentator recommended adding a clause that acknowledges life-care CCRC contracts and the existing procedures for residents who are moving through a continuum of care. The commentator stated a distinction be made between CCRC/life-care residents and per-diem residents when requiring a 72-hour rescission. The commentator further noted the termination notice should distinguish between a life-care resident and a per-diem care resident.

#### **Response**

This rulemaking defines licensure requirements for ALRs and is not intended to address other facility types.

#### **O. Comment**

Six commentators recommended the contract specify the rental amount and include 24-hour-a-day monitoring. They noted the regulations should clarify that the ALR has no right to unilaterally change an existing contract. They further stated the ALR could terminate and negotiate a new contract but not unilaterally modify the contract.

#### **Response**

The needs of each individual resident, including the degree to which a resident requires monitoring, will be determined by their assessment and support plan. Section 2800.220 (relating to service provision) has been amended to include "24-hour supervision, monitoring and emergency response" as a component of assisted living services. As to the unilateral amendment of the contract, the regulation provides that a resident is entitled to 30 days' advance written notice of changes to the contract. Whether to accept or reject such a change will be up to the resident.

## Section 2800.26 Quality Management

### A. Comment

One commentator recommended this regulation contain the following: indicate the right to review the quality management plan; state who will approve the plan; how the resident is informed of the procedure; how the complaint will be addressed and in what timeframe; and a non-retaliation provision.

### Response

The quality management plan in this section requires an ALR to establish and implement a plan that the Department reviews. The components of this plan mirror those in the PCH regulations, which the Department is required to meet or exceed. The quality management plan will be used as a management tool for an ALR to improve the quality of the ALR based upon the factors included in subsection (b)(1-5). This entails conducting a system-wide, overarching review to detect patterns of problems and to identify areas for improvement. This plan is not intended for residents to review, but rather for the ALR to use to improve its operations.

With respect to the commentator's concerns related to complaint procedures, the regulations provide comprehensive procedures for review and handling of resident complaints. For example, various sections in the regulation provide for the right to make a complaint without retaliation as requested by the commentator. Section 2800.41(a) (relating to notification of rights and complaint procedures) specifically requires "upon admission, each resident...shall be informed of residents' rights and the right to lodge complaints *without intimidation, retaliation or threats of retaliation* by the residence or its staff persons against the reporter." (Emphasis added.) Section 2800.42(t) (relating to specific rights) similarly provides, "A resident has the right to file complaints ... grievances or appeals with any individual or agency and recommend changes in policies, residence rules and services of the residence *without intimidation, retaliation or threat of discharge.*" (Emphasis added.) Further, not only does § 2800.44 (relating to complaint procedures) provide the language that complaints are permitted without retaliation or threat or retaliation, but this section specifically provides the complaint procedures process, including that within 2 business days after the submission of a written complaint, a status report shall be provided to the complainant and that within 7 days after the submission of a written complaint the ALR shall give the complainant a written decision explaining the investigation findings and the action the ALR plans to take. The Department maintains that these enhanced consumer protections should satisfy the commentator's concerns that resident complaints be dealt with in a timely manner without fear of retaliation.

### B. Comment

One commentator recommended the regulations state a family council at any ALR may, at its own discretion, organize, function and meet independently of the direction and control of the ALR. The commentator stated the ALR should work

directly with the family council to identify and solve problems, clarify issues and obtain solutions. In addition the commentator noted ALR staff, including the administrator and nursing staff, should be available to participate with the family council designees and to set agenda items and programs. The commentator noted that at the time of admission the ALR should provide notice to the residents and family members of the existence of the council and the names, phone numbers and email addresses of its officers, chairperson(s) or other designees.

**Response**

The Department notes that there is no requirement that ALRs have family or resident councils. The quality management plan must address resident or family councils, or both, if applicable. This language mirrors that of the PCH regulations under §2600.26 (relating to quality management), which the Department is required to meet or exceed.

**C. Comment**

One commentator stated that the regulations do not go far enough toward the promise of quality care. The commentator said that while the regulations take steps in the right direction, they do not make adequate strides towards assuring safe and accessible physical sites, meeting residents' care needs and guaranteeing that all consumers have meaningful rights of which they are aware and that they are free to exercise their rights. The commentator urged the Department to take steps toward ensuring that residents can be effectively served in ALRs.

**Response**

The Department submits that these regulations promote quality care. Section 2800.18 (relating to applicable laws) requires that ALRs comply with applicable Federal, State and local laws, ordinances and regulations. This would include laws that govern the accessibility of buildings, including the Americans with Disabilities Act. Section 2800.224 (relating to initial assessment and preliminary support plans) provides for an enhanced process whereby a residents' needs are identified through an initial assessment and a preliminary support plan is developed to address those needs. Under § 2800.225(c) (relating to additional assessments), additional assessments are to be completed annually, or more frequently if the condition of a resident changes, or at the request of the Department on cause to believe that an update is required. Under § 2800.227 (relating to development of the final support plan), final support plans are to be developed and reviewed on a quarterly basis. At the request of industry stakeholders, consumers and other interested parties, the regulations now include both an independent and an enhanced core package of services under § 2800.220 (relating to service provision). A provision has also been added to the Special Care Unit provisions in § 2800.231 (relating to admission) to allow for units for individuals with brain injury. Additionally, at the request of consumers, the Department has identified resident rights, which are found throughout the regulations, and has placed them in Appendix A (relating to resident rights).

**Section 2800.27**  
**SSI Recipients**

**A. Comment**

One commentator recommended "special needs trust" be included in subsection (b).

**Response**

The commentator's suggestion is beyond the scope of statutory language at 62 P.S. §1057.3(a)(8). The language in subsection (b) is taken directly from the law and mirrors the PCH regulations, which the Department is required to meet or exceed under Act 56.

**B. Comment**

One commentator questioned if SSI recipients or other eligible consumers would be able to qualify for the state supplement for PCH in ALRs.

**Response**

Current Department regulations at § 299.1 (relating to policy) provide for an SSP for individuals in Domiciliary Care Homes and in PCHs. To extend the SSP to individuals residing in an ALR would require amendment of § 299.22 (relating to eligibility requirements for SSA-administered optional SSP for DCS and PCS). Such an amendment is outside the scope of this rulemaking.

**C. Comment**

One commentator questioned if SSI funding would be taken from (or shared with) PCH.

**Response**

SSI funding is provided to individual consumers, not facilities.

**D. Comment**

One commentator noted SSI does not reflect fiscal circumstances of individuals supported by the Department of Health (DOH) and Department of Public Welfare (DPW) programs. The commentator noted that this section should address the terms of support under DOH and DPW residential programs.

**Response**

The Department submits that these regulations do not address funding issues but rather address the licensing of ALRs. Funding issues are outside the scope of these regulations.

**E. Comment**

Six commentators recommended neither SSI recipients nor third parties acting on behalf of SSI recipients should be charged for room, board or services required to

be provided by the facility outside of the SSI plus SSI Supplemental contract amount. Home and Community Based Services (HCBS) waiver residents should be charged for room and board, but not charged for services of any kind.

**Response**

Subsection (a) requires that if an ALR agrees to admit a resident who is eligible for SSI benefits, the ALR's charges for actual rent and other services may not exceed the SSI resident's actual current monthly income reduced by the current personal needs allowance. In regards to an HCBS waiver, waiver rates are outside the scope of these regulations.

**F. Comment**

Two commentators noted that the requirements for the ALR to deal with SSI income of residents are different from the standards utilized in the personal care regulations. They stated it is important, for the sake of the resident, to provide consistency and clarity regarding all financial management issues. They noted this would include the management of SSI benefits. In addition, they recommended that the administrator or staff should seek or accept payments from funds received as retroactive awards of SSI benefits, but only to the extent that the awards cover periods of time during which the resident actually resided in the ALR and for which full payment had not been received.

**Response**

The provisions of § 2800.27 (relating to SSI recipients) are based on the provisions of § 2600.27 (relating to SSI recipients). These include requiring that charges for actual rent or other services may not exceed the SSI resident's actual current monthly income reduced by the current personal needs allowance; and that the administrator or staff may seek and accept payments from funds received as retroactive awards of SSI benefits, but only to the extent that the retroactive awards cover periods of time during which the resident actually resided in the PCH or ALR and for which full payment has not been received. Both §§ 2800.27 and 2600.27 require that similar items or services be provided to residents at no extra charge, including personal hygiene items, laundry services for personal laundry and personal care services (in PCHs) or assistance or supervision in ADL or IADL, or both (in ALRs).

**G. Comment**

Twenty-eight commentators noted the proposed regulation does not include any means of additional publicly-funded reimbursement to ALRs. The commentators questioned whether there will be reimbursement and asked when ALRs can reasonably expect payment parameters to be established. The commentators noted there are many low-income individuals who would require care in an ALR who would be denied admission due to a lack of funds to pay privately.

**Response**

While the Department intends to apply for a Medicaid waiver after the final-form regulation is published, funding issues are outside the scope of these licensure regulations.

### **Section 2800.28 Refunds**

#### **A. Comment**

One commentator noted that when a resident leaves prior to the required 14 days, the resident should not be charged for supplemental health services if they are not provided directly by the ALR.

#### **Response**

If supplemental health services are not provided by the ALR, the contract between the resident and the provider of supplemental health care services would determine this issue. This is covered in the regulation which provides a refund for supplemental health care services will be given "if applicable."

#### **B. Comment**

Various comments were received suggesting changes in the timeframes for payment of refunds depending on the day the resident leaves the ALR.

#### **Response**

The Department has elected to retain the current language related to refunds and maintains that the provisions contain consumer protections that provide maximum consumer choice.

### **Section 2800.29 Hospice Care and Services**

#### **A. Comment**

One commentator stated the regulations should clarify that home health care and services are permitted in ALRs.

#### **Response**

The Department finds that the list of supplemental health care services listed in § 2800.220(e) (relating to service provision) includes home health services. Consequently these services are permitted in ALRs since the ALR must provide supplemental health care services as a condition of licensure.

#### **B. Comment**

One commentator is pleased hospice care is available in ALRs. However, the commentator requested clarification regarding the following: if a resident develops one of the excludable conditions and decides to elect hospice does the ALR request the exception for the excludable condition?

**Response**

It is up to the ALR decide whether to submit an exception for the excludable condition to the Department. See § 2800.229(f) (relating to excludable conditions; exceptions).

**Section 2800.30  
Informed Consent Process****A. Comment**

Sixteen commentators stated it is redundant to have the ombudsman present to address issues that a resident's legal representative is involved in. They stated that notifying the ombudsman in each instance of disagreement is punitive as it violates the resident's privacy and consent. In addition they noted the potential for unnecessary workload demands on the Area Agencies on Aging make this requirement unlikely to be used by the local ombudsman. They stated under no circumstance should the licensee directly notify the ombudsman of an informed consent process or any other resident matter. They further stated this type of involvement violates the confidentiality of the ombudsman-resident relationship and the resident's right to refuse ombudsman services. One commentator recommended the process the state of New Jersey has adopted in managing risk agreements.

**Response**

As recommended by commentators, the Department has amended subsection (c)(1) to limit the involvement of an ombudsman by requiring that an ALR only provide the competent resident with the ombudsman's contact information. The Department has retained the requirement that for an incompetent resident, the ombudsman be automatically notified by the ALR. The Department contends that there is no violation of privacy by merely requiring notice to the ombudsman. Regarding managed risk agreements, the state of New Jersey's managed risk agreements embody a process of balancing resident choice and independence with the health and safety of the resident and other persons in the facility or program. The Department finds the informed consent process of the final-form rulemaking more detailed and flexible than the New Jersey model and has, therefore, elected to retain it.

**B. Comment**

One commentator questioned if there is a specific form required to update an informed consent agreement following a significant change that affects the risk potential to residents. Another commentator requested that the form size, type of form and form content be specified along with a checklist of requirements.

**Response**

Informed consent agreements are highly individualized and unique to each situation. Subsection (j) requires that an informed consent agreement must be updated following a significant change in a resident's condition that affects the risk

potential to the resident or persons other than the resident. No specific form is required to update an informed consent agreement.

**C. Comment**

Five commentators stated that a resident who is unable to understand the choices and consequences of an informed consent agreement should have a health care decision maker appointed. They noted this appointed person should be permitted to speak for the resident.

**Response**

Matters related to appointment of a health care decision maker are governed by Pennsylvania law at 20 Pa.C.S. §§ 5421 *et seq.*

**D. Comment**

Two commentators recommended the following language: "When a licensee determines that a resident's decision, behavior or action creates a dangerous situation and places the resident at risk of harm by the resident's wish to exercise independence in directing the manner in which he/she receives care, the licensee may initiate an informed consent process to address the identified risk and to reach a mutually agreed upon plan of action with the resident or the resident's designated person. The initiation of an informed consent process does not guarantee an informed consent agreement, which is agreeable to all parties, will be reached and executed."

**Response**

The Department submits that this section already contains language which clearly states that initiation of the informed consent process does not guarantee that agreement will be reached or an informed consent agreement will be executed.

**E. Comment**

Ten commentators noted a full and complete disclosure to the resident and their representative on available alternatives should be made in writing to the resident prior to any negotiation. They also recommended the creation, within the Department or the Office of Long Term Living, of an independent Review Committee to hear disputed negotiations that would review the case before a resident is discharged.

**Response**

Under the definition of "informed consent agreement" in Act 56, these agreements are to be entered into after thorough discussion between the involved parties. The Department interprets thorough discussion to include a discussion between the parties of reasonable alternatives. The Department has elected not to establish an Independent Review Committee. Statutory language under 62 P.S. §1021(a)(2)(vii) requires that agreements be entered into upon mutual agreement of the resident and the ALR. It does not call for third-party involvement to hear disputed negotiations.

**F. Comment**

Seven commentators stated a resident should have the right at any time to terminate the informed consent agreement. They stated such termination would be effective upon issuance.

**Response**

In response to comments received, the Department added subsection (k), which requires that either party has a right to rescind the informed consent agreement within 30 days of execution of the agreement.

**G. Comment**

Eight commentators stated ALRs should be required to submit a copy of each informed consent agreement to the Department for tracking and review. Additionally, they stated an ALR must report to the Department any discharge resulting from an unsuccessful informed consent negotiation. In conclusion, they recommended the Department track and report patterns and practices on the use of informed consent agreements.

**Response**

The Department has elected not to require additional reporting by the ALR with regards to informed consent. Consent agreements will be reviewed as part of the record review of an ALR during a licensure survey or complaint investigation. In the event the parties agree, an informed consent agreement must be maintained in the resident's file. If the parties disagree, the licensee shall notify the resident and the resident's legal representative and other individuals involved.

**H. Comment**

Five commentators stated that an informed consent agreement should release an ALR from liability. Three commentators recommended the following language: "Execution of an informed consent agreement shall release the provider from liability for adverse outcomes resulting from actions consistent with the terms of the informed consent agreement. The agreement shall not constitute a waiver of liability with respect to acts of negligence or tort."

**Response**

Subsection (i) requires that "Execution of an informed consent agreement does not constitute a waiver of liability beyond the scope of the agreement or with respect to acts of negligence, tort, products defect, breach of fiduciary duty, contract violation, or any other claim or cause of action. An informed consent agreement does not relieve a licensee of liability for violation of statutory or regulatory requirements promulgated under this Chapter nor does it affect the enforceability of regulatory provisions including those provisions governing admission or discharge or the permissible level of care in an assisted living residence." The Department maintains that these provisions sufficiently address the commentators' concerns. Regarding the five commentators who suggest alternate language concerning

release of liability, the Department maintains that Act 56, in 62 P.S. § 1021(a)(2)(vii), makes clear that the informed consent agreement releases the facility from liability for adverse outcomes resulting from actions consistent with the terms of the informed consent agreement.

#### **I. Comment**

Two commentators noted the statement "cognitively impaired resident" is vague. They stated a resident whose impairment is medically documented may provide valuable insight and judgment in care planning. In conclusion, the commentators stated informed consent meetings should establish what types of measures will be used to evaluate the capacity of the individual to enter into an informed consent agreement. Three additional commentators stated that trying to initiate an informed consent agreement with a cognitively impaired resident requires the resident to fully comprehend choices and consequences.

#### **Response**

Based on comments received, the Department has amended this section by inserting "incompetent" instead of "cognitively impaired," and by distinguishing between competent and incompetent residents. The Department has looked to the definition found in the Pennsylvania Decedents, Estates and Fiduciaries Code related to health care directives and out-of-hospital nonresuscitation orders for guidance. The Department has also clarified that 20 Pa.C.S. § 5422 (relating to definitions) provides the following definition: "Competent." A condition in which an individual when provided appropriate medical information, communication supports and technical assistance, is documented by a health care provider to do all of the following: (1) understand the potential material benefits, risks and alternatives involved in a specific proposed health care decision. (2) make that health care decision on his own behalf. (3) communicate that health care decision to any other person. This term is intended to permit individuals to make some health care decisions, but incompetent to make others." "Incompetent" is defined as " a condition in which an individual, despite being provided appropriate medical information, communication supports and technical assistance, is documented by a health care provider to be: (1) unable to understand the potential material benefits, risks and alternatives involved in a specific proposed health care decision; (2) unable to make that health care decision on his own behalf; or (3) unable to communicate that health care decision to any other person.

#### **J. Comment**

One commentator stated informed consent for residents in special care units should include the resident, the resident's family, Power of Attorney, guardian and care team. Three other commentators noted the need to specify the process for informed consent agreements for residents with diagnosed or suspected dementia.

#### **Response**

In this section, the Department has distinguished between "competent" residents and "incompetent" residents as noted above. In the case of "incompetent"

residents, subsection (a)(2) provides that when the ALR initiates the informed consent process, an incompetent resident shall be eligible for an informed consent agreement only if the resident's legal representative is included in the negotiation of the informed consent agreement and executes the agreement. Section 2800.231(a) (relating to admission) provides the special care unit regulations are in addition to the other provisions of Chapter 2800.

#### **K. Comment**

Two commentators made the following recommendations: In the last line after "other residents", insert "or staff"; the expression "other residents or staff members" later becomes "persons other than himself" or similar expressions (the wording should be consistent); the wording "should the consumer so choose" should be added between the words "process" and "and".

#### **Response**

The Department agrees and has amended this section to use consistent terminology.

#### **L. Comment**

Two commentators noted this process will need to be a focal point of education/training programs to ensure its use and structure are fully understood and properly implemented. They stated the process should be clear so an ALR and its residents cannot be limited in handling a resident who causes problems. The commentators further noted the potential disruption to the operation of an ALR is a critical issue which must be carefully addressed. In conclusion, the commentator stated language of the current regulations suggests that cognitively impaired residents are more protected than others, yet both categories of residents are in need of advocacy.

#### **Response**

The Department agrees that this section will require training on the parameters and procedures relating to informed consent. The process outlined in the regulations was based on recommendations by the American Association of Retired Persons (AARP) during stakeholder meetings that included industry stakeholders, consumers and other interested parties. In response to the concern related to disruptive resident behavior, the informed consent process acknowledges that if the parties are unable to come to agreement, discharge may be an option for the ALR to pursue under subsection (f). In regards to the concern that the informed consent process provides more protection to individuals with cognitive impairment than others, subsection (c) requires that an individual who is not incompetent is entitled, but not required, to involve his legal representative and physician, and any other individual the resident wants involved, to participate in the informed consent process. The Department maintains that this is consistent with the legislative intent of Act 56 to provide residents with the ability to exercise decision-making and personal choice.

**M. Comment**

One commentator noted unsafe actions or behaviors on behalf of the resident should be explored to the greatest extent possible prior to admission. He stated some areas to consider include the following problem situations: alcohol abuse, drug use (both legal and illicit) and diabetics who are non-compliant with diet and/or medications.

**Response**

The Department submits that this concern would be addressed through the admission screening process, which includes a complete medical examination, an initial assessment, and a preliminary support plan. Furthermore, under Act 56, and ALR is required to refer an applicant whose needs cannot be met by the ALR to an appropriated assessment agency. See 62 P.S. § 1057.3 (a)(3).

**N. Comment**

One commentator stated the informed consent process should address how to discharge a resident if their behavior remains unacceptable.

**Response**

The Department finds that the relationship between informed consent and transfer and discharge is adequately addressed in subsection (f), which requires that the ALR must inform the resident, the resident's legal representative and the individuals involved in the negotiation at the resident's request whether the ALR will issue a notice of discharge. Section 2800.228 (relating to transfer and discharge) fully details the transfer and discharge process.

**O. Comment**

One commentator noted the resident's cognitive assessment should be evaluated prior to enrollment and then annually. The commentator stated that assessment should include the ability to participate in the informed consent process for any future bad behavior.

**Response**

Section 2800.224 (a)(5)(ii) (relating to initial assessment and preliminary support plan) details an enhanced assessment process that includes an assessment of one's mobility needs. As defined in § 2800.4 (relating to definitions), a resident with mobility needs includes an individual who has difficulty in understanding and carrying out instructions without the continued full assistance of other individuals. Thus, the assessment process does include an assessment of cognitive difficulties. The Department finds, however, that it is not feasible to include in assessments possible future "bad" behavior since behavior is unpredictable and not static.

**P. Comment**

One commentator noted there is no assistance or protections for those residents between the ages of 18 and 59. The commentator noted the long-term care

ombudsman only serves those residents age 60 and over. In conclusion the commentator stated this oversight should be corrected.

**Response**

The Department did not make this change. The Office of the State Long-Term Care Ombudsman, established by the Older Americans Act of 1965 (42 U.S.C.A. §§ 3001–3057g), is charged with the statewide reporting and investigative system for complaints made by or on behalf of adults who are age 60 years of age or older and who are consumers of a long-term care service. The Department cannot, through regulation, change statutory language.

**Q. Comment**

Two commentators noted the language used in the initial paragraph be rephrased so the terms “at imminent risk of substantial harm” are not confused with the Protective Services context of this wording. The commentators further stated the wording “...a resident’s decision, behavior or action creates a dangerous situation and places the resident, other residents or staff members at imminent risk of substantial harm...” be rephrased.

**Response**

Based on comments received, the Department has deleted language referring to “imminent” and “substantial” and has inserted language that tracks Act 56.

**R. Comment**

Three commentators oppose this section and urged its deletion. They stated the proposed regulation creates an informed consent process which allows an ALR to require a resident to sign an informed consent agreement or face eviction. The commentators stated these agreements favor ALRs by limiting their liability while providing no safeguards to ensure they will not be misinterpreted or used as a means to neglect residents. The commentators stated there are adequate options available to ALRs if the resident poses a risk to self or others. In conclusion they stated informed consent is an unnecessary procedure that could lead to residents waiving additional rights.

**Response**

The Department is required under Act 56 to establish standards for the informed consent process, hence its deletion is not possible. The Department maintains that the informed consent process promotes aging in place by, within reasonable parameters, giving residents an opportunity to negotiate with ALRs on any risks involved in directing their own care. There are provisions in this section that provide that informed consent agreements must be voluntary and individualized in nature. The Department finds it has struck an appropriate balance between resident choice and liability concerns of providers.

**S. Comment**

Two commentators stated ALRs should not implement an informed consent agreement as a standard condition of admission. They noted an applicant should not be denied admission for refusal to sign an informed consent agreement, particularly without the right to appeal.

**Response**

The Department directs the commentator to subsection (h), which requires that a licensee may not require execution of an informed consent agreement as a standard condition of admission. This should satisfy the commentator's concerns.

**T. Comment**

Two commentators noted that a cognitively intact resident has the right to make bad decisions but the ALR has the obligation to "intervene" if a bad decision is life-threatening. They stated this intervention may require ethical consultation.

**Response**

The legislative findings in Act 56 stress the importance of personal choice and decision-making of ALR residents. Although the commentators' comments are appreciated, the Department finds that the informed consent process in this final-form rulemaking meets the goals of Act 56. As to the issue of ethical consultation, it is not clear what is intended by the commentator.

**U. Comment**

One commentator recommended the following language for subsection (i): "Liability. The execution of informed consent agreement does not constitute any waiver of liability, nor shall it be considered to affect or relate to any claim with respect to acts of negligence, tort, products defect, breach of fiduciary duty, contract violation, or any other claim or cause of action. An informed consent agreement does not relieve a licensee of liability for violation of statutory or regulatory requirements promulgated under this Chapter, nor does it affect the enforceability of regulatory provisions including those provisions governing admission or discharge or the permissible level of care in an assisted living residence. The informed consent is merely a manner of describing self-directed care in those limited instances where it shall be permitted as applicable. The execution of said agreement has no bearing on any suit or claim for damages. "

**Response**

The Department adopted some of the language recommended by the commentator. The Department, however, did not remove the "beyond the scope of the agreement" language as originally proposed in the notice of proposed rulemaking. In addition, the Department did not adopt the suggested "execution of said agreement has no bearing on any suit or claim for damages" language. The Department determined that the addition of the language suggested by the commentator would potentially vitiate the liability protection that an informed consent agreement is intended to provide to the facility.

#### **V. Comment**

One commentator recommended that the definition of the phrase "wish to exercise independence directing the manner in which they receive care..." should only apply where a resident specifically requests care not provided by the ALR.

#### **Response**

The Department did not make this change because the language mirrors Act 56 at P.S. §1021(a)(2)(vii).

#### **W. Comment**

One commentator stated the phrase "imminent risk of substantial harm" should be changed to "imminent risk of substantial physical harm"; otherwise the terminology has no meaning. The commentator noted an ALR could deem itself to be in "substantial harm" under a variety of circumstances that are not particularly reasonable. The commentator stated an objectively reasonable standard should be imported. The commentator continued there does not appear to be a problem with rules and regulations which prohibit a resident from putting staff at the ALR at imminent risk of substantial physical harm. In conclusion the commentator noted, there should be a system which gives discretion to the ALRs to go through the informed consent process.

#### **Response**

In response to the commentator's concern that the informed consent process should be limited to physical harm, the Department does not concur with the commentator. The definition of informed consent in the statute does not limit the "risk of harm" to physical harm. See definition of "informed consent agreement" in 62 P.S. §1001. Furthermore, either the facility or the resident may initiate an informed consent process under the regulations. The Department has reviewed the statutory language for the definition of "informed consent agreement" and has decided to delete the terms "imminent" and "substantial" from the regulatory definition of informed consent since they do not appear in the statutory language.

#### **X. Comment**

One commentator noted the change in the resident's condition should not be the only reason for updates.

#### **Response**

Subsection (j) requires that an informed consent agreement be updated following a significant change in the resident's condition. This is not a preclusive requirement and it does not prevent further updates from being made. Instead, it establishes a minimum for updates.

#### **Y. Comment**

One commentator stated the informed consent process should address the role of the support personnel provided through public programs.

### **Response**

It is unclear what the commentator intends when referring to "support personnel provided through public programs." However, subsection (c) does provide that a resident is entitled to involve any individual he wants to involve in the informed consent process.

### **Z. Comment**

One commentator noted allowing residents to rescind contracts for up to 72 hours is consistent with the principle of informed consent. The commentator stated, however, that the regulations do not establish similar protections for ALRs.

### **Response**

The 72-hour standard noted by the commentator applies to § 2800.25(h) (relating to resident-residence contract). Regarding informed consent agreements, in response to comments received, the final-form regulation has been amended in subsection (k) to provide that an informed consent agreement can be rescinded by either party within 30 days of execution.

### **AA. Comment**

Three commentators recommended that language should be added to this section that requires the resident to cease and desist any action or behavior that prompted the negotiation of an informed consent agreement during the negotiation of an acceptable agreement. They stated it is also necessary to provide for a contingency if the ALR deems the resident unable to grasp the discussions of the negotiation. Two commentators recommended the following language: "a resident shall not have the right to place persons other than himself at risk, but, consistent with statutory and regulatory requirements, may elect to proceed with a decision, behavior or action affecting only his own safety or health status, foregoing alternatives for mitigating the risk, after consideration of the benefits and disadvantages of the alternatives including the wish to exercise independence in directing the manner in which he receives care. During the negotiation of the informed consent agreement, the resident shall cease the actions and/or behavior that prompted the initiation of the negotiation and comport himself according to the original care plan and according to all rules and policies of the provider. The ALR shall evaluate whether the resident understands and appreciates the nature and consequences of the risk, including the significant benefits and disadvantages of each alternative considered, and then further ascertain whether the resident is consenting to accept or mitigate the risk with full knowledge and forethought. If the ALR determines the resident does not understand and appreciate the nature of the discussion, the negotiation shall be treated as unsuccessful according to subsection (f)."

### **Response**

Act 56 requires that informed consent agreements be mutually agreed upon. The Department submits that to require a resident to change behavior that prompted the informed consent agreement prior to the negotiation of the informed consent

process would be something that should be subject to a thorough discussion between the parties negotiating an informed consent agreement. Regarding individuals who are unable to grasp the informed consent process, subsection (d)(1) provides that in the case of an incompetent resident, the resident's legal representative is required to participate in the process. The Department finds that these provisions satisfactorily balance the needs of residents and ALRs in the informed consent process.

**BB. Comment**

Two commentators noted concern with the consistency of the proposed language of this section in maintaining the ability of the resident to direct their own care. The commentators noted that if the resident wishes to enter into an informed consent agreement that may be inconsistent with a regulatory provision, it should be left to the resident's discretion to opt out of them, provided the ALR agrees. They stated the proposed language should mirror the language provided in Act 56.

**Response**

A response to this question would necessitate additional facts about what regulatory provisions the commentator refers to. The Department declines to respond in the absence of specific circumstances.

**CC. Comment**

One commentator stated that this is a corruption of the term as commonly understood by the public. They noted the statement a "cognitively impaired resident" must have his legal representative present to negotiate care/behavioral agreements is vague. They questioned who determines whether or not a resident has impairment.

**Response**

As noted above, based on comments received, the Department has amended this section by replacing "incompetent" for "cognitively impaired resident." Section 2800.224(a)(5)(ii) (relating to initial assessment and preliminary support plan) details an enhanced assessment process that includes an assessment of one's mobility needs. As defined in § 2800.4 (relating to definitions), a resident with mobility needs includes an individual who has difficulty in understanding and carrying out instructions without the continued full assistance of other individuals. Thus, the assessment process includes an assessment of cognitive difficulties.

**Section 2800.41  
Notification of Rights and Complaint Procedures**

**A. Comment**

One commentator recommended the addition of a provision for when a resident is under hospice, there is a do not resuscitate status.

**Response**

Do not resuscitate orders are addressed in § 2800.143 (relating to emergency medical plan) and are to be available at all times for each resident, if applicable.

**B. Comment**

Two commentators recommended the posting of important public documents that include resident rights, labor laws and ALR policies. In addition, they stated they be posted to be seen by individuals using wheelchairs.

**Response**

The Department agrees that communication of resident rights is important and has provided different venues in which those rights are to be communicated. For example, in addition to the posting of rights required under § 2800.41(c) (relating to notification of rights and complaint procedures) it is required that written rights be part of the resident-residence contract under § 2800.25(c)(13) (relating to resident-residence contract). Also, § 2800.41(b) (relating to notification and rights procedures) requires that notification of rights and complaint procedures must be communicated in an easily understood manner and in a language understood by, or mode of communication used by, the resident and, if applicable, the residents designated person. The Department's poster of resident rights shall be posted in a conspicuous and public place in the ALR. See § 2800.41(d). The Department maintains that these options are sufficient to provide that individuals with different communication and physical needs have access to information about their rights.

**C. Comment**

Six commentators noted there should be a standardized complaint procedure that ALRs follow when a resident complaint is received. They noted these would be developed by the Department and include procedures for completing an investigation.

**Response**

The Department submits that § 2800.44 (relating to complaint procedures) provides for a detailed complaint process that sufficiently protects residents of ALRs.

**D. Comment**

Three commentators noted resident rights should be organized in one place in the regulation. The commentators stated consumers should be provided meaningful rights and protections beyond what is already in place in the PCH regulation. They continued, saying these rights should be given to the resident or designated person prior to admission, along with complaint procedures.

**Response**

In response to this comment, resident rights that are found throughout the regulation can also be found in Appendix A (relating to resident rights). The regulations provide that upon application and prior to admission to the residence,

the potential resident or his designated person must be given written disclosures that include a list of resident nonwaivable rights. § 2800.22(e)(1). In addition, § 2800.44(a) provides that prior to admission, the residence shall inform the resident and the resident's designated person of the right to file and the procedure for filing a complaint with the Department and other agencies.

**E. Comment**

Five commentators noted that the proposed regulations must ensure that consumers with disabilities can be safely served in ALRs and that fundamental consumer protections for all residents and applicants be added to the regulations.

**Response**

Section 2800.22(b)(1) (relating to application and admission) requires a certification prior to admission that the needs of a potential resident can be met by the services provided by the ALR. With regard to consumer protections, the Department directs the commentator to § 2800.1 (relating to purpose), which states that the purpose of this Chapter is to protect the health, safety and well-being of ALR residents. Additionally, § 2800.42 (relating to specific rights) details specific rights of ALR residents as does Appendix A (relating to resident rights). Also, § 2800.18 (relating to applicable laws) requires that ALRs comply with applicable Federal, State and local laws, ordinances and regulations. This incorporates by reference laws that relate to people with disabilities. The Department submits that these provisions should address the commentators' concerns.

**F. Comment**

One commentator recommended providing policies and procedures that allow residents the ability to challenge a facility's decision regarding their care and placement or non-placement in an ALR.

**Response**

Section 2800.44 (relating to complaint procedures) adequately addresses the commentator's concerns.

**Section 2800.42  
Specific Rights**

The specific rights delineated in this section are based on the PCH regulations, which the Department is required to meet or exceed. These rights are consistent with the exception of areas where they exceed rights provided in PCHs as follows:

- A resident must be free from mental, physical, and sexual abuse and exploitation, neglect, financial exploitation and involuntary seclusion (see subsection(b)).
- A resident has the right to receive visitors at any time provided that the visits do not adversely affect other residents (see subsection (r)).

- A resident has the right to file not only complaints but also grievances or appeals (see subsection(t)).
- If a supplemental health care service provider other than the ALR is used, its services must be consistent with the ALR's systems for caring for residents (see subsection (y)).
- A resident has the right to choose his primary care physician (see subsection (z)).

#### **A. Comment**

Two commentators noted a possible typographic error in the last statement. It reads "If a residence adopts such policies and procedures they shall be binding on the residence." They noted the statement should read "If an ALR adopts such policies and procedures they shall be binding on the RESIDENT."

#### **Response**

The language of subsection (r) was incorrectly published in the *Pennsylvania Bulletin*. In the original submission by the Department to the Legislative Reference Bureau, the language was "residence," not "residents." This language has been corrected on final-form rulemaking as follows: "If the residence adopts those policies and procedures, they will be binding on the residence."

#### **B. Comment**

One legislator and fourteen commentators recommended ALRs allow residents to choose or continue to use their own health care providers, such as doctors, psychiatrists and pharmacy services. They stated this would allow freedom of choice. They continued, saying this basic right should also be given to other organizations such as hospice and home care.

#### **Response**

Based on comments received, the regulations have been amended in subsection (z) to provide a resident with the right to choose his own primary care physician. Regarding pharmacies, hospices and other providers of supplemental health care services, Act 56 at 62 PS 1057.3(a)(12) allows ALRs to require residents to use providers of supplemental health care services designated by the ALR if they prominently disclose this in an admission agreement with the resident. The Department cannot supersede the intent of the legislature as evinced through statute. However, a prospective resident who prefers to use his own providers of supplemental health care services has the option of searching for an ALR that does not require use of the ALR's service providers.

#### **C. Comment**

Eight commentators stated the regulations should include expanded resident rights. A resident should be free from mental abuse, sexual abuse, exploitation, financial exploitation, involuntary seclusion and all restraints.

#### **Response**

The Department agrees with the commentator and, based on comments received, notes that these additional areas have been incorporated into this section at subsection (b).

**D. Comment**

One commentator recommended the discrimination statement include gender identification.

**Response**

The issue is more appropriately addressed by the General Assembly. In the current session of the General Assembly, House Bill 300 provides for the amendment of the Pennsylvania Human Relations Act to prohibit discrimination based on sexual orientation and gender identity or expression. If enacted, the law would be applicable to ALRs under § 2800.18 (relating to applicable laws).

**E. Comment**

One commentator stated that the right to communicate with legal counsel and advocacy services should be included.

**Response**

Subsection (g) includes the right of a resident to communicate privately with, and to access, the local ombudsman. Subsection (o) includes the right of a resident to freely associate, organize and communicate privately with his friends, family, physician, attorney and other persons.

**F. Comment**

One commentator stated the regulations should also list the right for residents to be free from seclusion. They stated this is mentioned in § 2800.202 as a "safe management technique" but needs to be included as a resident right.

**Response**

As a result of agreement with industry stakeholders, consumers and other interested parties, freedom from involuntary seclusion has been added in subsection (b) as a specific right.

**G. Comment**

One commentator stated this section should include the resident's right to register and vote in elections.

**Response**

The Department declines to make this change. Qualifications for voting are subject to state law.

**H. Comment**

Seven commentators urged the addition of a section 2800.42(a) regarding rights upon transfer or discharge. Another commentator noted that there should be protection from involuntary transfers and discharges.

**Response**

The Department submits that the rights of, and protections for, residents in the transfer and discharge processes are already enumerated in § 2800.228 (relating to transfer and discharge).

**I. Comment**

One commentator encouraged consideration of a regulatory requirement allowing the ALR to require residents to provide medication in special packaging, such as unit-dose or multi-dose packaging. The commentator stated multiple medication delivery systems have yielded undesirable results. They further stated that reducing process variation is a standard principle of continuous quality improvement thereby reducing the risk of medication errors.

**Response**

Language has been added to subsection (y) which was agreed to by industry stakeholders, consumers and other interested parties. The language clarifies that supplemental health care service providers chosen by a resident must be consistent with the ALR's systems for care for residents, including the handling and assisting with the administration of resident's medications.

**J. Comment**

Eight commentators urge the addition of a § 2800.40 regarding applicant and resident rights.

**Response**

Resident rights found throughout the regulations can now also be found in Appendix A (relating to resident rights). Additionally, § 2800.22(b)(3) (relating to application and admission) requires that the basis for denial of admission must be provided in writing.

**K. Comment**

Two commentators noted the absence of a resident's right to have visitors. The commentators stated the regulations should add rights for residents to have 24 hour, 7 days per week access to family and friends.

**Response**

Section 2800.42 (r) (relating to specific rights) provides that a resident has the right to receive visitors at any time provided that the visits do not adversely affect other residents. The regulation, however, also provides that a residence may adopt reasonable rules related to visitation.

**L. Comment**

One commentator stated resident rights should be expanded to address the need for resident and family councils. The commentator noted residents should be able to organize and meet in the ALRs in a private space without the presence of staff unless invited by the group. The commentator continued, saying the ALR should designate a staff person to assist the group and respond to any written requests from the meetings. The commentator noted the ALR should respond to any complaints or recommendations made by the council. The commentator noted the same rights should be granted to family members wishing to organize and meet about care and services. In conclusion, the commentator stated the addition of resident and family councils fits with the Department's description of the proposed rulemaking.

#### **Response**

The Department refers the commentator to § 2800.42(n) (relating to specific rights), which has been revised to allow for residents to freely associate, organize and communicate *privately*. (Emphasis added.) Regarding resident and family councils, the Department submits that it is a matter of choice as to whether or not residents and their families want to establish such councils in an ALR. If they choose to do so, § 2800.26 (relating to quality management) requires ALRs to establish and implement a quality management plan that will provide for periodic review of resident and/or family councils to assure compliance with the law and with the relevant standard of care.

#### **M. Comment**

One commentator urged the addition of the following a new subsection to § 2800.42. (z) "Notwithstanding any rights listed in this section or in this Chapter, residents shall comply with applicable subsidized residence rules if the resident resides in an assisted living residence whose operations must comply with the requirements of one or more federal housing subsidies. In the event of a conflict, the subsidized residence rules shall prevail over the requirements of this Chapter."

#### **Response**

The Department finds that the commentator's recommendation is beyond the scope of this rulemaking since this rulemaking addresses ALR licensing, not funding issues.

#### **N. Comment**

Six commentators recommended a right be included that a resident has the right to freely contract for services from providers at their expense as long as the provider complies with the ALR's reasonable policies and procedures.

#### **Response**

As specified in Act 56, subsection (y) provides that residents may choose their supplemental health care provider unless the ALR has prominently disclosed in the written resident-residence contract that residents must use the supplemental health care services provided by the ALR. Language is included in § 2800.42(y) that

requires the actions and procedures of a supplemental health care provider chosen by the resident must be consistent with the systems of care provided by the ALR. In addition, based on comments received, the Department added subsection (z) to permit residents to choose their primary care physicians.

**O. Comment**

Seven commentators recommended that a resident has the right to refuse treatments or services.

**Response**

Section 2800.30 (relating to informed consent process) addresses this concern.

**P. Comment**

Six commentators recommended a right be included that a resident has the right to self-administer medications.

**Response**

The Department agrees that residents should have the ability to self-administer medications if their final support plan identifies that they are able to do so and if the conditions in section 2800.181(e) (relating to self-administration) are met. Section 2800.227(e) (relating to development of the final support plan) requires that the final support plan must document the ability of the resident to self-administer medications.

**Q. Comment**

Nine commentators recommended a right be included that states a resident has the right to file complaints, grievances or appeals with any individual or agency and recommend changes in policy, home rules and services without retaliation, intimidation or threat of discharge.

**Response**

The Department submits that both §§ 2800.41(a) and 2800.42(t) (relating to notification of rights and complaint procedures; specific rights) address the commentators' concerns.

**R. Comment**

Six commentators recommended a resident have the right to refuse the ALR or any ALR employee assuming power of attorney, guardianship or representative payee.

**Response**

Under § 2800.20(b)(7), an ALR, the administrator and staff persons are prohibited from being assigned power of attorney or guardianship of a resident or a resident's estate. For SSI benefits, the Social Security Administration (SSA) selects a representative payee under 20 CFR 416.620 (relating to information considered in selecting a representative payee) for payment of benefits. Federal regulations specifically address various topics regarding the representative payee function,

including the SSA's determination of when a representative payee is needed and the order of preference for a representative payee. See 20 CFR 601 – 665. For these reasons, the Department did not adopt the commentators' suggestions.

#### **S. Comment**

Six commentators recommended a right be included that a resident has the right to receive all written and oral communications in a format that is accessible to persons with cognitive and sensory disabilities. Seven other commentators recommended that written and oral communications should be provided in a language that is understood by the resident to include American Sign Language interpreter, oral interpreter, large print, audio recording or Braille.

#### **Response**

The requirement that ALRs provide communications in a manner that is understood by a resident is incorporated throughout the regulations, including the following sections: § 2800.41(b) (relating to notification of rights and complaint procedures), which requires that notification of rights and complaint procedures be communicated in a manner understood by residents; § 2800.143 (relating to emergency medical plan), which addresses speech, hearing or vision needs in emergency medical plans; § 2800.228 (relating to transfer and discharge), which requires that notice of transfer or discharge be provided in writing in language in which the resident understands, or performed in American Sign Language or presented orally in a language the resident understands if the resident does not speak standard English; and § 2800.252 (relating to content of resident records), which requires that a language, speech, hearing or vision need which requires accommodation or awareness of during oral or written communication be included in resident records. Regarding cognitive and all other disabilities, § 2800.227(e) (relating to development of the final support plan) requires that strategies that promote interactive communication on the part of and between direct care staff and individual residents be included in the final support plan.

#### **T. Comment**

Seven commentators recommended a resident have the right to choose and involve a personal advocate.

#### **Response**

This comment is addressed in subsection (o), which provides that a resident has the right to freely associate, organize and communicate privately with his friends, family, physician, attorney and other persons. The Department submits that "other persons" is a broad term that would include advocates.

#### **U. Comment**

Six commentators recommended a right be included stating a resident has the right to receive a report of suspected abuse or neglect involving the resident.

#### **Response**

Reporting of suspected abuse, as defined under § 2800.4 (relating to definitions), to the resident and the resident's designated person when the suspected abuse or neglect involves the resident is required under § 2800.15 (relating to abuse reporting covered by law).

**V. Comment**

Six commentators recommended a right be included stating a resident has the right to age in place, including the right to receive hospice care.

**Response**

Hospice care is one of the supplemental health care services that an ALR must provide under §2800.220(e) (relating to service provision). As contemplated in Act 56 and stated in § 2800.1(b) (relating to purpose) the intent of both the law and this final-form rulemaking is to provide a setting where residents can age in place. However, this has limits that the General Assembly has recognized in providing for excludable conditions that may preclude an individual from aging in place unless an exception is granted by the Department. See 62 P.S. §1057.3(e).

**W. Comment**

Six commentators recommended a right be included stating a resident has the right to have records kept confidentially.

**Response**

Confidentiality of records is required under § 2800.17 (relating to confidentiality of records).

**X. Comment**

Six commentators recommended a right be included stating a resident has the right to receive waiver notices and to challenge them. In addition, the commentator stated residents be given written notice of any waivers that are granted or that are being rescinded.

**Response**

Waivers under § 2800.19 (relating to waivers) govern the licensee's ability to seek waivers from certain provisions of these regulations. Under the provisions of that section, an ALR must provide to the affected resident and designated persons a copy of the request at least 30 days prior to submission of the waiver request to the Department. There is then an opportunity for the involved resident(s) to submit comments to the Department. Additionally, the Department is required to post on its website a copy of the waiver request with a 30-day public comment period prior to final review and decision on the requested waiver. This provides an opportunity for the resident to challenge the waiver request. The ALR is required to provide to the affected resident(s) and designated person(s) a decision on the approval or denial of the waiver and a copy of it is to be posted in a conspicuous and public place in the ALR. Regarding the issue of notice of rescission of waivers, the Department will consider adding this information to its website pursuant to Act 2008-44 (Section 8).

#### **Y. Comment**

Six commentators recommended a right be included stating a resident has the right to view inspection reports, incident reports, fire safety approvals, violation reports and other licensure and enforcement documents on file.

#### **Response**

Section 2800.3(d) (relating to inspections and licenses) requires that the ALR post license inspection summaries; Section 2800.16(c) and (e) (relating to reportable incidents) both require that incident reports be provided to the affected resident and other residents who could potentially be harmed; Section 2800.18 (applicable laws) requires that ALRs comply with applicable Federal, State and local laws, ordinances and regulations, which would address existing fire safety laws and codes; and § 2800.268 (relating to notice of violations) requires that administrators provide to each resident and their designated persons written notification of Class I violations (violations have resulted in or have a substantial probability of resulting in death or serious mental or physical harm to a resident) and Class II violations (violations have a substantial adverse effect upon the health, safety or well-being of a resident). It is unclear what "other licensure and enforcement documents" the commentator is referring to. Act 56 requires that statutes relating to PCHs also include ALRs. Thus, in addition to the above provisions, Act 44 of 2008, which requires that PCHs post information on the Department's website and update it annually relating to the licensure and inspection of personal care homes, would also apply to ALRs. The Department submits that these provisions should address the commentators' concerns.

#### **Z. Comment**

Six commentators recommended a resident have a right to consult the independent review panel about an informed consent agreement the ALR wants the resident to sign.

#### **Response**

Neither Act 56 nor the Department in the regulations has included a provision for an independent review panel.

#### **AA. Comment**

Seven commentators recommended a resident has the right to a single room.

#### **Response**

Section 2800.101(c) (relating to resident living units) addresses this issue by stating that a licensee may not require residents to share a living unit. This right is included in Appendix A (relating to resident rights).

#### **BB. Comment**

Six commentators recommended a resident has the right to accessible design to maximize independence.

**Response**

The Department submits that § 2800.81 (relating to physical accommodations and equipment) requires that ALRs 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 the ALR and exiting from the ALR.

**CC. Comment**

Six commentators recommended a resident should have the right to assistive technology and, upon discharge or transfer, to retain the technology.

**Response**

The Department submits that the need for assistive technology and services would be identified in the assessment process and in the development of a resident's support plans. A resident's contract with the ALR, as provided in § 2800.25(c)(4) (relating to resident-residence contract), would reflect who is to pay for such services if they are needed. The Department declines to identify assistive services as a resident right in that the term is broad and undefined. Additionally, no similar right is included in the PCH regulations, which the Department is required to meet or exceed. In regards to retaining assistive technology upon discharge and transfer, this issue is addressed in § 2800.228 (a) (relating to transfer and discharge), which requires that the ALR be responsible for ensuring that a resident's durable medical equipment is transferred with the resident.

**DD. Comment**

Six commentators recommended a resident have the right to transportation for the following: medical appointments, community activities and social activities.

**Response**

As specified in § 2800.220 (relating to services) ALRs are required to provide or arrange for transportation to those residents receiving the enhanced core package of services. Additionally, § 2800.171 (relating to transportation) has been amended to require that ALRs provide or arrange for transportation on a regular weekly basis that permits residents to schedule medical and social appointments within a reasonable local area. Community activities are included within the scope of "social activities."

**EE. Comment**

Six commentators recommended a resident has the right to conduct their own ADLs or IADLs.

**Response**

Section 2800.220(h)(4) requires an ALR to provide assistance with performing ADLs and IADLs. Sections 2800.220(c)(1) and (c)(2) (relating to service provision) provide for an independent core package and an enhanced core package which are based on the level of assistance a resident requires. The level of required assistance is

determined by a resident's assessments, as provided in §§ 2800.224(a)(5)(i) and 2800.225(b)(1) (relating to initial assessment and preliminary support plan; additional assessments).

**FF.Comment**

Seven commentators recommended a resident have the right to manage their financial affairs. They noted the ALR should not require a resident to deposit personal funds with the ALR.

**Response**

Subsections 2800.20(a) and (b) (relating to financial management) provide that a resident may manage his personal finances unless he has a guardian of his estate.

**GG. Comment**

Six commentators recommended a resident have the right to terminate an informed consent agreement without advance written notice.

**Response**

In order to balance the rights of consumers and the needs of ALRs, the Department has revised § 2800.30 (relating to informed consent process) to require that either party has a right to rescind the informed consent agreement within 30 days of the execution of the agreement.

**HH. Comment**

Six commentators recommended a resident have the right from the ALR to receive assistance to relocate to another ALR. They stated the assistance shall include: helping the resident get information about living arrangements, making telephone calls and transferring records. Six other commentators recommended a resident have the right to a safe and orderly transfer and discharge. Six additional commentators recommended a resident have the right to decide the place for discharge or relocation.

**Response**

The Department finds that these issues are addressed in subsection (n), which requires that residents have the right to relocate and to request and receive assistance from the ALR in relocating to another facility. ALRs are also required in subsection (n) to provide assistance in the transfer process, which may include getting information about living arrangements, making telephone calls and transferring records. Additionally, in the case of a discharge based on a resident's functional level, § 2800.228(h)(3) (relating to transfer and discharge), requires that a plan for other placement be made as soon as possible by the ALR administrator in conjunction with the resident and the resident's designated person. The Department agrees that transfers and discharges should be safe and orderly. This issue is addressed in § 2800.228 (a) (relating to transfer and discharge), which requires that the ALR ensure that a transfer or discharge is safe and orderly.

## **II Comment**

Six commentators recommended a resident have the right to terminate their residency or service agreement with 14 days' advance written notice.

### **Response**

The Department submits that this is addressed under § 2800.25(b) (relating to resident-residence contract), which requires that the contract shall run month-to-month with automatic renewal unless terminated by the resident with 14 days' notice.

## **JJ. Comment**

Six commentators recommended a resident have the right to a full accounting and the return of monies held by the ALR (under financial management agreement with the resident) within 7 days of discharge.

### **Response**

Section 2800.20(b)(8) (relating to financial management) provides that an ALR shall give the resident and the resident's designated person an itemized account of financial transactions made on the resident's behalf on a quarterly basis. Section 2800.28(g) (relating to refunds) requires that upon discharge of the resident or transfer of the resident, the administrator shall return the resident's funds being managed or stored by the ALR to the resident within 2 business days from the date the living unit is cleared of the resident's personal property.

## **KK. Comment**

Seven commentators recommended a resident have the right to remain in the ALR, to age in place, and not be involuntarily discharged unless the ALR has documented the following: (a) the resident presents an imminent physical threat or danger to self or others which cannot be managed by interventions or service planning; (b) the resident has failed to pay after reasonable efforts by the facility to obtain payment and is not eligible for publicly funded programs that can provide payment; (c) the resident has medical needs which cannot be met in an ALR; or (d) the ALR closes.

### **Response**

The Department submits that all of the concerns raised by the commentators are addressed in the regulations. Concern (a) is addressed in § 2800.228(h)(1) (relating to transfer and discharge), which provides that a ground for transfer or discharge is if a resident is a danger to himself or others and the behavior cannot be managed through interventions, services planning or informed consent agreements. Concern (b) is addressed in § 2800.228(h)(5), which provides that another ground for transfer or discharge is if the resident has failed to pay after reasonable documented efforts by the ALR to obtain payment. Concern (c) is addressed in § 2800.229(a) (relating to excludable conditions; exceptions) insofar as excludable conditions are specified. Concern (d) is addressed in § 2800.228(b), which provides for transfer or discharge in the case of the closure of an ALR.

**LL. Comment**

Six commentators recommended the resident have the right to choose among the available ALRs after an opportunity to visit the alternative ALRs. They continued, saying these procedures apply even if the resident is placed in a temporary living situation.

**Response**

The Department submits that nothing in this rulemaking excludes the ability of a person to choose among available ALRs or to visit other ALRs. It is unclear what circumstances are intended by the commentator when referring to "even if the resident is placed in a temporary living arrangement " so the Department is unable to respond to this issue.

**MM. Comment**

Six commentators recommended the resident has the right to appeal a discharge and the hearing be held within 14 days from the date of the appeal. They noted that in emergency situations, the Department shall provide for an interim telephone hearing within 3 business days, at which time it shall be determined whether the resident may remain in the ALR pending a full hearing. They stated in the event a resident is transferred from the ALR pending a full hearing, the ALR shall hold the resident's bed and/or waiver slot pending the full hearing.

**Response**

The Department does not have jurisdiction to adjudicate cases unless such authority is granted by statute. Article X of the Public Welfare Code does not grant authority to the Department to hold hearings or decide disputes related to resident appeals of actions taken by an ALR. Instead, it is a matter of contract law between the residence and the resident.

**NN. Comment**

Six commentators recommended a resident have the right to participate in decisions related to transfer to a secured dementia unit.

**Response**

This issue is addressed in § 2800.231(relating to admission), which requires that each resident or potential resident, and when appropriate, the resident's designated person or the resident's family, have agreed to the resident's admission or transfer to the special care unit.

**OO. Comment**

Six commentators recommended a resident have the right to a 30-day room-hold while hospitalized or longer if they continue to pay residency agreements/rental amounts owed.

**Response**

This issue is addressed § 2800.25(c)(12) (relating to resident-residence contract) where it requires that a contract specify the charges to the resident of holding a bed during hospitalization or other extended absences from the ALR.

**PP. Comment**

Six commentators recommended a resident have the right to refuse a room transfer.

**Response**

Act 56 addresses this issue by providing that portions or sections of an ALR may be designated for use by residents not requiring supplemental health care services, or an ALR may provide services both to residents receiving supplemental health care services and to residents not receiving such service within the same portions or sections of the ALR. See 62 P.S. § 1057.3(h)(ii). The legislature clearly intended that an ALR may choose to design its residence in a way that requires residents to move from one portion or section of the ALR to another as their needs change.

The Department is required to comply with Act 56 and, therefore, cannot make the suggested change. In addition, this issue should be addressed in the resident-residence contract. Prospective residents have the option of choosing an ALR that does not make room distinctions based on resident supplemental health care service needs.

**QQ. Comment**

Seven commentators recommended a resident have the right to choose ADL and IADL providers.

**Response**

Assisted living services are required to be provided by the ALR as set forth in § 2800.23 (relating to activities) where it requires that ALRs provide each resident with assistance with ADLs and IADLs as indicated in the resident's assessment and support plan. This language mirrors the PCH regulations, which the Department is required to meet or exceed.

**RR. Comment**

Six commentators recommended that a resident, the resident's designated person and other individuals upon the resident's written approval, should have the right to purchase, at a cost not to exceed the community standard, photocopies of the resident's records within 24 normal business hours.

**Response**

Section 2800.251(e) (relating to resident records) provides that resident records be made available to the resident and the resident's designated person during normal working hours. The Department elects to provide ALRs with discretion on the timeframe and cost for photocopying of resident records.

**SS. Comment**

Six commentators recommended a resident have the right to lock their door.

**Response**

Under Act 56 and these regulations, ALRs shall provide residents with lockable doors except where a lock in a unit under a special care designation would pose a risk or be unsafe. See 62 P.S. §1021(a)(2)(vii) and § 2800.101(h) (relating to resident living units).

**TT. Comment**

Seven commentators recommended a resident have the right to an initial interview and tour of the ALR prior to admission.

**Response**

The Department defers this issue to the individual ALR as a business decision.

**UU. Comment**

Six commentators recommended a resident have the right to an initial screening upon application for admission.

**Response**

Section 2800.224 (relating to initial assessment and preliminary support plan) requires that initial assessments occur within 30 days prior to admission, except in instances where a resident is coming directly from a hospital, is escaping an abusive situation or has no alternative living arrangement. In those cases initial assessments are permitted to be conducted within 15 days of admission.

**VV. Comment**

Seven commentators recommended a resident have the right to a written decision regarding acceptance/denial into the ALR.

**Response**

In response to comments received by industry stakeholders, consumers, and other interested parties, the Department has added language in § 2800.22(b.3) (relating to application and admission) to require that a potential resident whose needs cannot be met by the ALR be provided with a written decision denying his admission that gives a basis for the denial. In the case of acceptance into the ALR, the written contract would constitute acceptance.

**WW. Comment**

Six commentators recommended a resident have the right to appeal (or seek exception) to the Department if admission is denied because of an excludable condition.

**Response**

Article X of the Public Welfare Code does not grant jurisdiction to the Department to hold hearings and render decisions related to resident appeals of actions taken by an ALR.

**XX. Comment**

Six commentators recommended a resident have the right to a medical evaluation from a provider of the resident's choice.

**Response**

In response to comments received, the regulations now provide that residents are permitted to use the services of their own primary care physician. See § 2008.42(z) (relating to specific rights). There is nothing in the regulations that would prohibit a resident from using his own physician for medical evaluations.

**YY. Comment**

Six commentators recommended a resident have the right to participate (along with others invited by the resident) in their comprehensive support plan prior to admission or within 14 days of admission following an urgent or emergent admission due to hospital discharge. They continued that the resident should receive a copy of their current support plan without charge.

**Response**

Sections 2800.224(c)(7) (relating to initial assessment and preliminary support plan) requires that an individual be encouraged to be involved in development of his preliminary support plan and that he may include a designated person or family member in that process. The preliminary support plan must be developed within 30 days prior to admission, unless certain conditions apply as set forth in subsection (c) of § 2800.224 (relating to initial assessment and preliminary support plan). Section 2800.227(f) (relating to development of the final support plan) provides a parallel process regarding development of the final support plan. Sections 2800.224(c)(10) and 2800.227(k) (relating to initial assessment and preliminary support plan; development of the final support plan) require that the ALR provide copies of the preliminary and final support plans to the resident and his designated person. These provisions should satisfy the commentators' concerns.

**ZZ. Comment**

Six commentators recommended a resident have the right to receive at the interview written information that includes the following: the range and pricing of each of the services provided at the ALR, including services provided directly and services provided through identified third-party providers; the amount of rent for the living unit, including any packaged services such as housekeeping, laundry and basic meals; the rules, policies and procedures expected to be adhered to by all residents; based on the current needs of the prospective resident, including any need for physician services whether the ALR expects to be able to accommodate the current needs of the prospective resident including any physician services; the

types of daily program activities and socialization opportunities offered through the ALR; the availability of health care and social services not provided at the ALR but which are available in the community, such as hospice care, home health care, transportation and similar services to support a resident who is aging in place; any additional information required by the Department. Also the right to receive at or before the initial interview certain "mandatory disclosures" of important information, including: contact information for the following: the Department, for the purpose of obtaining information on the licensing requirements and licensing status of ALR; the long-term care ombudsman, with information on the ombudsman's role and availability; the Department's 24-hour hotline for making complaints, along with information on how a resident can make a complaint and the Department's investigation process; a delineation of resident rights; the following additional information: a copy of the ALR's policies and procedures affecting residents; information regarding the ALR's quality improvement program; details about the internal dispute resolution process used by the ALR; information on transfer and discharge policies; copies of all charge schedules and rates, including those separate charges for each of the following: utilities, telephone, cable television, internet access, garage fees, maintenance or management services, minimum or extended meal plans, bed and linen fees, if any, and any additional services related to occupancy; the department established "independent review panel" for guidance on an informed consent agreement, what it means, how it works, what to consider and whether it is fair and appropriate; the right to not be forced to contract for services that the resident does not want; the right to rescind the residency agreement for up to 72 hours after the initial dated signature of the contract and pay only for the services received. They noted rescission of the contract must be in writing addressed to the ALR. In addition they stated residents have the right to share a room with a spouse or significant other.

### **Response**

The Department agrees that residents must be informed of the costs of ALR services. This issue is addressed in § 2800.25(c)(2) (relating to resident-residence contract) by requiring that the ALR provide a fee schedule for the actual amount for each of the assisted living services in a resident's core service package. Section 2800.25(l) requires the separate listing of the prices of supplemental health care services. Section 2800.25(c)(11) requires disclosure of the costs of food, shelter and services. Under § 2800.22(e)(3) (relating to application and admission), ALRs must provide residents, prior to admission, with a copy of ALR rules and a resident handbook. Section 2800.22 (b.1) (relating to application and admission) requires that a certification be made, prior to admission, that the needs of the potential resident can be met by the services provided by the ALR. The fee schedule must also list the daily planned social activities and socialization opportunities in the individual's core service package under § 2800.25(c)(2)(vii). Section 2800.142(b) (relating to assistance with medical care and supplemental health care services) requires that ALRs assist residents in securing medical care and supplemental health care services. Section 2800.222 (relating to community social services) provides that ALRs shall encourage and assist residents in accessing social

services in the community. Upon application to an ALR, potential residents must be provided with the Department's contact information under 2800.22(e)(4)(iv). Also, ALRs are required under § 8 of Act 44 of 2008 to post information on the Department's internet website regarding licensure and inspection information. Prior to admission, § 2800.44(g) (relating to complaint procedures) requires that the ALR post, in large print in a conspicuous and public place in the ALR, the telephone number of the Department's Assisted Living Residence Licensing Office, the local ombudsman or protective services unit in the Area Agency on Aging, the Disability Rights Network, the local law enforcement agency, the Commonwealth Information Center and the ALR complaint hotline. Section 2800.25(c)(13) requires that written information on the resident's rights and complaint procedures be part of the resident-residence contract. Section 2800.42 (relating to specific rights) contains rights of residents and Appendix A provides a listing of all resident rights found throughout the regulations. Both quality improvement and dispute resolution have already been addressed above. Section 2800.25(c)(9) requires that the contract include the conditions under which the resident-residence contract may be terminated. Regarding the recommendation that residents should have the right to contract only for services they want, the Department maintains that it has found a balance by the establishment of two core service packages that are based on the degree of assistance an individual requires. A resident may also "opt out" of receiving certain services and not be charged for them. Section 2800.25(h) allows a resident to rescind the contract up to 72 hours after signing it and the resident is only required to pay for the services received. Rescission of the contract must be in writing addressed to the ALR. Nothing in the regulations would preclude the sharing of a room with a spouse or significant other. The regulation, instead, provides that two consenting adults may share a living unit. See § 2800.101(g) (relating to resident living units). Regarding the other items enumerated by the commentators, including charges for utilities, telephone, cable television, internet access, garage fees, maintenance or management service and any additional services related to occupancy, § 2800.25(l) requires that services provided by or contracted for by the ALR other than supplemental health care services must be priced separately from the service package in the resident-residence contract.

#### **AAA. Comment**

Four commentators noted the regulations should reflect the confidentiality rights of residents by stating their right to freely and privately associate, organize and communicate with individuals of their choosing.

#### **Response**

The Department concurs with the commentators. As a result of agreement between industry stakeholders, consumers and other interested parties, § 2800.42(o) (relating to specific rights) was amended to provide that a resident has the right to freely associate, organize and communicate privately with friends, family, physician, attorney and any other person.

#### **BBB. Comment**

One commentator noted the regulations should mirror the PCH regulations and stated a resident has the right to receive visitors for a minimum of 12 hours daily, 7 days a week.

**Response**

Section 2800.42(r) (relating to specific rights) provides that a resident has a right to receive visitors *at any time* provided that such visits do not adversely affect other residents. The regulation does, however, provide that an ALR may adopt reasonable policies related to visitation.

**CCC. Comment**

One commentator noted that the right of a resident under the law and regulations should be acknowledged pertaining to the rights of residents' agents under power of attorney documents.

**Response**

Section 2800.41 (relating to notification of rights and complaint procedures) provides that upon admission, each resident and, if applicable, the resident's designated person, shall be informed of resident rights and the right to lodge complaints. Subsection (e) of § 2800.41 requires that a statement signed by the resident, and, if applicable, the resident's designated person, acknowledging receipt of a copy of the resident's rights and complaint procedures shall be kept in the resident's file. Since a resident's designated person may include a legal representative, which is defined, *inter alia*, as a power of attorney (see § 2800.4 (relating to definitions)), the language in the regulation should satisfy the concerns raised by the commentator.

**DDD. Comment**

One commentator recommended the following resident rights: right to refuse treatment; right to be fully informed in advance about care, treatment and changes and to direct their own plan of care; self-determination and participation to make choices about aspects of his life in the ALR that are significant to the resident; and that the ALR must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.

**Response**

Section 2800.30 (relating to informed consent process) addresses resident choice and independence in directing care. Specifically, in that section a process is established that would be available to residents to use in cases where they choose to refuse treatment and would prefer to direct their own care. The Department submits that the overall purpose of these regulations and the intent of Act 56 is to provide an environment where residents can age in place, maintain their independence and exercise decision-making and personal choice.

**EEE. Comment**

One commentator recommended deletion of the phrase "resident's designated person" from this section.

**Response**

Assignment of a designated person is purely at the discretion of the resident. The Department submits that there is no requirement in the regulations that a resident is required to name such a person if he chooses not to. However, by affirmatively offering that option it presents an opportunity to empower the resident to receive support in advocating for his needs.

**FFF. Comment**

One commentator stated subsection (m) should be amended as follows: "A resident has the right to leave and return to the residence as he or she chooses, consistent with the resident's support plan." The commentator stated the residents should have the right to come and go freely, subject to any limitations in the support plan arising from risks faced by a particular resident, such as wandering.

**Response**

The language in subsection (m) provides that a resident has the right to leave and return to the ALR at times consistent with the ALR rules and the resident's support plan. This language mirrors the PCH regulations, which the Department is required to meet or exceed.

**GGG. Comment**

One commentator suggested a change in subsection (y): delete the period after the last word ("provider") and insert "with the agreement of the licensee."

**Response**

Subsection (y) has been amended to address the commentator's concerns by requiring that, if an ALR permits residents to choose a supplemental health care provider, the provider's "actions and procedures must be consistent with the ALR's systems for caring for residents."

**HHH. Comment**

Two commentators suggested the regulations provide an overarching and fundamental set of "rights" that afford seniors a modicum of security if their ALR purchase will be a sound one and, in the event it is not, they have a clearly defined path for redress.

**Response**

The Department submits that it has carefully crafted the resident rights section to provide a balance between industry stakeholders and consumers. It further finds that it has met, and in some cases exceeded, the resident rights in the PCH regulations. The Department, however, cannot guarantee the soundness of a purchase.

**III. Comment**

Two commentators stated the ALR should undertake due diligence to assure the policies and procedures of third parties meet the needs of the resident and comply with DPW regulations.

### **Response**

The regulations, under § 2800.4 (relating to definitions) were amended to include a definition of third-party provider as any contractor, subcontractor, agents or designated providers under contract with the resident or ALR to provide services to any resident. In the case of third-party providers under contract with the ALR, the Department submits that a prudent provider will ensure that due diligence is undertaken to protect the ALR from liability. With regards to supplemental health care service providers chosen by residents, subsection (y) has been amended to require that they must act consistently with the ALR's systems for caring for residents.

### **JJJ. Comment**

One commentator stated where third-party providers, such as pharmacies, have or obtain knowledge about missing medications for residents, the pharmacy should provide a timely report to the ALR and to the resident and/or their family of the occurrence. The commentator noted any pharmacy contracted with by an ALR should be able to provide for delivery of medications on an emergency basis. The commentator stated this provision not should be limited to or left to the discretion of the pharmacy to designate such an event as an "emergency". The commentator continued, saying if a pharmacy is unable to provide services or delivery of medications under such circumstances, the ALR should notify residents and their families in writing, and develop a plan with the resident, their family and their physician to obtain such medications which should become part of the resident's support plan. In addition, the commentator noted that although a pharmaceutical item may not be deemed an "emergency" by a pharmacist, the resident or their family or physician may deem that it is in the best interests of the resident to get the medication. The commentator stated the same situation should be addressed when a resident's pharmacy cannot deliver medications on an emergency or urgent basis. The commentator noted that residents should never be required to abandon any service provider that they have used since past service providers are part of their medical health team.

### **Response**

Since pharmacies are licensed under the Department of State, only their licensing board can dictate their responsibilities with respect to reporting missing medication. The Department has no authority to regulate pharmacists. Having said that, the commentator is directed to § 2800.185(5) (relating to accountability of medication and controlled substances), which provides that, to the extent indicated in the resident's support plan, the ALR must obtain prescribed medication for residents and keep an adequate supply of resident medication on hand at all times. Additionally, at § 2800.188(b) (relating to medication errors), medical errors must be immediately reported to the resident, the resident's designated person and the

prescriber. Sections 2800.224 (relating to initial assessment and preliminary support plan) and 2800.227(e) (relating to development of the final support plan) require that both preliminary and final support plans contain a resident's need for medication. In regards to which service providers are available to a resident, § 2800.42(6) (relating to specific rights) requires that to the extent prominently displayed in the written resident-residence contract, an ALR may require residents to use providers of supplemental health care services as provided in § 2800.142 (relating to assistance with medical care and supplemental health care services). This provision mirrors Act 56 under 62 P.S. §1057.3 (a)(12). When the ALR does not designate, the resident may choose the supplemental health care provider.

#### **KKK. Comment**

One commentator noted that while the regulation mention advocates and guardians, many with brain injury have no one interested in filling this role for them or their relatives do not have the money to pay for a guardianship. The regulation should include measures for residents with brain injury to more easily secure a guardianship, including a set of standards for an organization to contract with the state to provide guardianship for individuals in this situation.

#### **Response**

The Department finds that the appointment of guardianship protocols for residents with brain injury raised by the commentator are outside the scope of these regulations.

#### **LLL. Comment**

One commentator questioned whether consumers will understand their rights regarding choices about the sources and costs of medication.

#### **Response**

Section 2800.25(a) (relating to resident-residence contract) requires that, prior to admission or within 24 hours after admission, a written resident-residence contract between the resident and the residence must be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature. Section 2800.25(c)(4) requires that the contract must specify the party responsible for payment. The Department submits that these provisions address the commentator's concerns.

### **Section 2800.44 Complaint Procedures**

#### **A. Comment**

One commentator suggested there should be a section indicating that these regulations do not, in any way, affect the right to file a suit or a claim for damages.

**Response**

The Department agrees with this comment and has made the requested change by adding a new subsection (h) to this section.

**B. Comment**

One commentator stated that, while notifications of residents regarding right to file complaints with the Department, the ombudsman and others are important, the ALR should encourage residents to utilize the residence's complaint process in non-emergency situations.

**Response**

Section 2800.25(c) (13) (relating to resident-residence contract) requires that ALRs provide residents with information on their rights and complaint procedures. Additionally, § 2800.44(a) (relating to complaint procedures) requires that prior to admission, the ALR shall inform the resident and his designated person of the right to file, and the procedure for filing, a complaint with the Department's ALR Licensing Office, local ombudsman or protective services unit in the Area Agency on Aging, the Disability Rights Network or law enforcement. In subsection (c), it is provided that if a resident indicates that he wishes to make a written complaint but needs assistance in reducing the complaint to writing, the residence shall assist the resident in writing the complaint. The Department submits that these provisions adequately address the commentator's concerns.

**C. Comment**

One commentator noted individuals age 60 and over may contact Older Adult Protective Services for support, but nothing exists for individuals with disabilities under the age of 60. The commentator recommended an adult protective services system be established for individuals ages 18-59.

**Response**

The Department submits that any new law relating to adult protective services is a matter for the legislature to address and it is, therefore, outside the scope of this rulemaking.

**D. Comment**

One commentator recommended that permission to independently seek assistance from outside legal counsel and/or advocacy services to make written complaints should be included. The commentator suggested the resident receive a written status report in response to any written complaint within 2 business days.

**Response**

Section 2800.42(o) (relating to specific rights), clearly allows a resident to communicate privately with his attorney or other persons. Additionally, § 2800.44(e) requires a status report shall be provided to a complainant within 2 business days after the submission of a written complaint.

**E. Comment**

One commentator noted that there needs to be an independent entity designated to help consumers with an appeals process. The commentator stated residents must also be advised of their right to appeal to this independent entity.

**Response**

The Department has not adopted this recommendation. Disputes are subject to resolution as provided by the resident-residence contract.

**F. Comment**

One commentator recommended the addition of a section requiring providers to maintain a log of complaints and responses to complaints files under this section. The commentator noted that this log should be available for DPW inspections and considered part of a resident's record.

**Response**

The Department agrees and has amended subsection (d) to provide that the ALR shall keep a log of all complaints and the outcome of the complaints. This record is subject to Department access under § 2800.5(a).

**G. Comment**

Three commentators recommended the long-term care ombudsman poster be displayed in a conspicuous location on every floor or unit of the ALR.

**Response**

The Department submits that subsection § 2800.44 (g), which requires the ALR to post the following information in large print and in a conspicuous and public place in an ALR, is sufficient: the telephone number of the Department's ALR Licensing Office, the local ombudsman or protective services unit in the Area Agency on Aging, the Disability Rights Network, the local law enforcement agency, the Commonwealth Information Center and the ALR complaint hotline.

**Section 2800.51  
Criminal History Checks**

**A. Comment**

Six commentators stated that all persons working for or under contract with an ALR should have to go through a criminal history background check. Another commentator noted there should be a provision to grandfather all current staff and not require them to have another criminal history background check. This commentator noted this would be an added expense that should not be necessary.

**Response**

The Department of Aging's Older Adult Protective Services Act Older Adult

Protective Services Act (OAPSA) (35 P. S. §§ 10225.101--10225.5102), and 6 Pa. Code Chapter 15 (relating to protective services for older adults) govern criminal history records checks.

**Section 2800.53**  
**Qualifications and Responsibilities of Administrators**

**A. Comment**

Twenty-five commentators stated a grandfathering provision should be included that exempts individuals currently serving as PCH administrators and nursing facility administrators considering the duties and obligations of these roles are nearly identical to those proposed for assisted living administrators. They noted that these individuals are credentialed, qualified and have received countless training hours. They noted it is illogical and costly for these administrators to attend assisted living classes or re-take board examinations. In addition, they noted this could also be a hardship for many ALRs. One legislator commented that instead of grandfathering, staff and administrators at existing facilities applying for ALR licensure should be allowed a certain period of time to meet the higher standards.

**Response**

In response to comments, § 2800.64(g) (relating to administrator training and orientation) has been amended to add language regarding training requirements of an administrator. Specifically, licensed nursing home administrators who are employed as such prior to the effective date of the regulations, are exempted from the administrator qualification requirements and initial training requirements of the Chapter if they continue to meet the applicable nursing home administrator licensing requirements promulgated by the Department of State. A licensed nursing home administrator hired after the effective date of this rulemaking is required to complete and pass a Department-approved assisted living administrator competency-based test.

Additionally, the Department has revised the regulations to allow PCH administrators to become ALR administrators if they meet the requirements outlined in section § 2800.53(a)(6). These requirements include being employed as a PCH administrator for at least 2 years prior to the effective date of the regulation, having completed the administrator training requirements and having passed the Department-approved competency-based training test under § 2800.64(a)(3). Note that PCH administrators qualified under § 2600.53(a)(5) (relating to qualifications and responsibilities of administrators) are not included. PCH administrators who qualified as such under the specific requirement that they work in homes serving 8 or fewer residents, have a general education development diploma or high school diploma and 2 years direct care or administrative experience in the human services field will be excluded from qualifying as an ALR administrator under this Chapter.

## **B. Comment**

Six commentators recommend adding a requirement that the person who manages and controls the operations of the ALR has prior experience in the health or human services field. They stated along with the responsibilities of the administrator, the administrator should have the ability to provide assisted living services, supplemental health care and to supervise or direct the staff to provide assisted living services and supplemental health care.

### **Response**

Under this section, the qualifications for an ALR administrator require that the person have experience in a health care or human services field. Subsection (d) of this section requires that ALR administrators have the ability to provide assisted living services. However, regarding supplemental health care services, Act 56 does not place the responsibility on ALR administrators to personally provide these services but rather, under 62 P.S. §1057.3(a)(12), requires that the ALR demonstrate the ability to provide supplemental health care services in a manner duly protective of the health, safety and well-being of its residents utilizing employees, independent contractors or contractual arrangements with other health care facilities or practitioners licensed, registered or certified to the extent required by law.

## **C. Comment**

Three commentators stated that the requirement for the 100-hour training course plus 4 hours of dementia training is unnecessary as the new ALR regulations so closely mirror the PCH regulations. They noted these provisions place a significant amount of stress on administrators. They stated it is unreasonable that the requirements for an ALR administrator are greater than a personal care administrator.

### **Response**

The Department points out that a 100-hour training course is required under the PCH regulations, which Act 56 requires the Department to meet or exceed. The Department submits that the 4 hours of dementia training required under § 2800.69 (relating to additional dementia-specific training) is not an unreasonable burden and is needed due to the likelihood that, as residents age in place, they may have higher cognitive impairment levels and need a higher level of assistance than they would receive in PCHs. The Department has relied on the expertise of professionals in the fields of dementia and Alzheimer's disease in developing this requirement.

## **D. Comment**

Four commentators stated the minimum educational requirements for the administrator are insufficient. They stated an individual could have as little as an LPN license with one year of experience or have just 60 hours of college and 2 years experience in the human services field and become an administrator. The proposed regulations include only minimal standards for administrators. Another

commentator noted there is no geriatric experience required and recommends a minimum of 1 year experience in geriatrics and long-term care.

**Response**

This provision meets the statutory requirement that these regulations meet or exceed the PCH regulations. The Department maintains that the administrator educational requirements are sufficient to meet the health and safety needs of residents. Regarding geriatric experience, § 2800.231(c)(1) (relating to admission) requires that in special care units for residents with Alzheimer's disease or dementia, a physician or geriatric assessment team be involved in a cognitive preadmission screening.

**E. Comment**

One commentator noted administrator qualifications remain largely at the discretion of the provider due to the "menu" approach of possible ways to satisfy requirements to be an ALR administrator. No requirements are stated for the qualifications of third-party providers.

**Response**

The Department maintains that the administrator qualification requirements protect the health and safety needs of residents, but, as pointed out by the commentator, provide flexibility to licensees to choose a range of qualified individuals to serve as an administrator. In terms of the qualifications of third-party providers, § 2800.142(a) (relating to assistance with medical care and supplemental health care service) requires that ALRs demonstrate the ability to provide or arrange for the provision of supplemental health care services in a manner protective of the safety and well-being of its residents and that they utilize employees, independent contractors or contractual arrangements with other health care facilities or practitioners licensed, registered or certified to the extent required by law to provide the service. The General Assembly, therefore, has set the standard for qualification of third-party providers.

**F. Comment**

One commentator noted there are no requirements that administrators obtain specific education or training in the behavior and needs of people with cognitive limitations other than education and training related to credentials.

**Response**

Based on public comment, § 2800.64 (b)(10)(relating to administrator training) has been revised to require that prior to initial employment as an administrator, training must be completed on care for residents with cognitive and neurological impairments and other special needs.

**G. Comment**

One commentator noted qualifications are inconsistent with credentialing criteria given the various levels of training. The commentator stated that under current

nurse practice laws, the LPN must be supervised by an RN or physician.

**Response**

This rulemaking's scope relates to the qualifications for a person filling the role of an ALR administrator, regardless of other titles or licenses he may hold. Individuals acting within the scope of their practice are required to abide by the provisions of the appropriate licensing board under the Department of State.

**H. Comment**

One commentator stated that the regulations should incorporate staffing qualifications that permit a wider range of licensing and qualification regimes to allow for hiring at an ALR. In addition, the commentator noted there should be additional and on-going training for its experienced property managers, who are otherwise qualified under the current regulations, to enable these managers to also serve as ALR administrators. The commentator recommended the state of New Jersey's model be reviewed and adopted relative to programs permissible for qualification as a direct care staff person qualified to work in an ALR.

**Response**

The Department notes that the stated qualifications in this Chapter for administrators and direct care staff are minimum qualification only and that, as required by Act 56, these qualifications meet or exceed the PCH regulations. In regards to the New Jersey model, personal care assistants working in New Jersey ALRs are required to pass the state Nurse Aide Certification Examination; be certified by the state board as a homemaker-home health aide; or have a personal care assistant certification issued by the state. No such state certification is available in Pennsylvania.

**Section 2800.54  
Qualifications for Direct Care Staff Persons**

**A. Comment**

One commentator noted that requiring an administrator to be CPR and first aid certified would remove individuals who physically could not perform CPR. The commentator stated all direct care staff should meet the CPR and first aid requirement. The commentator noted that programs where administrators are not performing as direct care staff should be exempt from this requirement. The commentator continued, saying it is discriminatory to purposefully exclude capable individuals from the role of administrator, specifically those licensed as nursing home administrators, who direct operations with residents requiring a much higher level of care.

**Response**

The Department elects to retain the requirement that administrators be required to be certified in CPR and trained in first aid. This provision mirrors the PCH regulations, which the Department is required to meet or exceed. The Department

agrees that direct care staff should meet the CPR and first aid requirement and has revised § 2800.65(c) (relating to staff orientation and direct care staff person training and orientation) to require that direct care staff shall be certified in first aid and CPR before providing direct care to residents.

**B. Comment**

One commentator noted there is no geriatric experience required and recommends a minimum of 1 year experience in geriatrics and long-term care. The commentator stated there should be a demonstration of competency in ADLs and care of persons prior to employment.

**Response**

Section 2800.65(g)(1) (relating to staff orientation and direct care staff person training and orientation) requires before direct care staff may provide unsupervised assisted living services, 18 hours of training must occur, including a demonstration of job duties, followed by supervised training. Sections 2800.65(g)(3)(ix) and (xix) require initial direct care staff training in gerontology and person-centered care and aging in place. It is the Department's position that the direct care worker training requirements are adequate for the jobs they perform and sufficient to ensure that the health and safety needs of residents are met.

**C. Comment**

Two commentators suggested exceptions for people such as Amish, Mennonites or immigrants who may not have a high school diploma but could still be great caregivers.

**Response**

The Department finds that the educational requirements of these regulations meet or exceed the PCH regulations as required by Act 56. They are necessary to meet the health and safety needs of residents.

**D. Comment**

Seven commentators stated it is extremely important that existing personal care administrators and other staff members be grandfathered into the qualification requirements. They stated that to not grandfather these individuals would be counterproductive in an already understaffed field. They noted that PCH administrators currently serving in that capacity have duties and responsibilities that are almost identical to those proposed for assisted living.

**Response**

The Department has changed the regulations to allow PCH administrators to become ALR administrators if they meet the requirements outlined in § 2800.53 (a)(6) (relating to qualifications and responsibilities of administrators). These requirements include being employed as a PCH administrator for at least 2 years prior to the effective date of the regulation, having completed the administrator training requirements and passed the Department-approved competency-based

training test at § 2800.64 (relating to administrator training and orientation) within 1 year. This does not apply, however, to PCH administrators qualified under § 2600.53(a)(5) (relating to qualifications and responsibilities of administrators). This exception disqualifies those PCH administrators who qualified under the specific requirement that they work in homes serving 8 or fewer residents, have a general education development diploma or high school diploma and 2 years direct care or administrative experience in the human services field.

Regarding direct care staff persons, no provision for exceptions to the qualification requirements have been provided. The Department finds that because ALR residents will be able to age in place, these residents will need different services and types of support than PCH residents. For these reasons, the Department has elected not to provide grandfathering.

#### **E. Comment**

One commentator is concerned over the provisions that place a significant amount of stress on the staff in ALRs. The commentator noted the additional training and education requirements are beyond what is necessary.

#### **Response**

The Department does not view the education and training requirements of these regulations as being burdensome or excessive. These requirements are needed to ensure that ALRs are properly staffed to ensure the health and safety of residents and to allow for aging in place.

#### **F. Comment**

One commentator stated the proposed regulations confer significant discretion on the provider to make decisions about quantity and quality of staff. Another commentator recommends there should be flexibility in staffing ALRs to best meet the unique needs of each individual resident. The commentator stated ALRs will serve seniors with varying health conditions, and service packages should not be rigid, but responsive to the needs of the resident. The commentator noted that staffing flexibility facilitates the goal of Act 56 to permit residents to age in place by providing seniors with the services they need and by not mandating unnecessary services.

#### **Response**

The Department maintains that it has developed sufficient educational requirements, training requirements and staffing requirements to meet resident needs. For example, § 2800.56 (relating to administrative staffing) requires 1 hour of direct care staff to each mobile resident and 2 hours for residents who have mobility needs. Section 2800.60 (relating to additional staffing based on the needs of the residents) requires staffing to be based on the needs of the resident and specified in the resident's support plan. In addition, § 2800.65(h) (relating to staff orientation and direct care staff person training and orientation) has been enhanced to require 16 hours of annual training. Section 2800.69 (relating to

additional dementia-specific training), requires 4 hours of dementia-specific training within 30 days of hire and at least 2 hours annually thereafter.

**G. Comment**

One commentator noted all employees must undergo and pass a criminal background check as well as pass a drug test for employment. The commentator noted individual employees may only be given responsibilities commensurate with their level of education and experience. The commentator stated those with no formal advanced medical training may not perform any medical-related duties.

**Response**

The Department submits that the qualifications for direct care staff persons meet or exceed the PCH regulations as required by Act 56. It further submits that the specific requirements of background checks are governed by the Older Adults Protective Services Act, known as OAPSA (35 P. S. §§ 10225.101–10225.5102). Regarding staff training, § 2800.60 (a) (relating to additional staffing based on the needs of the residents), staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan. An ALR is responsible for having a staff that is capable of ensuring that resident needs are met.

**H. Comment**

One commentator stated the regulations on age of personnel should conform to the Medicaid waiver requirements. The commentator noted staffing requirements should conform to accreditation standards when ALRs maintain accreditation.

**Response**

These requirements follow Act 56, which requires the Department to meet or exceed the PCH regulations. The Medicaid waiver requirements are outside the scope of these regulations. In addition, the Department is not aware of any national, generally accepted accreditation staffing standards at this time. However, we note that Act 56 contemplates national accreditation of secured ALRs at some point in the future. See 62 P.S. § 1057.3(d).

**I. Comment**

One commentator noted there is a contradiction in the proposed regulation, stating food service workers and housekeepers can be 16 years of age and older, but the regulation does not waive the educational requirements for these persons as it waives the age minimum of 18 years.

**Response**

The definition of direct care staff person does not include ancillary staff that may include housekeepers and cooking staff. The educational requirements in subsection (a)(2) apply to direct care staff persons, not to ancillary staff.

**J. Comment**

Six commentators urged the creation of a new section covering qualifications and training for ancillary staff, other staff or volunteers to address minimum training and qualifications for: food service, housekeeping, administrative or supervisory staff, medical directors, service planners/care managers and third-party contractors. They stated all supervisory staff should have at least the direct care staff training requirements.

**Response**

In regards to training, the Department has included the requirement that direct care staff persons and other staff persons, including ancillary staff persons, have an orientation and training as defined in § 2800.65 (relating to staff orientation and direct care staff person training and orientation). In addition, administrative staff, direct care staff, ancillary staff, substitute personnel and volunteers are all required to receive at least 4 hours of dementia-specific training within 30 days of hire and at least 2 hours of dementia-specific training annually in addition to the training required in this Chapter. The Department finds that these provisions are adequate and meet or exceed the PCH regulations.

**Section 2800.55  
Portability of Staff Training**

**A. Comment**

Six commentators recommend a staff person who transfers either to another licensed residence or from a licensed PCH should be given credit for any completed hours of training required on an annual basis "and have been completed in the calendar year of transfer."

**Response**

The Department interprets the current section allowing portability of training to be specific to each individual from the date of training that is received by that individual for the year, rather than being tied to completion of the trainings in a calendar year.

**B. Comment**

One commentator recommended the addition of a reciprocity agreement.

**Response**

The Department finds that the provisions of the regulations related to portability of staff qualifications and training are sufficient, and that reciprocity agreements among all facilities would be unduly burdensome.

**Section 2800.56  
Administrator Staffing**

**A. Comment**

One commentator recommended changing the term "home" to "assisted living residence." They stated this will clarify an ALR administrator can effectively serve a cluster of assisted living units in the community by spending 20 hours a week on the entire cluster, as opposed to each individual building or unit contained in that cluster.

#### **Response**

Multiple buildings located on the same premises may apply for a single ALR license. See § 2800.11(e) (relating to procedural requirements for licensure or approval of assisted living residences; special care designation and dual licensure). "Home" is not used in this section. Section 2800.11(g)(2) has been revised to allow a dually-licensed facility to request approval from the Department to share an administrator.

#### **B. Comment**

One commentator noted that because problems occurring on weekends will not necessarily get the same attention as those which occur during the week, administrative personnel are needed on the weekends as well. The commentator believes administrative staffing should also be required on Saturdays and Sundays during that same period as "normal business hours."

#### **Response**

The Department has made several significant changes in the regulations that affect administrative staffing. Subsection (b) provides that if the administrator is unavailable to meet the hourly requirements in subsection (a) due to a temporary absence, the administrator shall assign an administrator designee in writing to supervise the ALR during the administrator's temporary absence. Subsection (c) requires that the administrator assign a staff person in writing to supervise the ALR during the administrator's or administrator designee's absence. The administrator designee is required to meet the qualification requirements under subsection (b). The assigned staff person is required to meet the requirements of a direct care staff person. Subsection (d) requires that during the administrator's and administrator designee's absence, the administrator or administrator designee be on-call.

#### **C. Comment**

One commentator questioned if the designees in this section are also required to have the same training as administrators.

#### **Response**

On proposed rulemaking, the designee was required to have the same training as required for the administrator. However, based on the comments received, the Department amended the administrator designee requirements, including the training requirements. As provided in subsection (b), an administrator designee shall meet all of the following requirements:

1. Have 3,000 hours of direct operational responsibility.

2. Pass the Department-approved competency-based administrator training test under § 2800.64(a)(3) (relating to administrator training and orientation).
3. Meet the qualifications and training requirements of a direct care staff person under §§ 2800.54 and 2800.65 (relating to qualifications for direct care staff persons; and staff orientation and direct care staff person training and orientation).

**Section 2800.57**  
**Direct Care Staffing**

**A. Comment**

One commentator stated the ratio of staff to resident is inadequate. The commentator stated that, based on the formula listed in the regulation, only one person would be required each for 24 mobile residents and 12 residents with limited mobility in a 24-hour period. Another commentator noted the proposed regulations do not assure ALRs have sufficient numbers of direct care staff. The commentator continued, requirements are vague and base staffing on a largely irrelevant distinction between mobile and immobile residents. Another commentator maintained that enough direct care staff should be required to ensure at least two hours of care be delivered to each resident each day.

**Response**

Subsections 2800.60 (a) and (b) (relating to additional staffing based on the needs of the residents) require that staffing be provided to meet the needs of the residents as specified in their assessment and support plan and in the design and construction of the ALR. The staffing requirements in the regulations are minimum staffing levels only and are based on the PCH regulations, which the ALR regulations must meet or exceed. The designation of "mobile" and "immobile" residents is based on 62 P.S. § 1001 (relating to definitions).

**B. Comment**

One commentator suggested the following: (1) a social worker should be readily available to all residents; (2) a recreation director should be actively involved; (3) and physician oversight should be available for review of facility issues acutely and on a monthly basis.

**Response**

The Department submits that the specific staffing requirements in the regulation are minimum staffing requirements only. Section 2800.60(a) (relating to additional staffing based on the needs of the residents) requires that staffing be provided to meet the needs of a resident as specified in his assessment and support plan. In addition, subsections 2800.142(a) and (b) (relating to assistance with medical care and supplemental health care services) require the ALR to provide or arrange for supplemental health care services and to assist the resident to secure medical care and supplemental health care services. Sections 2800.221 and 2800.222 (relating to activities program; community social services) address daily activities and community social services.

**C. Comment**

One legislator and thirteen commentators stated that staffing levels should allow for at least 2 hours per resident per day with actual care hours determined based on the assessed needs of residents. They noted the ALR should have the ability to meet unexpected emergencies and meet all anticipated needs as defined in a care plan.

**Response**

The Department submits that § 2800.60 (relating to additional staffing based on the needs of the residents) requires that staffing be provided to meet the needs of the residents as specified in their assessments and support plans. Furthermore, §§ 2800.220(c)(1)(i) and (v) (relating to service provision) require the independent core package to include emergency response and assistance with unanticipated ADLs. Similarly, subparagraphs 2800.220(c)(2)(i) and (c)(2)(ii) (relating to service provision), require the enhanced core package to include emergency response and assistance with unanticipated ADLs. The Department maintains that these provisions should allay the commentators' concerns.

**E. Comment**

The proposed regulations should establish separate staffing ratios for different levels of care, including special care units.

**Response**

Section 2800.60 (relating to additional staffing based on the needs of the residents) requires that staffing be provided to meet the needs of the residents as specified in their assessments and support plans. Section 2800.238 (relating to staffing) requires that a resident in a special care unit be considered a resident with mobility needs. Under § 2800.57(c) (relating to direct care staffing) residents with mobility needs are to be provided with at least 2 hours per day of assisted living services.

**Section 2800.58  
Awake Staff Persons**

**A. Comment**

One commentator stated the regulations should specify that at least one person shall be awake at all times, regardless of whether or not that person is direct care staff.

**Response**

This section requires that direct care staff persons on duty in the ALR shall be awake at all times.

**B. Comment**

One commentator strongly recommends language state the administrator is awake during "presence in the residence."

**Response**

Section 2800.56(a) (relating to administrator staffing) requires that administrators be present in the ALR an average of 36 hours or more per week in each calendar month and that at least 30 hours per week be during normal business hours. The Department interprets normal business hours to require the administrator to be awake.

**Section 2800.59  
Multiple Buildings**

**A. Comment**

One commentator noted that it is unclear from the language but it seems all direct care staff might be absent when they are needed. It is recommended that there be minimum staff persons present in each building at all times when residents are present.

**Response**

The Department has clarified this section by deleting subsection (a) and requiring that ALRs with multiple buildings meet the direct care staff requirements under § 2800.57 (relating to direct care staffing).

**Section 2800.60  
Additional Staffing Based on the Needs of the Residents**

**A. Comment**

Nineteen commentators stated that being required to have a nurse on-call essentially requires that a nurse be employed 24 hours a day. They noted this will be cost prohibitive and will end up resulting in higher fees. In addition, two other commentators suggested that a nurse be on-site at all time, not just on-call.

**Response**

Based on comments received, the regulations have been amended in subsection (b) to require that an ALR must have a licensed nurse available in the building or on call at all times. The Department finds that to allow residents to age in place, it is necessary to have nursing care available to residents to meet their higher acuity needs. The costs are outweighed by the benefits to consumers.

**B. Comment**

Two commentators stated the on-call nurse should be required to be able to be on-site within one hour.

**Response**

The Department finds that it is sufficient to have a licensed nurse either on-call or available in the building at all times. Nursing care coverage will be provided in either event on a continuous basis. Specifying a one-hour physical presence should be left to the ALR to decide.

**C. Comment**

One commentator stated the provisions in section (b) are too open-ended and give the Department the ability to require more staff based on their unnamed requirements.

**Response**

This language mirrors the PCH regulations at § 2600.60 (relating to additional staffing based on the needs of the residents), except for a clarification that the staffing level is minimum only. The Department is required to meet or exceed the PCH regulations under Act 56. The Department has elected to maintain the current language in the regulations. It is imperative, given that this is a new service model in the long-term care continuum, that the Department has flexibility to require additional staffing. Subsection (b) requires additional staffing to be based on the resident's assessment and support plan, the design and construction of the ALR and the operation and management of the ALR.

**D. Comment**

One commentator stated that the timeframe that additional staffing is required needs to be defined into specific terms, i.e. shift, day, etc.

**Response**

The Department has elected not to make this change so that maximum flexibility in meeting residents' needs is preserved.

**E. Comment**

One commentator noted this regulation takes away resident choice. The commentator stated that if an ALR has a dietician available for other levels of care, why require one additional? Another commentator stated that having a dietician on staff or under contract would prove to be a financial hardship.

**Response**

Subsection (e) requires an ALR to have a dietician on staff or under contract to provide for any special dietary needs of a resident as indicated in his support plan. The purpose of this requirement is to ensure that any special dietary needs of a resident are met. It is not clear why the commentator is objecting to this provision. It is unclear how this provision takes away resident choice, nor is it apparent why there is an objection to having a dietician available for other "levels of care"...and "one additional." This section is the only regulatory requirement related to having a dietician on staff as a licensure requirement. Nevertheless, in spite of these objections, the Department finds that the benefit of meeting the needs of residents

who require the expertise of a dietician as indicated on the resident's support plan outweighs the cost.

#### **F. Comment**

One commentator stated it is essential that medically-trained supervisors are on staff. They noted that, without this, the quality of care and number of staff can become a problem. Another commentator stated that the language never requires a nurse to be in the facility to do rounds, deliver or provide oversight of care but, it would appear, only to approve care plans. The commentator went on to say it is unclear how the State proposes that high-quality care will be delivered to residents in ALRs if the staff is absent to oversee and deliver care. It is recommended that there be, at a minimum, a pre-admission and annual assessment by the dietician for all residents as seniors' nutritional health becomes even more critical for them as they age.

#### **Response**

The Department shares the commentators' commitment to quality care and services and finds that the regulations provide for sufficient availability of medical staff, such as an on-call licensed nurse or nurse on the premises, to assure the health of residents. Additionally, the ALR administrator is the individual who is charged with the general administration of the residence. See § 2800.4 (relating to definitions). Furthermore, subsection (a) requires that staffing be provided to meet the needs of the residents as provided in the resident's assessment and support plan. Additionally, ALR staff or service providers who provide services to residents are required to meet their applicable professional licensure requirements. Also, § 2800.142 (relating to assistance with medical care and supplemental health care services) requires that ALRs use employees, independent contractors or have contractual arrangements with other health care facilities or practitioners licensed, registered or certified to the extent required by law to provide supplemental health care services. The Department additionally points to § 2800.26(b) (relating to quality management), which requires a quality management plan be developed to ensure compliance with law and with the relevant standard of care. All of these protections are designed to ensure quality of care. Finally, in response to commentators' concerns about quality of care, the Department has amended § 2800.42(z) (relating to specific rights) to provide a resident with the right to choose his own primary care physician.

In regards to nursing rounds, it is important to remember that ALRs are not medical facilities, but rather, are to provide a supportive environment where residents can age in place in a home-like setting since assisted living is an alternative to nursing facility care. (See Act 56, Findings, paragraph 3.) Staffing must meet the needs of the resident as specified in the resident's assessment and support plan. Regarding nutritional needs, under §§ 2800.224 and 2800.227 (relating to initial assessment and preliminary support plan; development of the final support plan) support plans are to be completed with the involvement of licensed nurses and are to include documentation of dietary needs for each

resident. The Department maintains that these support plans will sufficiently identify any problems in terms of resident nutritional needs.

#### **G. Comment**

Eleven commentators suggested clarification in the following areas: Is the on-call nurse requirement over and above the routine staffing when there may already be a nurse in the ALR at that time? Must they be available to answer questions via telephone? Are there timeframes intended for their availability? "On-call" is not clearly defined; does the nurse have to be employed by the facility or could a home health nurse be on-call?

#### **Response**

Based on comments received, the Department has amended subsection (d) to require that ALRs have a licensed nurse available, either physically present in the building or on call at all times. The purpose of this requirement is to have a licensed nurse available to answer questions or provide professional care either in person or through other means such as by telephone. As to whether the licensed nurse must be employed by the ALR or is a contracted employee, this is up to the ALR to decide.

#### **H. Comment**

Eight commentators have the following recommendations: a licensed nurse should be on staff or under contract to participate in all initial or ongoing needs assessments; a dietician should be involved in all menu planning and meal preparation oversight; adequate staff should be on hand to meet the requirements for activities and socialization.

#### **Response**

Sections 2800.224 and 2800.225 (relating to initial assessment and preliminary support plan; additional assessments) require that the administrator or designee, or a licensed practical nurse, under the supervision of a registered nurse, or a registered nurse must complete initial and annual assessments; section 2800.60(e) (relating to additional staffing based on the needs of the residents) requires that ALRs must have a dietician on staff or under contract to provide for any special dietary needs of a resident as indicated in the resident's support plan.

Also, under § 2800.60(a), ALRs are required to have sufficient staff to meet the needs of residents as indicated in their assessment and support plans. Regarding activities and socialization, § 2800.221(a) (relating to activities program) requires that ALRs develop a program of daily activities to promote each resident's active involvement with other residents, the resident's family and the community. Finally, § 2800.221(c) provides that the ALR shall provide verbal cueing and reminders of activities, their start times and locations within the residence. The Department submits that these provisions adequately address the commentators' concerns.

#### **I. Comment**

Eight commentators stated an ALR should be allowed to assess resident needs and to staff accordingly based on the resident's support plan. They noted the needs of the residents, according to their support plan, should set the standard for staffing.

#### **Response**

The Department agrees. Subsection (a) requires that staffing be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

#### **J. Comment**

One commentator recommended that the Department establish several levels of assisted living and adjust some of the requirements (e.g. staffing) to the needs of the residents in each level. In addition, the commentator recommended that an ALR serving residents with dementia should meet additional requirements. Another commentator stated that staffing levels are too low for the intensity that Alzheimer's patients need and said that the regulations need to be more stringent. The commentator recommended that a provision be added to ensure individuals with Alzheimer's can be safely and effectively served.

#### **Response**

Based on comments received, the Department has amended § 2800.220(c) (relating to service provision) to provide for two core packages that are based on different levels of need: an independent core package and an enhanced core package. Also, § 2800.60(a) (relating to additional staffing based on the needs of the residents) provides that additional staffing be provided to meet the needs of residents as specified in their assessments and support plans.

Regarding residents with dementia, § 2800.231 (relating to admission) provides for special care units for individuals with dementia and special care units for those with brain injury. Section 2800.238 (relating to staffing), requires that each resident in a special care unit be considered a resident with mobility needs. Residents with mobility needs are provided with higher staffing levels under § 2800.57 (relating to direct care staffing). A minimum of 2 hours of staff time per day is the requirement for residents with mobility needs.

### **Section 2800.61 Substitute Personnel**

#### **A. Comment**

Two commentators suggested exceptions for agency staff or staff used very short-term. One commentator stated that the regulation requires substitute personnel to meet the qualifications but they may work for an agency that has different training requirements.

#### **Response**

The Department submits that it is important that substitute personnel have the same training and qualifications as the regularly-scheduled direct care staff. It further submits that the health and safety of residents outweighs the cost of this provision.

**B. Comment**

One commentator suggested that there should be a requirement that contracted employees have the minimum training, licensure or certification as other staff.

**Response**

All direct care staff persons, whether employed by the ALR or through contract, must meet the direct care staff qualifications and training requirements currently in the regulations. See § 2800.54 (relating to qualifications for direct care staff.) They must also meet the staff training requirements in § 2800.65 (relating to staff orientation and direct care staff person training and orientation). Section 2800.142(a) (relating to assistance with medical care and supplemental health care services) further requires that ALRs utilize employees, independent contractors or have contractual arrangements with other health care facilities or practitioners licensed, registered or certified to the extent required by law to provide the service.

**C. Comment**

One commentator recommended the administrator should arrange for coverage by substitute personnel who meet the direct care staff qualifications and training for every absence.

**Response**

Section 2800.60(a) (relating to additional staffing based on the needs of the residents) requires that staffing be provided to meet the needs of the residents as specified in the resident's assessment and support plan. The administrator is responsible for ensuring staff coverage as part of the overall administration of the ALR. See § 2800.4 (relating to definitions).

**Section 2800.63  
First Aid, CPR and Obstructed Airway Training**

**A. Comment**

Fourteen commentators recommend that ALL staff be trained and certified in CPR and first aid, not just "sufficient" staff. Others noted that "sufficient staff" is not defined and could add to payroll and training costs. Others recommended that the ratio of CPR-trained staff to residents should be one for every 50 residents.

**Response**

In response to comments received, the regulations have been amended to require, in § 2800.65 (relating to staff orientation and direct care staff person training and

orientation), that all direct care staff be certified in CPR and trained in first aid. Similarly, administrators are required in § 2800.64(b)(3) (relating to administrator training and orientation) to be certified in CPR and trained in first aid. Section 2800.63(a) has been amended to require that an ALR establish a CPR-trained staff to resident ratio of one CPR-trained direct care staff person for every 35 residents, reducing the requirement from the proposed requirement of one CPR-trained direct care staff person for every 20 residents.

### **Section 2800.64 Administrator Training and Orientation**

#### **A. Comment**

One commentator suggested adding "care for residents with acquired brain injury."

#### **Response**

In response to comments received, the Department has added in paragraph (b)(10) a requirement that administrators receive training on the care of residents with cognitive and neurological impairments and other special needs. This would include care for residents with acquired brain injury.

#### **B. Comment**

Seven commentators stated that since the new regulations so closely mirror the PCH regulations, the dementia care-centered education should be blended into the annual training requirements. They noted the educational requirements of administrators should be strengthened and the number of hours required to be Department-approved be increased to 150. They stated that training requirements should not be waived for any PCH administrator whose employment pre-dated October 25, 2005.

#### **Response**

The Department chose not to blend dementia-specific training with the other training requirements. The dementia-specific training requirements at § 2800.69 (relating to additional dementia-specific training) are in addition to 100-hour standardized Department-approved administrator training course. In addition to the 100-hour administrator training course and dementia-specific training, administrators must have at least 24 hours of annual training relating to their job duties. These administrator training requirements, along with a required passing score on the Department-approved competency-based training test, are designed to ensure the health and safety of residents.

Furthermore, Act 56 requires that the Department must meet or exceed the PCH regulations. By requiring that ALR administrators have administrative experience in a health or human services field, this final-form regulation exceeds the qualifications and responsibilities for PCH administrators required under § 2600.53 (relating to qualifications and responsibilities of administrators), as required by Act 56's mandate that all ALRs shall identify and appoint an administrator or

administrators that meet the qualifications for PCH administrators and any additional standards pertaining to the operations of ALRs as the Department may establish by regulation. (62 P.S. §§ 213(a.1) and (c)).

For PCH administrators who desire to be ALR administrators, they are required to meet the following qualifications: (1) be employed as a PCH administrator for at least 2 years prior to the effective date of the regulation; (2) complete the administrator training requirements; and (3) pass the Department-approved competency-based training test at § 2800.64 within 1 year of the effective date of the regulation; except for PCH administrators qualified under § 2600.53(a)(5) (relating to qualifications and responsibilities of administrators). Section 2600.53(a)(5) disqualifies those PCH administrators who qualified under the specific requirement that they work in homes serving 8 or fewer residents, have a general education development diploma or high school diploma and 2 years direct care or administrative experience in the human services field.

#### **C. Comment**

Thirty-four commentators noted the proposed regulations do not provide an exception for a nursing home administrator with a valid license from substituting credits to keep their nursing home administrator license current. They recommended a paragraph be added to allow an exception that permits a licensed nursing home administrator, employed as an administrator of an ALR, to be exempt from training and educational requirements of this Chapter if the administrator continues to meet the requirements of the Department for an active nursing home administrator license. They stated requiring current nursing home administrators to take a 120-hour course would be a considerable costly, especially for classes that have already been taken. They continued, saying it is critical that the Department accept continuing education credits from courses produced by the National Association of Boards of Long-term Care Administrators and National Continuing Education Review Services. They stated the regulations will raise costs to residents.

#### **Response**

Based on comments received, the Department added subsection (g), which provides that a licensed nursing home administrator who is employed as an administrator prior to the effective date of this regulation is exempt from the initial training and educational requirement of this Chapter. A licensed nursing home administrator hired after the effective date of this regulation is required to complete and pass a Department-approved assisted living administrator competency-based test.

#### **D. Comment**

Numerous comments were received noting that the administrator training course should be developed in consultation with stakeholders including consumers, advocates and others. They also stated there should be no exceptions or waivers of the administrative training requirements. Numerous comments were also

received by the Department recommending that various topics be added to the training topics listed in this section.

**Response**

It is the Department's intention to develop training with input from industry stakeholders, consumers and other interested parties. Based on comments received by the Department, § 2800.19 (c) (relating to waivers) was amended to prohibit waiver of staff training requirements. Regarding course topics, based on comments received, the Department has added a number of required training topic areas to § 2800.64 (relating to administrator training and orientation) including care for resident with cognitive and neurological impairments and other special needs, infection control, training specific to the resident composition, training on person-centered care, informed consent, aging in place, the availability of services to support aging in place and incident management and incident reporting.

**E. Comment**

Two commentators recommended that the regulations require the Department to have the 100-hour course curriculum and competency test prepared prior to the effective date of the regulations.

**Response**

The Department does not regulate itself, but instead, is required by Act 56 to regulate ALRs. However, the Department plans to have the course materials prepared in advance of the effective date of the final-form regulation.

**F. Comment**

One commentator stated ALRs should include in their training of administrative and nursing personnel the meaning of legal documents which appoint agents under power of attorney documents, and shall have designated on a resident's service plan who the agent is under a POA. The commentator stated this will assure important decisions regarding resident's medical, financial or other issues are made by the POA and not by ALR personnel by default, and should include specific directives of the agent when the ALR cannot contact the agent in an emergency situation. The commentator stated this will ensure the desires of residents will be met by ALRs.

**Response**

The Department has elected not to include training on legal documents in order to avoid situations where staff could be put in a position to provide legal advice, which they are not qualified to do. Instead, ALR staff should consult with ALR legal counsel on this matter.

**G. Comment**

One commentator believes that staff that are certified as PCH trainers for resident rights should be automatically approved as trainers for ALRs.

**Response**

Section 2800.68 (relating to instructor approval) establishes the qualifications for instructors who providing administrator training. Because there are differences between PCHs and ALRs, and because the regulations governing each are different, the Department finds that automatic approval is not appropriate. All instructors must meet the requirements of this section independent of their certification as a PCH trainer.

**Section 2800.65**  
**Staff Orientation and Direct Care Staff**  
**Person Training and Orientation**

**A. Comment**

Two commentators suggested adding "care of persons who have sustained an acquired brain injury" to subsections (d)(3) and (f).

**Response**

Act 56 provides defines special care designation to mean a licensed ALR or a distinct part of the ALR which is specifically designated by the Department as capable of providing cognitive support services to residents with severe cognitive impairments, including, but not limited to, dementia or Alzheimer's disease. The Department, based on comments received, expanded the scope of individuals being served in special care units under §§ 2800.231 to 2800.239 (relating to admission; application to the Department). The Department specifically points the commentators to § 2800.236 (relating to training), which establishes training requirements for direct care staff working in units for those who need intense neurobehavioral rehabilitation after brain injury. The Department maintains that these provisions address the commentators' concerns.

**B. Comment**

One commentator stated direct care staff members who have successfully completed certified nursing assistant training should be permitted to provide ALR services while unsupervised.

**Response**

The Department based the direct care staff person training and orientation on the PCH regulations, which it is required to meet or exceed. Because ALR residents will be able to age in place, their acuity levels at some time will most likely require a higher level of care. The Department, therefore, finds that the training outlined in subsection (g) is necessary to protect resident health and safety. Consequently, the requested change has not been made.

**C. Comment**

Eleven commentators stated all ALR staff should be trained in the final ALR regulations and standards, regardless of their experiences with personal care, nursing facilities and other systems. They noted that there needs to be a minimum baseline for ALR staff and grandfathering should not be permitted. They noted

however, that in fairness, abbreviated training for those who have met the PCH qualifications and training requirements since October 2005 should be recognized.

### **Response**

Based on comments received, the Department carefully considered the issue of grandfathering of training requirements and decided, due to the anticipated increased acuity levels of ALR residents, grandfathering is not appropriate. Instead, the regulations allow for a limited number of exceptions to the training and qualification requirements. In particular, the Department considered the expertise that nursing home administrators and PCH administrators possess. In the case of nursing home administrators, § 2800.64(g) (relating to administrator training and orientation) allows a nursing home administrator employed as an administrator prior to the effective date of this regulation, to be exempt from the qualification and training requirements under §§ 2800.53 and 2800.64 (relating to qualifications and responsibilities of administrators; administrator training and orientation) if the administrator continues to meet the applicable licensing requirements. A licensed nursing home administrator hired as an administrator after the effective date of this regulation is required to pass the Department-approved assisted living administrator competency-based test.

In the case of PCH administrators, § 2800.53(a)(6) provides that those employed as PCH administrators for 2 years prior to the effective date of this regulation and who have completed the administrator training requirements and passed the Department-approved competency-based training test at § 2800.64 within 1 year of the effective date of the regulation qualify as ALR administrators.

For all other staff, required training is mandatory and no exceptions have been made.

### **D. Comment**

Eleven commentators made the following recommendations: direct care staff shall complete an initial orientation program approved by the Department prior to the first day of providing direct care to residents; all direct care staff must be certified in first aid and CPR prior to the first day of providing direct care to residents; direct care staff persons, substitute direct care personnel and volunteers shall complete at least 77 hours of training in a Department-approved core curriculum.

### **Response**

The regulations provide that prior to or during the first work day, direct care staff shall have an orientation. This orientation is to consist of training in seven topics related to general fire safety and emergency preparedness essential to ensuring the health and safety of residents. In addition, direct care staff persons are required to complete an initial orientation approved by the Department before providing direct care to residents. Direct care staff are also required to be certified in first aid and CPR before providing direct care to residents. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute

personnel are to have an orientation training consisting of six topics. Direct care staff persons may not provide unsupervised assisted living services until completion of 18 hours of training covered by the 19 training topics listed in subsection (g). In response to commentators, the original list was amended to include the signs and symptoms of infections and infection control; behavioral management techniques; understanding of the resident's assessment and how to implement the resident's support plan; and person-centered care and aging in place. Care for residents with neurological impairments was added to the list for annual training topics in subsection (i)(3). The Department submits that the direct staff training requirements outlined in § 2800.65 of the regulations are sufficient to ensure the health and safety of residents.

With regards to the recommendation that the hourly training requirement be increased, the Department has increased the training hours in subsection (g) over and above what is required in the PCH regulations, which the Department is required to meet or exceed. Additionally, subsection (e) has been amended to increase the hours of required annual direct care staff training. The Department submits that the training requirements meet or exceed those of the PCH regulations and that they sufficiently protect the health and safety of residents.

#### **E. Comment**

Fourteen commentators stated the training program should include the following: a demonstration of job duties, followed by supervised practice; successful completion and passing of the Department-approved direct care training course and passing of the competency test; initial direct care staff person training to include the following: behavioral management techniques, understanding of the resident's assessment and how to implement the resident's support plan, the signs and symptoms of infections and the philosophy of choice and aging in place. They also recommended direct care staff persons have at least 16 hours of training relating to their job duties and the training required in §2800.69 (relating to dementia-specific training) be in addition to the 16 hour annual training. They stated training of staff needs to be specific to the needs of older adults with regard to the following: safe ambulation and transfers, bed mobility, skin care and personal hygiene, nutrition and hydration and behavior management. They noted staff also be trained on caring for individuals with dementia, mental illness and mental retardation.

#### **Response**

After carefully reviewing the required 19 training topics in subsection (g) and (i)(7), the Department is satisfied that the regulations address the commentators' recommended topics. Training in subsection (g), which is required in order to provide unsupervised assisted living services, has been expanded to include training on the signs and symptoms of infections and infection; behavioral management techniques; understanding of the resident's assessment and how to implement the resident's support plan; safety management; safe management techniques; person-centered care and aging in place. Care for residents with

mental illness, neurological impairments and mental illness is covered in subsection (i)(3)..

#### **F. Comment**

Twelve commentators noted core competency training should include the following: person-centered care; communication, problem-solving and relationship skills; nutritional support according to resident preference. They also recommended ancillary staff persons have a general orientation to their specific job functions as it relates to their position prior to working in that capacity. They noted direct care staff should also pass a safe serve certification and it should be considered for staff to pass either home health aid or nursing assistant certification.

#### **Response**

The Department agrees and the core competency training items recommended by the commentators are all contained in the provisions of subsection (e)(6). Subsection (f) addresses the commentators' recommendation to include a general orientation for ancillary staff that relates to their specific job functions as it relates to their position prior to working in that capacity. The Department has elected not to include the remaining recommendations as they are not required in the PCH regulations, which the Department is required to meet or exceed.

#### **G. Comment**

Eleven commentators suggested the addition of a § 2800.70 regarding third-party care providers, stating all of those under contract with an ALR must meet the direct care worker requirements. They continued that those employees under contract with a resident should comply with the requirements of their licensure standards and with the policies and procedures of the ALR (if they are separately licensed in the state).

#### **Response**

The Department has not added a new section and finds that the definition of "ancillary staff person" in § 2800.4 (relating to definitions) addresses the commentators' concerns. The definition states that an ancillary staff person is an individual who provides services for the residents other than direct assistance with activities of daily living. They may include staff who do not provide direct care but who conduct assessment, care planning or care management activities, and who meet the direct care staff qualifications and training requirements. Ancillary staff may also include RNs, LPNs, dieticians, or skilled professionals who meet the requirements of their professional licensure and the direct care staff requirements, if they also provide direct assistance with activities of daily living. Other ancillary staff may include activities planners, housekeepers, cooking staff or facilities staff.

Regarding ALR policies, § 2800.42(y) (relating to specific rights) requires that the actions and procedures utilized by a supplemental health care service provider chosen by a resident must be consistent with the ALR's systems for caring for residents.

#### **H. Comment**

One commentator recommended training on cultural sensitivity be included as part of the direct care staff person training requirements.

#### **Response**

While the Department has not used the exact words "training on cultural sensitivity," it does require in subsection (g)(3)(xix) that initial direct care staff person training include training on person-centered care and aging in place. The Department submits that the term "person-centered care" is broad enough to include instruction on the awareness of, and sensitivity to, the cultural backgrounds and preferences of each resident.

#### **I. Comment**

Three commentators recommend establishing staffing requirements for social services, activities, housekeeping and administration. They noted the regulations should reflect a higher standard in terms of staffing levels and training. They continued, noting that all staff, including administrators, should receive training about caring for cognitively-impaired residents. They noted staff training and credentials must be equivalent to those required in other health care facilities where such care is delivered.

#### **Response**

The provisions of Act 56 reject the idea that ALRs are health care facilities. The definition of supplemental health care services found in 62 P.S. §1001 specifically excludes supplemental health care services that are required by law to be provided by a health care facility pursuant to the act of July 19, 1979 (P.L.130, No.48) known as the "Health Care Facilities Act." In regards to the statement that these regulations should reflect a higher standard in terms of staffing levels and training, the staffing levels meet the requirements of the PCH regulations which the Department must meet or exceed. The training level is increased beyond the PCH requirements. As to the recommendation that the Department establish specific staffing levels, the Department submits that the needs of residents, as contained in their support plans, will drive the provision of support services and that it is not appropriate for it to provide specific standards in this area. Finally, as to training for care of cognitively-impaired individuals, § 2800.64(b)(10) (relating to administrator training and orientation) requires that administrators receive training on care for residents with cognitive and neurological impairments. Also, § 2800.65 (i)(3) (relating to staff orientation and direct care staff person training and orientation) requires that direct care staff receive annual training in caring for residents with dementia, cognitive and neurological impairments.

#### **J. Comment**

One commentator recommended administrators, as well as those persons with medical licenses and certification (physicians, RNs, graduate practical nurses, LPNs, certified nursing assistants), be exempt from the training requirements.

**Response**

The Department submits that, due to health and safety concerns, it cannot make the blanket exemptions related to training requirements suggested by the commentator. The Department points out, however, that §§ 2800.53 and 2800.64 (relating to qualifications and responsibilities of administrators; administrator training and orientation) do provide special consideration for nursing home administrators and PCH administrators because of their levels of expertise.

**K. Comment**

Two commentators stated a minimum number of hours should be designated for training and orientation. One commentator suggested a minimum of 24 hours for direct care staff.

**Response**

The Department agrees there should be a minimum training requirements and has revised subsection (g) by requiring that direct care staff persons may not provide unsupervised assisted living services until completion of 18 hours of training. In addition, § 2800.69 (relating to additional dementia-specific training) requires that administrative staff, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall receive at least 4 hours of dementia-specific training within 30 days of hire and at least 2 hours of dementia-specific training annually thereafter.

This training is in addition to an orientation in general fire safety and emergency preparedness required for direct care staff and other staff including ancillary staff persons, substitute personnel and volunteers; the additional orientation for direct care staff; an orientation training for direct care staff, ancillary staff, substitute personnel and volunteers; and the job-specific general orientation for ancillary staff persons.

**L. Comment**

Thirteen commentators stated the training requirements are excessive. They noted the additional time required to train people will be valuable time taken away from caring for residents. They continued, saying that staff will have to be removed from direct care duties to participate in training. They noted it is believed that in-service education programming could be appropriately provided with a maximum 12-hour annual in-service requirement.

**Response**

The Department submits that the training required in the final-form regulation is necessary and appropriate to provide for the health, safety and well-being of ALR residents. The benefits of training outweigh its cost.

**M. Comment**

Two commentators noted it is unclear who is overseeing training of staff, as well as what is involved in the Department-approved direct care training course. They stated it is unclear who determines competency of staff and how many hours of training are required before direct care staff are allowed to begin work. They noted it is unclear what is meant by "gerontology" and what staff need "orientation". In addition, they noted it is not specified what denotes "department-approved course of study", so it is difficult to determine whether or not this is adequate.

**Response**

The Department submits that the commentators' questions relate more appropriately to implementation of the training elements of the regulation. These elements were first incorporated into the PCH regulations in 2005 and were implemented successfully. The Department is required to meet or exceed the PCH regulations and will be guided in the precedent set in the training for PCHs as it moves forward with implementation of this Chapter.

**N. Comment**

Two commentators stated all supervisory staff should meet at least the direct care staff training requirements.

**Response**

It is unclear what "supervisory staff" the commentators are referring to. If it is referring to administrators, § 2800.53(d) (relating to qualifications and responsibilities of administrators) requires that they have the ability to provide assisted living services or to supervise or direct the work to provide assisted living services. Under § 2800.56(b)(3) and (c) (relating to administrator staffing), an administrator designee and staff persons assigned to act in the absence of both the administrator and administrator designee must meet the qualification and training requirements of a direct care staff person under §§ 2800.54 and 2800.65 (relating to qualifications for direct care staff persons; and staff orientation and direct care staff person training and orientation). The Department submits that these provisions should address the commentators' concerns.

**O. Comment**

One commentator stated the Department should make a distinction or clarify for facility employee training purposes the difference between training of staff and orienting new staff to a specific resident - especially where residents share a room with another resident. The commentator stated the location of a resident's clothing and personal belongings, and preferences in use of personal hygiene and continence products or methods should be identified as an "orientation" for a specific resident. The commentator noted this should be included in the employee training so residents do not wear each other's clothing and there is continuity in how the resident wants certain things done.

**Response**

Training for direct care staff has been changed to include "person-centered care," which embodies the philosophy of developing services and support in such a way that individual resident preferences are at the core of those services and support. The Department maintains that this training will address the commentator's concerns.

**P. Comment**

One commentator recommended deletion of the provision allowing volunteers to provide direct care services to residents.

**Response**

The Department does not concur with the commentator. Section 2800.54(b) (relating to qualifications for direct care staff persons) provides that a volunteer who performs or provides ADLs shall meet the direct staff person qualifications and training requirements specified in this Chapter. This provision mirrors the PCH regulations, which the Department is required to meet or exceed.

**Q. Comment**

One commentator stated direct care staff training and orientation should be developed in accordance with the experience of the assisted living programs to recruit and maintain staff.

**Response**

The Department submits that it is required by Act 56 (see 62 P.S. §1021(a)) to adopt regulations that set minimum standards for building, equipment, operation, care, program and services, training and staffing and for the issuance of licenses. 62 P.S. § 1021(a)(1). To permit ALRs to develop training based on their experience would be contrary to statutory requirements.

**R. Comment**

One commentator stated they would like to see, somewhere in the regulations, knowledgeable and appropriate physician education to staff be encouraged.

**Response**

The Department is unclear what is intended by "physician education to staff be encouraged." However, it submits that the training for administrators, direct care staff persons and ancillary staff persons contained in this final-form rulemaking exceeds what is in the PCH regulations, which is the standard that the legislature has set in Act 56. The Department finds that the training in the regulations is appropriate to protect the health and safety of ALR residents.

**S. Comment**

One commentator stated that residence staff should be knowledgeable and skilled in carrying out important components of geriatric care, including safe medication administration, falls prevention, incontinence care, communication techniques,

dementia care, skin care and being able to recognize the changes that can signal acute illness, delirium and depression.

**Response**

The Department agrees with the commentator. Subsection (i)(1) requires annual training in medication administration, (j)(5) requires training on falls prevention, (g)(3)(xvi) requires training in incontinence care, (e)(6)(ii) requires training in communication skills and (g)(3)(xvi) requires training in prevention of decubitus ulcers. Additionally, subsection (g)(3)(xviii) requires training in understanding resident assessment and implementation of the resident's support plan. Changes in the resident's condition are documented in the ongoing assessment and support plan process. Regarding dementia, § 2800.69 (relating to additional dementia-specific training) requires 4 hours of initial and 2 hours of annual dementia-specific training for all administrative staff, direct care staff persons, ancillary staff persons, substitute personnel and volunteers. These provisions should satisfy the commentator's concerns.

**Section 2800.66  
Staff Training Plan**

**A. Comment**

One commentator stated the training plan should require dates, times and locations of trainings and be given at the start of each training year.

**Response**

The Department submits that the training plan requirements under subsection (b)(3) include the information suggested by the commentator.

**B. Comment**

One commentator recommended, at a minimum, an annual training plan, which includes retraining of all staff regarding the following: hearing loss, including the identification, use and maintenance of hearing aids, cochlear implants, assistive listening systems, captioned telephones, alerting systems and hearing dogs, and other technology for people with hearing loss.

**Response**

The type of training provided on topics such as those recommended by the commentator would fall under subsection (b), which requires that staff training plans be aimed at improving the knowledge and skills of an ALR's direct care staff persons in carrying out their job responsibilities. This type of training is designed to be tailored to the specific needs of residents, some of whom may have hearing impairments.

**Section 2800.67**

## **Training Institution Registration**

### **A. Comment**

One commentator recommended the Department accept course credits from conferences and symposia sponsored by the National Association of Boards of Examiners of Long-term Care Administrators and the National Continuing Education Review Service as well as classes that are sanctioned by the Bureau of Professional and Occupational Affairs and the Department of State.

### **Response**

This section provides an opportunity for institutions, associations, professional societies or organizations to become registered and approved by the Department to provide ALR administrator training.

## **Section 2800.68 Instructor Approval**

### **A. Comment**

One commentator noted it is unclear who is conducting staff training.

### **Response**

Training for administrators under § 2800.64(a)(2) (relating to administrator training and orientation) is to be Department-approved. Administrator annual training under § 2800.64(d) (relating to instructor approval) is to be provided by Department-approved training sources or through approved courses provided by an accredited college or university. Section 2800.67 (relating to training institution registration) addresses how approval is attained. Additionally, the Department must approve an initial orientation for direct care staff persons under § 2800.65(b) (relating to staff orientation and direct care staff person training and orientation). The Department notes that in the PCH regulations, which the Department is required to meet or exceed, the person who is to conduct non-administrator staff training is not spelled out. ALRs are responsible to ensure that their staff meet the training requirements of this final-form rulemaking.

## **Section 2800.69 Additional Dementia-Specific Training**

### **A. Comment**

One commentator stated the regulations should better reflect a higher standard in terms of staffing levels and training. The commentator noted the regulations do not ensure an adequate number of staff or enough training to meet the needs of residents. The commentator stated it is imperative all staff, including administrators, receive training about caring for cognitively-impaired residents.

### **Response**

The Department submits that the staffing levels and training embodied in this final-form rulemaking are designed to meet the health and safety needs of residents. Staffing levels, rather than being artificially imposed, are based on the needs of residents as reflected in their assessments and support plans under §§ 2800.224, 2800.225, and 2800.227 (relating to initial assessment and preliminary support plan; additional assessments; development of the final support plan). Regarding training on how to care for residents who are cognitively impaired, as specified in the proposed regulations at § 2800.65(g)(3)(iv) and (v) (relating to staff orientation and direct care staff person training and orientation), direct care staff training must cover care of resident with mental illness, neurological impairments, mental retardation and other mental disabilities, and the normal aging-cognitive, psychological and functional abilities of individuals who are older. Annual direct care staff person training must cover care for residents with dementia, cognitive and neurological impairments under § 2800.65(i)(3). Under § 2800.64(b)(10) (relating to administrator training and orientation), the language was amended to require training for administrators on care for residents with cognitive and neurological impairments. Additionally, administrative staff, direct care staff persons, ancillary staff persons, substitute personnel and volunteers must all receive at least 4 hours of dementia-specific training within 30 days of hire and at least 2 hours of dementia-specific training annually under § 2800.69 (relating to dementia-specific training). These provisions should address the commentator's concerns.

#### **B. Comment**

One commentator noted that direct care staff needs training specific to safe behavior management, dealing with uncooperative patients, continence care and changes in cognition.

#### **Response**

Under § 2800.65(e)(5) and (e)(6)(ii) (relating to staff orientation and direct care staff person training and orientation) safe management techniques and communication, problem solving and relationship skills are included in orientation training for direct care staff persons, ancillary staff persons, substitute personnel and volunteers.

Based on comments received the Department has added in § 2800.65(g)(3)(xvii) behavioral management techniques training for direct care staff persons, ancillary staff persons, substitute personnel and volunteers. Training on care for individuals with incontinence is required in § 2800.65 (g)(xvi) for direct care staff persons. Training to identify changes in cognition are addressed under (g)(3)(v), which provides for training related to the normal aging-cognitive, psychological and functional ability of individuals who are older.

#### **C. Comment**

One commentator questioned why dementia training is required if, in certain cases, it is not the population being served.

### **Response**

ALRs are designed to allow individuals to age in place. While the initial and annual assessments identify each resident's existing and changing needs, the Department submits that it is vital to the health and safety of residents that administrators, direct care staff persons, ancillary staff persons, substitute personnel and volunteers be able to identify the sometimes slowly evolving signs of dementia so that appropriate treatment can be initiated.

### **D. Comment**

Twenty-nine commentators stated that the requirement for dementia care-centered education should be in addition to, and separate and apart from, the already mandated educational requirement will not contribute to improved resident care. They noted that dementia education can easily be incorporated into the already robust educational requirements. They stated that, as these regulations stand, direct care workers are being asked to obtain more continuing education units than RNs, which is costly and unnecessary. They stated that this would have the effect of removing staff from direct care duties. They noted that dementia training should be an expectation for all core curriculum as well as hospice and palliative care for an aging population. Other commentators recommended different timeframes for dementia training. Some thought a more reasonable timeframe for completing the initial 4-hour dementia specific training is within the first year of employment rather than the first 30 days. Others suggested that the training be provided in the first six months. Other suggested changing the requirement to "at least one (1) hour of dementia specific training within 30 days of hire and at least one (1) hour of dementia specific training annually thereafter

### **Response**

This section, which was recommended by the Alzheimer's Association, requires that administrative staff, direct care staff persons, ancillary staff persons, substitute personnel and volunteers receive at least 4 hours of dementia-specific training within 30 days of hire and at least 2 hours of dementia-specific training annually thereafter in addition to the training requirements of this Chapter. The Department submits that this requirement is not overly-burdensome and that the benefits of this training to support the health and safety of residents outweigh its costs.

## **Section 2800.81**

### **Physical Accommodations and Equipment**

#### **A. Comment**

One commentator noted there was not a requirement that all hallways and common areas be wheelchair accessible.

### **Response**

The Department submits that subsection (a) provides a specific licensing requirement of this Chapter that ALRs 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 the ALR and exit in from the ALR. This provision mirrors the PCH regulations, which the Department must meet or exceed.

**B. Comment**

Three commentators believe that grandfathering should not be allowed and recommended that since this is a new system it should start clean and clear from the biases of existing systems. Other commentators said that grandfathering of existing ALRs and PCHs should be allowed under the proposed changes in regulations, stating that many providers will not be able to afford the costs of coming into full compliance.

**Response**

The Department gave serious consideration to all views on this issue and chose to make distinctions in a number of areas between existing facilities and new construction. While this is a new licensure category, the Department submits that it is appropriate to recognize that many existing PCHs may meet the licensing standards under this Chapter if a limited number of changes are made. The fiscal cost of this regulation is in fact based upon the number of existing PCHs that can potentially convert to ALRs. Furthermore, the General Assembly's acknowledgment that there are similarities between PCHs and ALRs is reflected by its requirement in Act 56 that ALRs meet or exceed the PCH regulations. The Department submits that, by making a limited number of exceptions to the regulatory requirements, it has successfully made conversion affordable for many PCHs, which will result in expanded choice and the opportunity for more consumers to age in place.

**Section 2800.82  
Poisons**

**A. Comment**

One commentator recommended provisions be made for certain personal care products or commonly used cleaning products to be kept in a locked cabinet in the resident's room. The commentator stated some of these are considered poisonous if ingested, but this should not preclude competent residents from safely storing and using these products.

**Response**

There is no prohibition in the regulation against securely storing personal care products or commonly used cleaning products in a competent resident's room for his own use. The Department will be guided by PCH policy, which states that poisonous materials shall be stored in their original, labeled containers; poisonous materials shall be stored separately from food, food preparation surfaces and dining surfaces; and poisonous materials shall be kept locked and inaccessible to

residents, unless all of the residents living in the home are able to safely use or avoid poisonous materials.

### **Section 2800.83 Temperature**

#### **A. Comment**

One commentator noted an indoor maximum temperature should be indicated. They noted that the Department of Aging requires a 78 degree maximum in a senior center. Other commentators suggested an ALR should have a minimum and maximum temperature standard. Another comment received stated that the requirement for central air or window units for every resident does not take into consideration the needs or desires of the elderly. Another commentator suggested that each resident/unit should have the ability to control the temperature. Four commentators said individually controlled thermostats would be cost-prohibitive.

#### **Response**

As the General Assembly directed in Act 56, the ALR regulations are to meet or exceed the requirements of the PCH regulations, which do not require air conditioning at all. This final-form rulemaking establishes air conditioning as the standard in ALRs and thus exceeds the PCH regulations. Under subsection (c), for new construction, central air conditioning is required. Under subsection (b), for existing residences, central air conditioning is required unless it is not feasible or is cost prohibitive, in which case window air conditioning units are to be provided. The ALR is required to submit justification to the Department for the use of window air conditioning units.

These regulations were developed to provide for an environment in which residents can maintain maximum independence, exercise decision-making and personal choice. Section 2800.101(a)(3) (relating to resident living units) requires that each living unit must have an individually controlled thermostat for heating and cooling. As such, ALR residents will have the ability to exercise their personal preferences related to room temperature.

#### **B. Comment**

Five commentators stated it is unreasonable to require existing facilities to "submit justification to the Department for the use of window air conditioners." Additional commentators pointed at the cost of installing central air.

#### **Response**

The Department submits that subsections (b) and (c) establish central air conditioning as the standard for ALRs. As a result, any deviation from that standard must be justified to the Department, which will consider requests for exceptions to the standard. The Department submits that the standard is a reasonable one and that its benefit to residents outweighs the cost.

**C. Comment**

Six commentators requested the use of "through-the-wall" heating and air conditioning units as a means of controlling the temperature within an ALR. They stated window units are sufficient to provide resident comfort. They noted window units have not been proven unsafe or unfit for congregate living facilities, and are an acceptable method to heat or cool an ALR.

**Response**

Central air conditioning is the cooling standard for ALRs. A facility must justify why central air conditioning cannot be installed. The Department is aware of the cost associated with installing central air conditioning and will consider reasonable waiver requests for window units. As to "through-the-wall" heating and air conditioning units, the regulations do not specify the type of an ALR's heating and air conditioning system.

**Section 2800.85  
Sanitation**

**A. Comment**

One commentator stated that a sewage permit should be required for ALRs with 4 or more resident rooms that do not connect to a public sewer system.

**Response**

Section 2800.85(f) mirrors the PCH regulations, which the Department is required to meet or exceed.

**B. Comment**

One commentator recommended ALRs that empty trash daily be exempt from lids on the receptacles. The commentator noted residents have difficulty with covered trash cans due to vision, mobility and dexterity limitations.

**Response**

This provision mirrors the PCH regulations, which the Department is required to meet or exceed. The Department submits that covered trash receptacles are an important sanitation protection.

**C. Comment**

Regarding subsection (c), one commentator stated it should say the premises be sanitary and all trash removed in a timely manner.

**Response**

The weekly minimum standard specified in the regulations is an industry standard for trash removal. Regardless of this, subsection (a) already requires that sanitary conditions shall be maintained.

**Section 2800.86**

## Ventilation

### A. Comment

Eight commentators recommended that ALRs should be required to use carbon monoxide detectors.

### Response

There is no statutory requirement that carbon monoxide detectors be provided and these detectors are not a requirement under the PCH regulations, which the ALR regulations are required to meet or exceed. Legislation that would require carbon monoxide detectors in PCHs and ALRs is pending in the General Assembly. (HB 2062, PN 2841; The Care Facility Carbon Monoxide Alarm Act.)

## Section 2800.88 Surfaces

### A. Comment

Eight commentators recommended any asbestos on site be appropriately remedied. They noted if asbestos is in a building or contained in any part of the structure, the building must have a certification from an asbestos remediation company the building is safe.

### Response

As IRRC recommended, the Department undertook additional meetings to secure input from industry stakeholders, consumers and other interested parties on these final-form regulations. A new subsection (c) was added to address this concern both as a result of those meetings and other comments the Department has received.

## Section 2800.89 Water

### A. Comment

One commentator stated there is no mention of safety checks of water temperature. The commentator noted persons with dementia need to be protected against being washed with cold as well as hot water, for safety as well as dignity and comfort.

### Response

This section mirrors the PCH regulations, which the Department is required under Act 56 to meet or exceed. The Department's intent is to be guided by PCH policy, which includes provisions for the testing of hot water temperature. If the intent of the commentator is to provide for protection from abuse, § 2800.42(b) (relating to specific rights) provides protection from physical abuse.

## Section 2800.90

## Communication System

### A. Comment

Seven commentators stated the need for at least one phone located on each floor that is accessible to persons with sight and/or hearing impairments.

### Response

The Department has elected not to make this change. Subsection (a) requires that an ALR have a working, noncoin operated, landline telephone that is accessible in emergencies and accessible to individuals with disabilities. This language mirrors provisions of the PCH regulations, which the Department is required to meet or exceed.

### B. Comment

One commentator stated the landline telephone be amended to include a cell phone in order to keep the regulations in tune with today's culture.

### Response

The regulation requires that the ALR provide at least one accessible landline in a common area for resident use. The Department has elected not to make the requested change since a cell phone may not be available in an emergency due to a power outage or low battery. This regulation mirrors the requirement in the PCH regulation which the Department must meet or exceed. The Department has, however, added that for internal communication within an ALR serving 9 or more residents that the system or method for communication include a cell phone system among other methods.

### C. Comment

One commentator suggested an alternate communication system be implemented for those with hearing loss. The commentator noted an analog line for captioned telephone, telecommunication device for the deaf or computer be made available for people who want to use telephone relay, captioning or video relay system. In addition the commentator stated alerting systems such as flashing doorknockers be made available. The commentator suggested televisions have captioning.

### Response

Under § 2800.18 (relating to applicable laws) ALRs are required to comply with applicable Federal, State and local laws, ordinances and regulations. As such, they are required under the Americans with Disabilities Act to provide reasonable accommodations for people with disabilities, including those with hearing loss. The Department leaves it to each ALR to establish ways to meet the needs of its residents within the requirements of the law and has elected not to mandate specific devices and communication systems that must be used. Having said that, there are provisions under § 2800.130(d) (relating to smoke detectors and fire alarms) that require a device approved by a fire safety expert be used and tested if

one or more residents or staff persons are not able to hear a smoke detector or fire alarm.

**Section 2800.91  
Emergency Telephone Numbers**

**A. Comment**

One commentator asked if 911 will suffice for police, fire, ambulance, poison control and local emergency. In addition, the commentator asked if the ALR complaint hotline is the current state number.

**Response**

This provision mirrors that of the PCH regulations, which the Department is required to meet or exceed. The Department asserts that 911 by itself is not sufficient. Specific phone numbers, as listed in this section, must be posted as it is not always appropriate to contact 911 directly for every type of emergency. The ALR complaint hotline referred to in this section will be established as a new telephone number by the Department.

**Section 2800.92  
Windows and Screens**

**A. Comment**

One commentator suggested windows above the ground floor have safety guards limiting their opening beyond 6 inches.

**Response**

The Department has elected to not change this provision. The provision mirrors that of the PCH regulations, which the Department is required to meet or exceed.

**Section 2800.93  
Handrails and Railings**

**A. Comment**

Four commentators recommended "hallways" be removed. They stated it institutionalizes a residential setting.

**Response**

The Department submits that having well-secured handrails in the hallways is vital to protecting the independence, health and safety of residents. This requirement exceeds the PCH regulations and reflects accommodations needed to meet the acuity levels of ALR residents to allow them to age in place.

**Section 2800.94  
Landing and Stairs**

**A. Comment**

One commentator questioned if there are any other requirements for the stair strips, such as non-skid or luminescent.

**Response**

The Department is required to meet or exceed the PCH regulations, which it has met in subsection (b) and which it has exceeded in subsection (c). Subsection (b) requires the use of non-skid surfaces on all stairways. Subsection (c) requires that stairs have strips for those with vision impairments. The Department submits that ALRs may use luminescent strips to fulfill this requirement, but will not limit the techniques used by an ALR to meet this regulation, as there may be others available.

**B. Comment**

Six commentators noted subsection (a) is not clear as to the intention.

**Response**

A resident who opens and proceeds through a door could potentially fall if stairs open directly into a stairway without having a landing. The Department submits that this requirement is a safety precaution. This provision meets the PCH regulations as required by Act 56.

**C. Comment**

Four commentators stated that vision markers on stairs should only be required in stairwells or emergency exit areas. They noted the use of strips in non-exit areas reduces the residential feel of an ALR.

**Response**

The Department has elected not to make this change and submits that as a safety protection, all stairs must have strips for those with vision impairments. This provision is reinforced in § 2800.87 (relating to lighting), which requires that ALR rooms, hallways, interior stairs, outside steps, outside doorways, porches, ramps, evacuation, routes, outside walkways and fire escapes be lighted and marked to ensure that residents, including those with vision impairments, can safely move through the ALR and safely evacuate.

**Section 2800.96  
First Aid Kit**

**A. Comment**

One legislator and fifty-four commentators stated the requirement that every first-aid kit include an AED is unnecessary and will be cost prohibitive. They stated this goes beyond what is required in skilled nursing facilities and will raise costs to residents. They continued this could also cause ALRs to reduce the number of first-aid kits. Another commentator recommended that ALRs be required to have only one AED on a crash cart that is accessible to all staff.

**Response**

Based on comments received and as a result of agreement reached at stakeholder meetings, this provision has been modified to require that an ALR have an AED in each building on the premises, not in each first aid kit.

**B. Comment**

One commentator noted the AED acronym, the "E" stands for "external", not "electronic." The commentator noted this is an error and should be changed.

**Response**

The Department has made this correction.

**C. Comment**

Seven commentators stated it is inappropriate for an ALR to have only one first aid kit. They stated each ALR have enough first aid kits in accessible locations to ensure staff can swiftly administer first aid treatments. Another commentator suggested that ALRs forgo a first aid kit if similar supplies are readily available.

**Response**

Subsections (b) and (c) require that a first aid kit be in a location that is easily accessible to staff persons and that staff persons know the location of the first aid kit. This requirement is the same as that of the PCH regulations, which the Department is required to meet or exceed. The Department submits that this requirement is sufficient to meet the health and safety needs of residents.

**D. Comment**

Four commentators stated an AED in the first aid kit creates an issue regarding resident advance directives.

**Response**

The Department has changed the requirement that an AED must be in first aid kits and, instead, requires in subsection (a) that there be one AED in each building on the premises. Individual circumstances will dictate whether a resident has an advance directive and, if so, what provisions are included. The Department provides for advance directives in § 2800.143(b)(11) (relating to emergency medical plan), which requires that information regarding advance directives and do not resuscitate orders be available at all times for each resident and accompany the resident when he needs emergency medical attention.

**E. Comment**

One commentator stated that in the event of an emergency requiring the use of an AED, 911 should be called and the person transferred.

**Response**

The Department has elected not to make this change. Training on the use of an AED by the appropriate training entity will determine the appropriate emergency procedures, including when it is appropriate to call 911 and transfer the person.

### **Section 2800.98 Indoor Activity Space**

#### **A. Comment**

Sixteen commentators stated two indoor common areas of at least 750 sq. ft. would be cost prohibitive and result in fewer facilities being able to be licensed as ALRs. They recommended the ALR's dining room be used as a universal space outside of meal time. They noted this would meet the indoor activity space requirements without having separate rooms. Three commentators also stated that this provision should apply only to new construction.

#### **Response**

The Department submits that there is no exclusion in the regulations that states the dining area cannot be considered one of the two common areas. The Department declines to apply these provisions only to new construction.

#### **B. Comment**

One commentator stated this regulation is contradictory. The commentator noted while the combined areas must accommodate all residents, this will not happen when 50 units would require 15 square feet per living area or 750 square feet, and 51 units or more are limited to a combined total of 750 square feet of living/lounge areas.

#### **Response**

The Department does not find this provision to be contradictory. Subsection (b) requires that the combined living room or lounge areas must accommodate all residents at one time. It further requires that ALRs that have up to 50 living units have at least 15 square feet per unit and that there must be a total of 750 square feet if there are more than 50 living units. It additionally requires that these rooms or areas must contain tables, chairs and lighting to accommodate the residents, their families and visitors. The guiding factor in these requirements is the resident population.

#### **C. Comment**

Eight commentators recommended all indoor activity space be accessible to all residents.

#### **Response**

Regarding accessibility issues, the American with Disabilities Act requires reasonable accommodation and § 2800.81(a) (relating to physical accommodations and equipment) requires that ALRS must 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 the ALR and exiting from the ALR. This requirement mirrors that in the PCH regulations, which the Department is required to meet or exceed. The Department maintains that this standard adequately addresses the commentators' concerns.

#### **D. Comment**

One commentator noted two common rooms within the residence are not necessary for quality care and recommended CCRCs be considered when defining activity space. Another commentator stated there should be more detail on resident "engagement." The commentator noted the proposed regulations use the term "recreation."

#### **Response**

The Department submits that the presence of common rooms within the ALR is a quality of care issue. A purpose of these regulations in § 2800.1 (relating to purpose) is to provide residents with the assistance they need to develop and maintain maximum independence. Socialization is one way to provide assistance in developing and maintaining independence. Additionally, the definition of IADL (instrumental activities of daily living) in § 2800.4 (relating to definitions) includes engaging in social and leisure activities. Common rooms encourage social and leisure activities. IADLs are included as assisted living services under § 2800.220 (b)(4) (relating to service provision). Section 2800.221(a) (relating to activities program) requires that ALRs shall develop a program of daily activities designed to promote each resident's active involvement with other residents, the resident's family and the community and provide the necessary space and equipment for activities in accordance with §§ 2800.98 and 2800.99 (relating to indoor activity space; and recreation space). As such, the Department submits that these provisions offer residents with opportunities to become socially engaged and provide sufficient basis for requiring common rooms within ALRs. As to the use of the term "recreation," the usual dictionary definition would apply. Regarding CCRCs, these regulations apply only to the ALR licensure category.

### **Section 2800.101 Resident Living Units**

#### **A. Comment**

One commentator stated if residents have kitchens in their rooms, it will discourage socialization. The commentator noted it is also cost prohibitive and a fire safety issue. Six other commentators stated the kitchenette requirement may not be suitable or cost-effective in dementia-specific units. They noted these appliances could pose a threat to their personal safety. Another commentator suggested providers have the option to charge for microwaves and refrigerators.

#### **Response**

The requirement for kitchen capacity is specified in Act 56. See 62 P.S. § 1021(a)(2)(iv). As for safety concerns, the Department notes that §§ 2800.224, 2800.225, 2800.227 (relating to initial assessment and preliminary support plan; additional assessments; development of the final support plan) provide for assessments and support plans, which would identify cognitive and behavioral issues that would make it unsafe for a resident to use cooking appliances. Similarly, for dementia-specific units, § 2800.231(b) and (c) (relating to admission) provides for preadmission screening, which would identify individuals for whom use of cooking appliances could pose a danger. Additionally, § 2800.101 (d)(1)(ii) and (d)(2)(ii)(B) require that appliances be designed so they can be disconnected and removed for resident safety. In terms of cost, the Department submits that the benefits to ALR residents to be able to choose whether or not to cook their own meals outweigh the cost to the ALR. Regarding socialization, the Department's goal is to provide personal choice for residents with regards to whether or not they prefer to do their own cooking. The Department submits that §§ 2800.221(b) and 2800.222 (relating to activities program; community social services) provide sufficient opportunities for resident socialization. Regarding the charging of a fee for appliances, § 2800.101 (d) provides that a resident may bring his own cooking appliance and small refrigerator if he so desires. If the appliances are provided by the ALR, any charge for their use would be a subject of the resident-residence contract.

#### **B. Comment**

Eighteen commentators noted microwaves and refrigerators in each living unit would be extremely cost prohibitive. They stated this should be a matter of choice. They stated most residents would not choose to use these appliances. They continued the ALR should be allowed to document the resident opted out of having these appliances. One commentator recommended allowing residents and/or resident's family members to provide these appliances.

#### **Response**

The Department agrees with the commentator. In response to comments received, the Department has amended paragraphs (d)(1)(i) and (d)(2)(ii)(A) to provide that the resident or his designated person may provide his own cooking appliance or small refrigerator, or both, so long as they meet the ALR's safety standards.

#### **C. Comment**

Six commentators noted current facilities will be unable to meet the requirements for kitchen capacity.

#### **Response**

The proposed regulations establish standards for existing PCHs that provide for flexibility in the area of kitchen capacity based on the recommendation of industry stakeholders during the stakeholder meetings held prior to the issuance of the proposed rulemaking. Subsection (d)(2)(ii) allows existing PCHs to avoid major

renovation costs by allowing them to meet the kitchen capacity requirements of this section by having a common resident kitchen. If existing facilities do not meet the standards for assisted living, then appropriate renovations must be made in order to pursue licensure for assisted living. The PCH licensing category will continue to exist after adoption of this final-form rulemaking. If a facility cannot meet the requirements of the ALR regulations, it may choose to remain a licensed PCH.

#### **D. Comment**

Six commentators recommended existing facilities be grandfathered and continue operating with 60 or 80 sq. ft. for private rooms. They noted it would be difficult and cost prohibitive to change the physical structure of many facilities. They stated if this does not occur, many facilities will be unable to obtain an ALR license.

#### **Response**

The Department has elected not to make this change. Act 56 directs the Department to establish minimum square footage requirements for individual living units. PCHs do not provide an opportunity for residents to age in place and thus they serve different functions than do ALRs. If a resident in an ALR requires supplemental health care services, the living unit must be large enough for those services to be provided. At the direction of IRRC, in October of 2008 the Department conducted a survey of the 1,437 PCHs in the Commonwealth. Based on the findings of that survey the Department estimates that there are approximately 243 PCHs that had at least 90% of their rooms that would qualify as to room size under these ALR regulations. As stated above, the PCH licensing category will continue to exist after adoption of this final-form rulemaking. If a facility cannot meet the requirements of the ALR regulations, it may choose to remain a licensed PCH.

#### **E. Comment**

Two commentators stated "space for storage of personal property" needs better defined. They questioned the following: Does it have to be on-site? How many square feet of space? Can the storage space be contained within their individual unit since they are all private rooms? Is this in addition to the living space mandated in the regulations? They noted this could raise the cost of operations.

#### **Response**

This language allows for flexibility in the location and size of the storage space. The storage area for clothing is specified as a chest of drawers and a closet. Other personal items could be stored in individual living unit closets. A reasonable amount of storage space must be provided by the ALR for storage of the resident's personal items. Large items of personal property and large furniture is the responsibility of the resident. Rental of a separate storage area needs to be arranged by the resident.

#### **F. Comment**

Three commentators stated the requirement for notification devices in living units and bathrooms may be beneficial to the high acuity or aged population, but rehabilitative residences may not require this amount of space. They questioned if an emergency notification system is necessary if all residents have necklace or bracelet notification systems? Will a necklace or bracelet system suffice?

**Response**

The Department finds that it is beneficial to have emergency notification devices installed in the living units rather than to require that devices such as bracelets be worn by residents. A pull cord in a bathroom will always be there in an emergency, while a resident may forget to put on a bracelet. A staff person assisting a resident in their room may also use this emergency notification device to alert others. Additionally, personal emergency response systems such as necklaces and bracelets typically notify outside entities of an emergency, whereas subsection (r) requires that notification devices in living units notify ALR staff in the event of an emergency.

**G. Comment**

Two commentators stated a door to the bedroom is unreasonable and not needed. They noted this will limit a resident's mobility within the ALR and result in increased costs. In addition, this requirement fails to take into consideration efficient floor plan designs, such as an alcove design.

**Response**

The Department has elected not to make this change based on its desire to provide residents with privacy and dignity. Subsection (o) requires that for living units with a separate bedroom, there must be a door on the bedroom.

**H. Comment**

One commentator questioned the requirement to have a lock on each living unit. The commentator proposed the following: What about an emergency, where access to several residents at once is needed? The commentator noted locks can be a hindrance.

**Response**

The requirement for a lock on a door is contained in Act 56 which requires that each living unit provide a door with a lock, except where a lock in a unit under special care designation would pose a risk or be unsafe. (See 62 P.S. § 1021(a)(2)(iv)). In consultation with the Department's PCH division, the Department concurs that there is, however, a need for the requirement that there be a master key for safety purposes. This should satisfy the commentator's concerns.

**I. Comment**

Twenty-eight commentators stated requiring fire-retardant mattresses takes away resident choice and residents should be able to bring their own mattress. They

also noted this would be cost-prohibitive to many facilities and PCHs should be grandfathered. One commentator suggested a fire-retardant mattress cover be permitted for those residents who use their own personal bed. They questioned if mattresses sold in the U.S. are fire-retardant.

#### **Response**

As agreed to by industry stakeholders, consumers and other interested parties, language in the regulations was amended to allow an exception to the fire retardant requirement for residents who bring their own mattresses.

#### **J. Comment**

Eight commentators stated a ceiling height averaging 7 feet is not accessible to chair lifts and other assistive devices. In addition, they stated it is not safe in the event of a fire. They noted ceiling height be no less than 8 feet throughout the living space.

#### **Response**

The Department submits that the ceiling height requirement of 7 feet is identical to that found in the PCH regulations, which the Department must meet or exceed.

#### **K. Comment**

Seven commentators stated it is inappropriate to require roommates to share dresser drawers, lamps and night tables. They recommended each living unit have a bathroom and storage closet and adequate storage space for resident storage to include medical equipment or assistive devices. In addition, they stated ALRs should respect the privacy of the resident and ensure entries are announced and minimally intrusive. One commentator also recommended 4 feet of clear access aisle and room for the maneuverability of durable medical equipment such as a Hoyer lift.

#### **Response**

The Department submits that it is important to note that a resident is not required to share a room under this regulation. A resident who does agree to share a room with another person is not required to share the items specified in subsection (j), which includes the items listed by the commentators. Instead, the regulation provides that these items "may" be shared. Section 2800.104 (relating to bathrooms) requires a bathroom and a storage closet as noted in subsection (j)(4). The Department submits that the minimum square footage requirements established under § 2800.101(b)(1) and (b)(2) provide sufficient space for residents to age in place and to accommodate their needs, including their ability to maneuver within the living unit. Regarding privacy, the regulations in subsection (h) require that each living unit must have a door with a lock unless it is under a special care designation and a lock would pose a risk or be unsafe. The Department submits that these provisions should allay the commentators' concerns.

**L. Comment**

One commentator stated it is wrong to limit the occupancy of a unit to only two residents. The commentator noted there are residences that provide for low-income individuals that can not afford the cost of a private or double room. The commentator continued, for residents on SSI, a triple room may be all that they can afford. The commentator noted this requirement would eliminate a segment of the low-income population that would be unable to afford to live in an ALR based on this criterion.

**Response**

Act 56 requires that ALRS provide a resident with his own living unit except that two residents may voluntarily agree to share a living unit. See 62 P.S. § 1021(2)(II).

**M. Comment**

Four commentators are concerned with the regulation requiring a private tub/shower. They stated this could limit seniors' access to ALRs and a private tub or shower would be a hazard, not an enhancement.

**Response**

Act 56 requires that each living unit contain a private bathroom. See 62 P.S. § 1021(a)(2)(iv). As defined in the tenth edition of the Merriam Webster's Collegiate Dictionary, the word "bathroom" means a room containing a bathtub or shower and usually a sink and toilet. This requirement meets or exceeds the PCH regulations, which require one shower/bathtub for every 15 residents. ALRs are designed to provide residents with their own living units that include a bathroom in order to provide them with dignity, privacy and independence.

**N. Comment**

One commentator stated requiring a minimum ceiling height or pools to have lifeguards is overly prescriptive and could result in fewer ALRs.

**Response**

The minimum ceiling height contained in the regulations is the current standard as stated in the PCH regulations, which the Department must meet or exceed. Section 2800.106 (relating to swimming areas) requires that if an ALR operates a swimming area that they must be in accordance with applicable laws and regulations and that they must have and implement written policies and procedures to protect the health, safety and well-being of residents. The Department does not view these regulations as overly prescriptive. Additionally, it is not required that an ALR have a swimming pool, but if it does, the regulations regarding swimming areas would apply.

**O. Comment**

One commentator recommended 4 feet of clear access aisle and room for the maneuverability of durable medical equipment such as a Hoyer lift.

**Response**

The Department submits that the square footage requirements under paragraphs (b)(1) and (b)(2) provide sufficient space for residents to maneuver and for the storage of durable medical equipment.

**P. Comment**

One commentator recommended each residence have a designated number of wheelchair accessible units, e.g. 75%, including accessible bathrooms (a reasonable percentage of which must have roll-in showers).

**Response**

The Department finds that the following provisions of the final-form regulations address the accessibility of ALR living units: Residents are provided with assessments under §§ 2800.224, 2800.225 (relating to initial assessment and preliminary support plan; additional assessments), which would identify individual accessibility needs; § 2800.81 (relating to physical accommodations and equipment) requires that the ALR 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 the ALR and exiting from the ALR; § 2800.101(b)(4) requires that the doors in living units, including entrance doors, must be accessible or adaptable for wheelchair use; and § 2800.102 (d) (relating to bathrooms) requires that toilet and bath areas in the living unit must have grab bars, hand rails or assist bars and that bathtubs and showers must have slip-resistant surfaces.

In addition to the above provisions, and based on public comment, the Department in § 2800.22(e)(4)(vi) (relating to application and admission), requires that an ALR disclose the number of living units in the ALR that comply with the Americans with Disabilities Act. The Department submits that this provision reflects the purpose of the regulations as specified under § 2800.1(b) (relating to purpose), which is to provide residents with personal choice and decision-making as to the resident's choice of an ALR.

**Q. Comment**

Two commentators stated a stovetop for hot food preparation in a common area is a significant safety issue. They requested this be removed from the regulations.

**Response**

Act 56 requires kitchen capacity in an ALR. Existing facilities have the option to either have kitchen capacity in the individual living units or in an accessible common area. A resident's individual support plan would identify whether he is capable of using a stovetop.

**R. Comment**

One commentator recommended each resident unit include the following: 250 sq. ft. of clear, usable floor area (any calculation of "clear and usable floor area" shall exclude closets, bathroom and kitchen space; if multiple occupancy is anticipated, this should increase by 90 sq. ft. per each additional person); private bedroom (studio/efficiency apartments meet this requirement); private bathroom; kitchen capacity; lockable door, unless otherwise specified by the regulations (at a minimum, kitchen capacity shall consist of the following: food preparation area, cabinets and food storage area, refrigerator, sink with hot and cold water, stove or microwave that can be removed or disconnected if required by a resident's support plan); habitable spaces, hallways, corridors, laundry areas, bathrooms, toilet rooms and kitchens shall have a clear ceiling height of not less than 7 feet; every habitable space except kitchens and bathrooms shall have at least one window or skylight; a room shall not be less than 10 feet in any plain dimension and shall be at least 120 sq. ft. overall; bathrooms and toilet rooms shall provide privacy to the occupant of the room and shall not be part of the only access to another space or means of egress; bathrooms shall include a shower or tub/shower with grab bars, a lavatory with a top at 34" height and knee space beneath at least 30" wide and 27" high and an ADA compliant toilet with grab bars; clearances within the room and at each fixture shall be in compliance with the Fair Housing Act; each unit shall be equipped with an emergency notification system in the bathroom and sleeping area.

## **Response**

The issue of required square footage is addressed extensively in the Preamble. Paragraphs (b)(1) and (b)(2) require that the square footage requirement is to exclude bathrooms and closet space and that there must be an additional 75 feet in new construction and 50 feet in existing facilities when a living unit is shared with another resident. This requirement meets or exceeds the PCH regulations. Subsection (a) requires that an ALR provide each resident with his own living unit unless he voluntarily agrees to share a living unit. Section 2800.102(e) (relating to bathrooms) requires that privacy in the living unit shall be provided for toilets, showers and bathtubs by partitions or doors. It also requires that bathroom doors in a double occupancy living unit be lockable by the resident, unless contraindicated by the support plan. Subsection (d) requires that toilet and bath areas in the living unit must have grab bars, hand rails or assist bars. Bathtubs and showers must have slip-resistant surfaces. The Department has elected not to specify the dimensions of the toilet or reference the Fair Housing Act since § 2800.18 (relating to applicable laws) require that ALRs comply with applicable Federal, State and local laws, ordinances and regulations. Kitchen capacity is required for all units under paragraphs (d)(1) and (d)(2) and meets or exceeds the PCH regulations. Subsection (h) requires that each living unit must have a door with a lock, except where a lock in a unit under a special care designation would pose a risk or be unsafe. Subsection (e) requires that the ceiling height in each living unit must be an average of at least 7 feet. This language mirrors the PCH regulations, which the Department must meet or exceed, and will permit the use of

bedrooms with irregular or sloped ceilings or dormer windows. Subsection (f) requires that each living unit must have at least one window with direct exposure to natural light; Section 2800.86(b) (relating to ventilation) requires that a bathroom that does not have an operable, outside window must be equipped with an exhaust fan for ventilation. Subsection (r) requires that each living unit be equipped with an emergency notification system to notify staff in the event of an emergency. The Department submits that the above provisions should address the concerns of the commentator.

#### **S. Comment**

Sixty-eight commentators questioned how will enhanced floor space enhance a resident's dignity if they have difficulty crossing the room? They continued, these regulations exceed what is required in skilled nursing homes.

#### **Response**

The Department submits that these regulations have been developed to allow residents to age in place. A resident's assessment and support plan will identify the services and supports that each resident needs in order to develop and maintain maximum independence, exercise decision-making and personal choice. Direct care staff are required under § 2800.57(c) (relating to direct care staffing) to provide at least 2 hours per day of assisted living services to each resident who has mobility needs, which may include assisting a resident to move around their living unit. In regards to requirements for skilled nursing homes, the Department maintains that ALRs are not nursing homes and will have residents with a range of capabilities, mobility and overall acuity levels. As such, the Department submits that the regulations provide the minimum requirements necessary to enable residents to age in place as required by Act 56.

#### **T. Comment**

Two legislators recommended the requirements should be written to state that while the average room size must meet the standard, 20% of the rooms on a floor could be 15% smaller than the stated requirement. They stated this would allow some existing personal care homes to become assisted living ALRs.

#### **Response**

Act 56 at 62 P.S. § 1021(a)(2)(v) allows the Department the discretion to make exceptions to the size of the living units. Section 2800.19 (relating to waivers) outlines the process to be used to seek waivers.

#### **U. Comment**

One commentator suggested grandfathering of existing assisted living and PCHs be permitted. The commentator noted existing facilities will be forced to shut down and residents could end up homeless. The commentator stated rural facilities can not afford to add additions and rip out walls to comply with the proposed square footage rules.

**Response**

The Department notes that there are currently no licensed ALRs in the Commonwealth, nor will ALR licenses be issued until final regulations are published per Act 56, section 11. There is no statutory or regulatory requirement that existing PCHs pursue ALR licensure. The Department estimates that there are approximately 243 PCHs that have at least 90% of their rooms that would qualify as to room size under these ALR regulations.

**Section 2800.102  
Bathrooms****A. Comment**

Seven commentators stated all toilet and bath areas in the resident's living unit have grab bars, handrails or assist bars. They stated bathroom doors, in a double occupancy living unit, must be lockable, unless otherwise indicated in the support plan.

**Response**

The requirement for grab bars, handrails, or assist bars is currently required under subsection (d). The recommendation for lockable doors in double occupancy living units has been added to the regulatory language in subsection (e), which states that bathroom doors in a double occupancy living unit must be lockable by the resident, unless contraindicated by the support plan.

**B. Comment**

One commentator suggested a soap dispenser is not needed if a bathroom is not shared.

**Response**

The Department agrees with the commentator. Language has been added to subsection (i) to require that either bar soap or a dispenser with soap be provided within reach of each bathroom sink unless a living unit is shared, in which case there shall be a separate bar clearly labeled for each resident sharing the living unit.

**C. Comment**

Two commentators recommend the sink and mirror do not have to be in the bathroom, but may be directly outside of the bathroom (this would be separate from the kitchen sink).

**Response**

The Department submits that current language in the regulations meets or exceeds that in the PCH regulations, which requires one sink and one wall mirror in the bathroom for every 6 or fewer users. See § 2600.102(b) (relating to bathrooms). This requirement in this Chapter underscores the differences between PCHs and

ALRs by establishing ALRs as places that provide for more autonomy and privacy for their residents.

**D. Comment**

One commentator noted living units have entrance doors that are wheelchair accessible, but bathroom doors are not addressed.

**Response**

The Department directs the commentator to § 2800.81(a) (relating to physical accommodations and equipment), which requires that ALRs 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 the ALR and exiting from the ALR. The Department submits that this provision addresses the commentator's concerns.

**E. Comment**

Three commentators stated existing residences be exempt ("grandfathered") from meeting the requirement of a private bathroom in every room. They noted it does not seem reasonable to exclude units without bathrooms or showers. They noted losing apartments due to this regulation would result in a loss of revenue, resulting in cost increases to residents.

**Response**

62 P.S. § 1021(a)(2)(iv) requires that each living unit contain a private bathroom. These regulations must conform to the statutory requirements in Act 56.

**F. Comment**

Two commentators requested modification allowing other emergency notification systems. They stated if additional systems need to be purchased, this would be cost prohibitive.

**Response**

The proposed regulation does not specify the type of emergency notification system to be used and the Department is unclear what the commentators mean by "other" emergency notification systems. Regarding cost, the Department considers emergency notification an essential safety provision for ALR residents and finds that its benefits to consumers outweigh the costs.

**G. Comment**

Two commentators recommended a 5 year delayed implementation of this requirement to allow facilities, who wish to undergo the necessary renovations, time to complete the construction.

**Response**

A facility that wishes to be licensed as an ALR but does not meet the regulatory standards can remain licensed as a PCH until necessary renovations are made.

While there will be PCHs that do not meet the ALR licensing requirements, the Department submits that a significant number of existing PCHs will either be eligible for dual licensure or for ALR licensure based on the Department's survey referenced in the Preamble.

### **Section 2800.103 Food Service**

#### **A. Comment**

One commentator stated the phrase "food shall be stored off the floor" be reworded and/or clarified.

#### **Response**

The Department submits that the term "off the floor" is clear as written to mean that food and beverages may not sit directly on the floor.

#### **B. Comment**

One commentator suggested training be provided for food staff and aides so they know what "mechanically soft" (and other) diets are and what they look like. The commentator noted this would ensure a resident is delivered consistent meals which meets the directive of their physician and dietitian.

#### **Response**

The Department submits that under §§ 2800.224 and 2800.225 (relating to initial assessment and preliminary support plan; additional assessments) a resident's specific dietary needs and restrictions would be identified. Subsequently, under §§ 2800.224 and 2800.227 (relating to development of the final support plan) a final plan would be developed and implemented to meet those needs. The Department further submits that under § 2800.65(f) (relating to staff orientation and direct care staff person training and orientation), ancillary staff persons are required to receive a general orientation to their specific job functions as it relates to their position prior to working in that capacity. Additionally, should any resident have special dietary needs as prescribed by a physician, physician's assistant, certified registered nurse practitioner or dietitian, an ALR is required under § 2800.161(d) (relating to nutrition) to meet those needs. The Department maintains that these provisions sufficiently address the commentator's concerns.

### **Section 2800.104 Dining Room**

#### **A. Comment**

One commentator asked that the availability of condiments at the dining table be at the discretion of the ALR.

#### **Response**

Under subsection (c) (relating to dining room) condiments are required to be available at the dining table. This provision mirrors that of the PCH regulations, which the Department is required to meet or exceed.

**B. Comment**

One commentator noted the mention of "adaptive eating equipment" should be available. The commentator noted this does not address the need of occupational therapy to do an evaluation. The commentator questioned how this item will be purchased.

**Response**

The need for adaptive equipment would be established through the assessment process under §§ 2800.224 and 2800.225 (relating to initial assessment and preliminary support plan; additional assessments). Once a need is established, it is the responsibility of the resident to either pay privately for the equipment or to seek reimbursement from a third-party payor such as the resident's insurer.

**C. Comment**

One commentator questioned the requirement of 15 sq. ft. per person. The commentator stated this could result in the loss of their facility or their residents having to pay a large increase to keep the residence open.

**Response**

Nothing in these regulations requires existing PCHs to become licensed as ALRs. They can continue to exist as they are, the only limitation being that no person, organization or program shall use the term "assisted living residence" in any name or written material, except as a licensee under Article X of the Public Welfare Code. (62 P.S. § 1057.3(i).)

**D. Comment**

One commentator feels that the square footage minimum should be capped at 750 sq. ft. and that this space should serve dual roles as a common area.

**Response**

The Pennsylvania Housing Finance Agency, based on their experience, recommended the 15 square feet per person requirement. In designing these regulations, the Department chose to adopt measurable, enforceable and objective requirements. Establishing that dining rooms must have 15 square feet per person for residents scheduled for meals at any one time meets that requirement.

**Section 2800.105  
Laundry**

**A. Comment**

Four commentators stated that the 24-hour return timeframe for laundry service is unreasonable, especially if the service is outsourced. They stated this is cost

prohibitive and should be eliminated. They suggested a more reasonable timeframe would be 72 hours for the return of laundry.

**Response**

The Department finds that this provision is reasonable and mirrors the PCH regulations, which Act 56 requires these regulations to meet or exceed.

**B. Comment**

Six commentators stated laundry be a part of the core benefit package a consumer receives with their price of admission. Another commentator stated that laundry service for bed linens and towels be a core service, however, a resident should have the choice of doing their own laundry. They recommended ALRs have the responsibility of making washers and dryers accessible for resident use.

**Response**

Laundry services are a part of the core service packages for all ALR residents. The cost of laundry services is part of the core service charge. Based on comments received, however, a change has been made to the final-form regulations to allow residents to "opt-out" of laundry service. See § 2800.220(d) (relating to service provision). Because the laundry service is part of the core packages, the cost must still be listed in the resident-residence contract. However, the resident may choose to not take the service and have their fee adjusted accordingly. Another change in this section makes it clear that if an ALR provides laundry facilities on the premises, residents may use them to do their own laundry. See § 2800.105(b) (relating to laundry).

**Section 2800.106  
Swimming Areas**

**A. Comment**

Six commentators suggested if an ALR has a pool, it be fenced in, have a latched gate and a Red Cross-certified lifeguard on duty during any hours residents are permitted to swim. Another commentator recommended pools not have lifeguards. The commentator noted this could result in fewer ALRs.

**Response**

Section 2800.18 (relating to applicable laws) requires that an ALR comply with applicable Federal, State and local laws, ordinances and regulations. This requirement mirrors the PCH regulations, which the Department is required to meet or exceed. Nothing in the regulations requires that an ALR have a pool. However, if they do have a pool, minimum standards as reflected in § 2800.18 must be applied to protect the health and safety of residents.

**Section 2800.107  
Emergency Preparedness**

**A. Comment**

Six commentators recommended an ALR have a 3-day supply of all resident medications on hand.

**Response**

Section 2800.185(b)(5) (relating to accountability of medication and controlled substances) requires ALRs to have an adequate supply of resident medication on hand at all times. A resident's support plan should specify what "adequate" means under individual circumstances.

**B. Comment**

One commentator noted there should be a requirement for duplicate emergency information to be stored off-site.

**Response**

Subsection (d) requires that written emergency procedures be reviewed, updated and submitted annually to the local emergency management agency. The Department submits that this means that there will always be a duplicate of the plan located off-site, with the local emergency management agency as the custodian.

**C. Comment**

One commentator recommended a copy of any emergency plan prepared by the ALR be available to residents and/or families, agents under Power of Attorney and Guardians.

**Response**

Section 2800.123(b) (relating to emergency evacuation) requires that copies of emergency procedures, as specified in § 2800.107 (relating to emergency preparedness), be posted in a conspicuous and public place in the ALR and a copy be kept. This requirement mirrors that of the PCH regulations, which the Department is required to meet or exceed. Nothing in these regulations, however, preclude an ALR from additionally providing the plan to others.

**D. Comment**

One commentator recommended each ALR maintain a current listing of non-ambulatory residents or those needing assistance with evacuation. The commentator stated this listing should be available to first responders and staff. The commentator noted the emergency plan contain provisions for internal and external disasters. The commentator continued that each ALR should work with the local emergency preparedness agency to determine the most appropriate options for evacuation. The commentator noted residents with more complex health care needs may need to be evacuated to another residential or health facility.

**Response**

Section 2800.124 (relating to notification of local fire officials) requires that an ALR notify the local fire department in writing of the address of the ALR, location of the living units and bedrooms, and the assistance needed to evacuate in an emergency. In terms of internal and external disasters, the Department will require ALRs to rely on established policies used in PCHs that address disasters of both types and by PCH policies regarding the development of specialized emergency plans to address resident evacuation options.

**E. Comment**

One commentator recommended additional emergency preparedness planning be included. The commentator stated ALRs should have updated disaster recovery or continuity of operations plans that are tested and practiced. The commentator noted staff should be encouraged to have a personal and family preparedness plan. The commentator continued health and other consumer records should be available (not lost) and accessible if there is a power failure, fire or other disaster. The commentator recommended requiring ALRs to have pre-planned contracts with fuel companies.

**Response**

The Department submits that the provisions of this section meet or exceed the PCH regulations. Additionally, § 2800.18 (relating to applicable laws) requires that an ALR comply with applicable Federal, State and local laws, ordinances and regulations, which would include those relating to safety and emergency preparedness. The commentator's request that the regulations address emergency preparedness plans for staff and their family is outside the scope of this regulation, which is to protect the health and safety of ALR residents. The ALR should take responsibility for ensuring staff safety. The purpose of this section is to coordinate ALR protection of residents with local emergency preparedness efforts. In regards to availability of resident records, § 2800.143(b) (relating to emergency plan) requires that specified emergency medical and health information be available at all times for each resident. As to fuel contracts, the Department submits that how such contracts are structured is a business decision for each ALR and, therefore, elects not to include the recommended change.

**Section 2800.108  
Firearms and Weapons**

**A. Comment**

Fourteen commentators stated firearms and weapons not be allowed in ALRs. Two other commentators recommended an ALR have a written policy regarding firearms in the possession of residents or staff. They stated an ALR is not required to permit firearms. They noted this proposed revision gives an ALR the option of not having a written policy if firearms are barred from the premises.

**Response**

Based on comments received and as a result of agreement reached by industry stakeholders, consumers and other interested parties, subsection (a) has been amended to require that an ALR have a written policy regarding firearms, weapons and ammunition where these items are on the premises or in possession of any resident or staff member. An ALR is not required to permit firearms, weapons and ammunition.

**Section 2800.109**  
**Pets**

**A. Comment**

Eight commentators recommended an ALR be required to disclose their policies regarding pets.

**Response**

The Department agrees with the commentators. Subsection (e) requires that an ALR disclose whether pets are permitted.

**B. Comment**

Ten commentators recommended ALRs be required to accept service animals (service and hearing dogs, etc.). They noted these pets are allowed under the Americans with Disabilities Act.

**Response**

The Department maintains that provisions of the Americans with Disabilities Act (ADA) address the issue of service animals and provide detailed and comprehensive guidance on it. Section 2800.18 (relating to applicable laws) of the regulations requires that an ALR comply with applicable Federal, State and local laws, ordinances and regulations. The Department thus defers to the Federal law, and directs ALRs to the following web site which provides guidance on the use of service animals: <http://www.ada.gov/qasvc.htm>.

**Section 2800.121**  
**Unobstructed Egress**

**A. Comment**

One legislator and one commentator recommended all facilities (including buildings that exist on the day the regulations take effect) should be required to meet the best available standards or practices for fire safety and accessibility.

**Response**

The regulations require, under § 2800.18 (relating to applicable laws), that an ALR comply with applicable Federal, State and local laws, ordinances and regulations.

These are minimum requirements. However, in order to further provide for the health and safety of residents, the Department encourages ALRs to adopt best practices but will refrain from establishing a mandate that they do so.

**B. Comment**

One commentator recommended that all staff should be trained in fire safety and fire drills held.

**Response**

The Department agrees with the commentator. The final-form regulations require in § 2800.65(a) (relating to staff orientation and direct care staff person training and orientation) that ALR administrators and staff receive fire safety training. In addition, § 2800.132(a) (relating to fire drills) requires unannounced monthly fire drills.

**§ 2800.124.**

**Notification of Local Fire Officials**

**A. Comment**

One commentator questioned the frequency of the written notification to the fire department. Four other commentators recommended an annual update to local emergency officials. They stated current language imposes undue and unnecessary burdens through interpretation. They noted it essentially mandates that first responders learn each significant change in a resident's health condition.

**Response**

The Department will follow the guidance established in PCH policies that requires initial notification followed by updated notice to the fire department only when the evacuation assistance needs of the residents change.

**B. Comment**

One commentator stated it is a waste of time and money to notify the fire department when there is a new resident in need of assistance to evacuate. They noted some fire departments prefer not to receive periodic updates.

**Response**

The Department submits that regardless of the preferences of the recipient of reports, this requirement is an important health and safety protection for ALR residents. This provision mirrors the PCH regulations, which the Department is required to meet or exceed.

**Section 2800.129  
Fireplaces**

**A. Comment**

One commentator stated that ALRs with a special care designation should not be permitted heating stoves and fireplaces due to safety concerns.

**Response**

In regards to special care units, the Department submits that § 2800.231(a)(1) and (2) (relating to admission) require that specialized care for residents be consistent with the resident's support plan. If the support plan precludes the use of a heating stove or fireplace, it will not be permitted for that resident. This requirement provides for the safety of the resident and others in the ALR.

**B. Comment**

Eight commentators stated chimneys and flues should be cleaned and serviced at least annually. They recommended written documentation of the servicing be kept.

**Response**

In response to commentator recommendations, the Department has amended § 2800.129(c) (relating to fireplaces) to require that chimneys and flues be cleaned and serviced at least annually and that written documentation of the servicing be kept.

**Section 2800.130  
Smoke Detectors and Fire Alarms**

**A. Comment**

One commentator stated the 48-hour timeframe for repair is not always possible.

**Response**

The Department submits that this provision mirrors that of the PCH regulations, which the Department is required to meet or exceed. Furthermore, the benefit to residents outweighs the cost.

**B. Comment**

One commentator stated testing smoke detectors and fire alarms once per month is labor intensive and costly.

**Response**

This provision mirrors that of the PCH regulations, which the Department is required to meet or exceed. The Department maintains that the benefits of functioning safety equipment outweigh the cost.

**C. Comment**

Seven commentators recommend smoke detectors be located in common areas, storage rooms, laundry rooms, dining rooms and kitchen areas in addition to those in living units.

**Response**

The Department finds that the requirements under this section exceed those of the PCH regulations by requiring that a smoke detector be located in each living unit, as opposed to a unit being placed within 15 feet of each bedroom door in a PCH.

**D. Comment**

Two commentators stated adding smoke detectors to each living unit will be cost prohibitive.

**Response**

The Department maintains that with regards to the safety of the residents, the benefits outweigh the cost. Additionally, living units will now have kitchen capacity. Smoke alarms are essential to protect the health and safety of residents under these circumstances.

**E. Comment**

One commentator recommended ALRs have smoke detectors on each floor, along with signaling devices and an active sprinkler system. The commentator noted standards should be the same regardless of size to protect those with mobility needs.

**Response**

Subsection (c) requires that if an ALR serves nine or more residents, there shall be at least one smoke detector on each floor interconnected and audible throughout the ALR or an automatic fire alarm system that is interconnected and audible throughout the ALR. Subsection (d) requires that if one or more residents or staff persons are not able to hear the smoke detector or fire alarm system, a signaling device shall be used. As mentioned above, these regulations exceed the PCH regulations by requiring a smoke detector in each living unit. In regards to sprinkler systems, the Department maintains that if a sprinkler system is needed, § 2800.18 (relating to applicable laws) would provide for it since ALRs are required to comply with applicable Federal, State and local laws, ordinances and regulations, including appropriate fire safety and building codes.

**Section 2800.131  
Fire Extinguishers**

**A. Comment**

One legislator and fifty-two commentators noted the placement of fire extinguishers in every living unit is a serious cause of concern. They stated residents could be injured by the extinguisher or the resident might battle a fire. They stated this is a safety concern for all residents, not to mention cost prohibitive. They noted this is a higher standard than nursing homes. They stated staff is trained to bring an extinguisher to the fire and in how to use the extinguisher. Another commentator suggested extinguishers be located throughout the community, on every floor, every 75 feet.

### **Response**

Based on concerns raised by industry stakeholders, consumers and other interested parties, this provision has been amended to remove the requirement for a fire extinguisher in each living unit. This change was made based on cost and safety concerns and was agreed to by the stakeholders.

## **Section 2800.132**

### **Fire Drills**

#### **A. Comment**

One commentator stated specific reference should be made regarding the evacuation of mobility-impaired residents, with cross-reference to § 2800.123. Another commentator noted that it is a nuisance and expense to obtain written approval by a fire safety expert of fire safety areas on the same floor as each resident with mobility needs. The commentator stated re-approval should be required only if the fire safety area has changed or if a new floor has residents with mobility needs.

#### **Response**

The Department submits that the current language related to evacuation is sufficient and that cross-referencing is unnecessary. Both requirements are equally applicable and necessary for compliance with these regulations regardless of whether or not they are cross-referenced. In regards to re-approval of fire safety areas, this requirement mirrors that of the PCH regulations, which the Department must meet or exceed.

#### **B. Comment**

One commentator stated fire drills should be held during sleeping hours every 6 months, but only if each residence is free to determine its own sleeping hours.

#### **Response**

The intent of fire drills during sleeping hours is to test evacuation readiness when the majority of residents are asleep for the night. Most fire deaths occur at night while people are sleeping and reaction time is generally slower when people wake abruptly. Fire drills at night are critical to protect residents in the event of an actual fire. The Department has elected not to specify specific sleeping hours in order to provide flexibility to ALRs in scheduling the drills.

#### **C. Comment**

One commentator noted it is not always safer to move residents from their rooms if they're behind fire-rated doors. They stated removing residents would remove a level of fire/smoke barrier which can protect the resident. They noted this is not the standard evacuation process used in hospitals or nursing homes and should not be mandatory in personal care or ALRs.

#### **Response**

This requirement mirrors that of the PCH regulations, which the Department is required to meet or exceed. The Department submits that the requirement is necessary to protect the health and safety of residents.

**Section 2800.133  
Exit Signs**

**A. Comment**

One commentator recommended the addition of exit signs at floor level. The commentator stated that due to smoke rising during a fire, common exit signs will be obscured. The commentator also noted that large, raised letters should be located on the interior side of the doors that are to be used, at both eye and floor level.

**Response**

The Department finds that this provision of the final-form rulemaking meets or exceeds the PCH regulations because the Department deleted the prefatory language in subsection (2) from the PCH regulations that provides "If the exit or way to reach the exit is not immediately visible,..." (§ 2600.133(2)).

**B. Comment**

One commentator recommended the regulations require access to exits in all ALRs be marked with readily visible signs indicating the direction of travel, not only ALRs with 9 or more residents.

**Response**

This section mirrors the PCH regulations, which the Department is required to meet or exceed. The Department has elected not to make the recommended change.

**Section 2800.141  
Resident Medical Evaluation and Health Care**

**A. Comment**

One commentator noted PPD (tuberculosis skin test) should be documented on the medical evaluation form. The commentator questioned since there is not a spot for PPD to be written on the form, is a separate page with results stapled to the medical evaluation acceptable?

**Response**

The Department acknowledges it will need to provide guidance on the completion of the medical evaluation form specific to documentation of PPD.

**B. Comment**

Two commentators are concerned with the TB test. They recommended this test be completed prior to admission (not within 15 days after admission). They questioned who is responsible for administering the test, the residence or the resident's physician? They also questioned; since this should not be a cost to the resident, who is responsible for the cost?

**Response**

The Department submits that this provision exceeds the PCH regulations, which are silent on TB testing. The intent of this provision is not to require that residents have a TB test performed by an ALR but, instead, to provide choice if the resident wants his own physician to perform the test. In regards to payment for the test, either the resident or his third-party insurance payor would be responsible for the cost. As to the 15 days, this conforms to the other provisions in the regulation that allow an exception for development of initial assessments and preliminary support plans if the admission to the ALR is due to exigent circumstances. See § 2800.224 (relating to initial assessment and preliminary support plan).

**C. Comment**

Six commentators stated that medical evaluations be completed at least every 6 months (not annually), upon a change in condition and within 30 days after a hospital discharge. They continued, saying the evaluation should include information about the resident's day-to-day personal care needs.

**Response**

The Department submits that a yearly medical evaluation is the standard for ALR residents with the caveat that, as provided in subsection (b)(2), a resident shall have a medical evaluation if the medical condition of the resident changes prior to the annual medical evaluation. This provision mirrors the PCH regulations, which the Department is required to meet or exceed. Regarding the language in subsection (a)(12), the Department concurs with the commentators with the exception that the term "personal care needs" has been replaced with "assisted living service needs" as defined in the regulations.

**D. Comment**

One commentator recommended adding the following to the medical evaluation: a physician, nurse practitioner or physician assistant should indicate whether advanced directives or physician orders for life-sustaining treatments have been discussed with the potential resident or family members and any outcomes or plans from that discussion.

**Response**

The Department finds that the issues of advance directives and life-sustaining treatment are ones that should be options for each individual. Consequently, it has elected not to require that ALRs initiate discussions with residents on these topics. Instead, § 2800.143(b)(11) (relating to emergency medical plan) requires that instructions regarding advance directives, do not resuscitate orders or organ

donations are to be part of the resident's written emergency medical plan, if applicable.

**E. Comment**

One commentator stated an assessment should include a standardized minimum screen to identify both executive and memory deficits.

**Response**

The Department submits that subsection (a)(10) requires that a mobility assessment be included in the medical evaluation. As defined in § 2800.4 (relating to definitions) a "resident with mobility needs" includes an adult who has difficulty in understanding and carrying out instructions without the continued full assistance of other individuals. While the Department maintains that this definition is broad enough to cover the commentator's concerns, as the Department works with industry stakeholders, consumers and other interested parties to develop forms, it will consider the inclusion of a standardized minimum screen to identify both executive and memory deficits.

**F. Comment**

One commentator recommended "at least annually" be changed to read "within a year and a month of the previous evaluation." The commentator noted this provides leeway in avoiding weekends or holidays when doctors don't do evaluations, gives a cushion to allow for scheduling conflicts and takes care of such situations as when the resident is ill and has to reschedule an appointment.

**Response**

The Department interprets "at least annually" to be based on a resident's annual anniversary date of the last evaluation. A prudent ALR would plan for a resident's upcoming annual anniversary and take appropriate action to include scheduling of the annual evaluation sufficiently ahead of time to meet this requirement.

**Section 2800.142  
Assistance with Medical Care and Supplemental  
Health Care Services**

**A. Comment**

Twenty-eight commentators stated allowing an ALR to limit a resident's choice of supplemental health care service providers is inconsistent with the ALR philosophy of making an ALR as home-like as possible. They stated a resident should have the right to choose a supplemental health care service provider unless the ALR can show the following: the provider is not covered under the relevant insurance program; is not in good standing with the appropriate licensing agency or is unwilling to follow legitimate ALR procedures. They recommended this provision be deleted, ensuring residents have the right to choose supplemental health care service providers.

**Response**

Regarding resident choice of supplemental health care service providers, the Department is constrained by Act 56, which provides that to the extent prominently disclosed in a written admission agreement, an ALR may require residents to use providers of supplemental health care services designated by the ALR. See 62 P.S. §1057.3(a)(12). If an ALR permits residents to choose their own supplemental health care providers, § 2800.42(y) (relating to specific rights) requires that the actions and procedures utilized by a supplemental health care service provider chosen by a resident must be consistent with the ALR's systems for caring for residents. Regarding professional licensure, § 2800.42 (a) requires that each ALR shall demonstrate the ability to provide or arrange for the provision of supplemental health care services in a manner protective of the health, safety and well-being of its residents utilizing employees, independent contractors or contractual arrangements with other health care facilities or practitioners licensed, registered or certified to the extent required by law to provide the service. This accords with 62 P.S. §1057.3(a)(12).

While the Department is constrained by Act 56 regarding choice of supplemental health care providers, based on comments received, the Department has added § 2800.42(z) to the final-form regulation to provide residents with the right to choose their own primary care physicians.

**B. Comment**

One commentator noted ALRs should ensure that health care providers that come to a facility to provide care meet certain criteria, such as criminal background checks, appropriate licensing, liability insurance, workers compensation and a medical evaluation (TB screening). The commentator stated the right to maintain a list of preferred supplemental health care providers who have written agreements with ALRs is also needed.

**Response**

The definition of supplemental health care services under § 2800.4 (relating to definitions) includes those services provided directly by the ALR or through contractors, subcontractors, agents or designated providers. In both of these cases, any employee or contract employee who has direct contact with residents or unsupervised access to their living quarters would be required to meet the requirements of the Department of Aging's Older Adult Protective Services Act (35 P. S. §§ 10225.101–10225.5102), and 6 Pa. Code Chapter 15 (relating to protective services for older adults), which will govern criminal history records checks in ALRs. Section 2800.142(a) (relating to assistance with medical care and supplemental health care services) requires ALRs to provide or arrange for the provision of supplemental health care services in a manner protective of the health, safety and well-being of its residents using employees, independent contractors or contractual arrangements with other health care facilities or practitioners licensed, registered or certified to the extent required by law to provide the service. It is the

responsibility of the ALR to ensure that supplemental health care services, either provided directly or by contract, are following all appropriate laws required under § 2800.18 (relating to applicable laws).

These regulations stress resident choice. If an ALR does not designate a supplemental health care service provider, there is nothing to prohibit a resident from choosing his own. In regards to a list of preferred providers, the Department has elected not to insist on such a list. However, nothing in the regulations precludes or prohibits an ALR for having such a list.

**C. Comment**

One commentator noted there are no appeal processes or rights for consumers to challenge an ALR decision to withhold approval of a provider. The commentator stated the term "unreasonable withholding" is not defined.

**Response**

The Department has deleted the term "unreasonably withheld" in subsection (b), which was formerly designated as subsection (a). The Department submits that the resident-residence contract governs matters between residents and ALRs. Disagreements between the two would thus be a matter of contract law.

**D. Comment**

One commentator recommended providers have the right to approve who is providing services in their community. The commentator noted the regulation should comply with legislation provisions. The commentator continued, saying the regulation supersedes that right by allowing residents to choose any provider.

**Response**

Paragraph (b)(ii) provides that an ALR may require the use of the ALR's providers of supplemental health care services to the extent that this is prominently displayed in the written admission agreement. Section 2800.42(y) (relating to specific rights) requires that if an ALR agrees to allow residents to use their own service providers, those providers must operate consistent with the ALR's systems for caring for residents.

**E. Comment**

Two commentators noted that supplemental health care providers may be restricted to a single provider approved by the ALR. They noted physicians should be excluded from this; they are not "supplemental" health care providers. They continued, saying if a consumer's physician wishes to continue caring for them, they should not have to give up that physician in order to obtain housing. They recommended ALRs allow residents to utilize their chosen practitioner as long as transportation to that practitioner, if provided by the facility, is within a reasonable time/distance parameter.

**Response**

Based on comments received, § 2800.42(z) (relating to specific rights) has been revised to allow resident choice of their primary care physician. As to transportation, under these final-form regulations, an ALR is required to provide for or arrange for transportation on a regular weekly basis to medical appointments within a reasonable local area. Section 2800.171 (relating to transportation).

**F. Comment**

One commentator stated the right granted to ALRs to control what outside providers are permitted to offer should be strictly adhered to. The commentator noted this provision should be constructed in a manner that is identical to the intent of the statute, which was to supply protections against having unwanted outside providers on the premises. The commentator continued, saying ALRs are more apt to permit only reputable outside providers on their premises to care for their residents.

**Response**

Residents must use an ALR's approved or designated supplemental health care providers if the ALR prominently displays in the written admission agreement that it requires residents to do so. See subsection (b)(ii). If an ALR chooses to allow residents to use their own providers, those providers, as specified in § 2800.42(y) (relating to specific rights), must operate consistent with the ALR's systems for caring for residents.

**G. Comment**

One legislator commented that the regulations need to ensure the resident's ability to choose their own supplemental health care provider and recommended language be revised in § 2800.142(a) to read as follows: "The residence shall assist the resident to secure medical care and supplemental health care services. The resident shall have the right to choose a supplemental health care service provider. Such provider shall be licensed, registered, certified or otherwise approved by the Commonwealth to provide such services. The residence shall document the resident's need for the medical care, including updating the resident's assessment and support plan."

**Response**

The Department is constrained by Act 56, which provides that, to the extent prominently disclosed in a written admission agreement, an ALR may require residents to use providers of supplemental health care services designated by the ALR. See 62 P.S. § 1057.3(a)(12). An ALR is required under § 2800.142(a) to provide or arrange for the provision of supplemental health care services in a manner protective of the health, safety and well-being of its residents utilizing employees, independent contractors or contractual arrangements with other health care facilities or practitioners licensed, registered or certified to the extent required by law to provide the service. Subsection (b)(iii) requires that ALRs document a resident's need for the medical care, including updating the resident's assessment

and support plan. The Department submits that these provisions address the commentator's concerns about documentation of needed medical care.

**Section 2800.143  
Emergency Medical Plan**

**A. Comment**

Six commentators recommended adding "any language, speech, hearing and/or vision need which requires accommodation and/or awareness of during oral and/or written communication (such as needing an interpreter for a particular language or American Sign Language)" to the emergency medical plan.

**Response**

Based on input from industry stakeholders, consumers and other interested parties, the Department added language in paragraphs (b)(12) and (b)(13) as recommended.

**B. Comment**

One commentator recommended the inclusion of food sensitivities (like sensitivity to wheat, soy or milk products).

**Response**

The Department maintains that paragraph (b)(6), which requires a list of allergies and paragraph (b)(7), which requires a list of other relevant medical conditions, address this concern.

**C. Comment**

One commentator noted that this section does not address advanced directives, living wills, etc.

**Response**

The Department submits that this issue is addressed in subsection (b)(11), which requires that personal information and related instructions regarding advance directives, do not resuscitate orders or organ donation, if applicable, be available at all times for each resident and accompany the resident when the resident needs emergency medical attention.

**D. Comment**

One commentator recommended the inclusion of any written directives of the agent under a Durable Power of Attorney or Guardian of the Person (as defined by PA law or by order of the court) signed by that person and notarized. The commentator noted that a copy of any document containing emergency health information of a resident should be provided to a resident, his Agent under a Durable POA or Guardian for review upon preparation and thereafter when changed.

**Response**

The Department submits that legal issues concerning durable power of attorney or guardian of the person are governed by § 2800.18 (regarding applicable laws). Personal information and related instructions regarding advance directives, do not resuscitate orders or organ donation are provided for under § 2800.143(b) (11) (relating to emergency medical plan). Section 2800.143(b) furthermore requires that this information be available at all times for each resident. The Department submits that these provisions should address the commentator's concerns.

**Section 2800.144  
Use of Tobacco****A. Comment**

One commentator suggested the total prohibition of smoking may be discriminatory.

**Response**

These regulations do not contain a total prohibition of smoking. Instead, the language in subsection (b) provides that an ALR must specify whether it is a smoking or nonsmoking facility.

**B. Comment**

One commentator suggested smoking be strongly discouraged by residents and the ALR provide information regarding the dangers of smoking and help residents utilize smoking-cessation programs.

**Response**

The language in this section mirrors the PCH regulations, which the Department is required to meet or exceed. There is nothing in the regulations to prohibit ALRs from providing information regarding the dangers of smoking, but the Department has elected not to mandate that they do so.

**Section 2800.161  
Nutritional Adequacy****A. Comment**

Two commentators noted the regulation is limiting as it requires the ALR to supply special diets but takes away the resident's choice as to whether or not they prefer to follow dietary prescriptions and restrictions. They stated this could also make the ALR feel more institutionalized.

**Response**

The Department does not agree that these provisions limit resident choice. A resident's nutritional and dietary needs are identified through the assessment process and are documented in his support plan. See §§ 2800.224(c)(3) and 2800.227(d) (relating to initial assessment and preliminary support plan; development of final support plan). Section 2800.161(b) requires that at least

three nutritionally well-balanced meals shall be offered daily to the resident. This provision must be read in harmony with § 2800.220(d) (relating to service provision), which has been added to allow residents to opt out of ALR-provided meals. An ALR must offer meals that meet the specifications of this Chapter but a resident has the choice of whether or not to opt for this service. A resident might also refuse to eat meals provided by the ALR even if he has paid for them. If disagreements arise concerning resident choice or nutritional adequacy, the informed consent process under § 2800.30 (relating to informed consent process) can be used by either the ALR or the resident to attempt to resolve such matters.

**B. Comment**

Two commentators stated that in order for the ALR to ensure the quality and nutritional value of between-meal snacks, the ALR must have the ability to determine what is offered to the residents (the residents should have input into this process). They noted that any independent purchasing of groceries for the purpose of preparing meals should not replace the initial resident agreement which includes the provision of meals.

**Response**

The purpose of these regulations under § 2800.1 (relating to purpose) is to protect the health and safety of residents and to provide an environment in which residents can develop and maintain maximum independence, exercise decision-making and exercise personal choice. The Department submits that these regulations provide a balance in meeting both of those provisions. As stated above, § 2800.161(d) requires that a resident's prescribed special dietary needs be met. Section 2800.220(d) (relating to service provision) has been added to allow residents to opt-out of ALR-provided meals. If necessary, the informed consent process under § 2800.30 (relating to informed consent process) is available to ALRs to use if they believe that the resident's action creates a dangerous situation and places the resident at risk of harm.

**C. Comment**

Six commentators stated all meal planning and preparation should be done in consultation with a single (same) dietician. They stated that planning and preparation should be under the supervision of staff or a consulting dietician.

**Response**

While the Department has not provided for a single dietician, § 2800.60(e) (relating to additional staffing based on the needs of the residents) should allay the concerns of the commentator by requiring that an ALR have a dietician on staff or under contract to provide for any special dietary needs of a resident as indicated in the resident's support plan. Additionally, the provisions of this section contain assurances that ALRs offer at least three nutritionally well-balanced meals daily under subsection (b) and that a resident's special dietary needs as prescribed by a physician, physician's assistant, certified registered nurse practitioner or dietitian

be met under subsection (d). As stated above, dietary needs are documented in a resident's support plan.

The polestar of the Department's interpretation of Act 56 is to provide ALR residents with maximum independence and an ability to exercise decision-making. As such, the Department has provided under § 2800.220(d) (relating to service provision) that residents may opt-out of ALR-provided meals.

#### **D. Comment**

One commentator had several questions: How is nutritional decline managed? How is poor oral intake documented and who documents it? How and with what frequency are weights checked to ensure nutritional adequacy?

#### **Response**

A medical evaluation of each resident is required within 60 days of admission under § 2800.141(a) (relating to resident medical evaluation and health care), except in certain circumstances under which a medical evaluation may be done within 15 days after admission. This would establish the baseline of a resident's medical status. The initial assessment and preliminary support plan as outlined in § 2800.224 (relating to initial assessment and preliminary support plan) documents a resident's health status and ALR service needs. Within 30 days of admission, a final support plan as outlined in § 2800.227 (relating to development of the final support plan) is developed. The final support plan would address and document the dietary, medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the individual to outside services if the individual's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. New language has been added to subsection (d) to ensure that the final support plan will document the assisted living services and supplemental health care services, if applicable, that will be provided to the resident. Additional assessments as specified in § 2800.225 (relating to additional assessments) shall be conducted on an annual basis, if the condition of the resident significantly changes prior to the annual assessment, or at the request of the Department upon cause to believe that an update is required. It is the responsibility of the ALR to conduct assessments and to develop and implement support plans to meet resident needs including those identified by the commentator. The assessments and support plans would guide the frequency of weight checks.

#### **E. Comment**

One commentator stated this section does not make sense. The commentator noted that if residents are encouraged to go out and buy groceries and prepare their own meals, how is the ALR going to monitor their nutritional intake? ALRs will be purchasing food and preparing resident meals, and if residents choose not to eat, this could raise the cost of operations.

#### **Response**

The intent of allowing that residents have the ability to purchase their own groceries and prepare their own meals is to provide them with choice and to allow them to maintain their independence and exercise decision-making. Section 2800.220(d) (relating to service provision) has been added to the regulations to allow residents to opt-out of paying for meals provided by an ALR as specified in the residence-resident contract. The monitoring required to ensure residents receive adequate nutrition is required to be performed by the ALR as part of the assessment and support planning process.

### **Section 2800.162**

#### **Meals**

##### **A. Comment**

Eleven commentators recommend cueing be encouraged only to those residents whose support plans call for it.

##### **Response**

The Department concurs and, based on comments received from IRRC, industry stakeholders, consumers and other interested parties, it has revised subsection (g) accordingly to require cueing only as indicated in the resident's support plan.

##### **B. Comment**

One commentator questioned what levels of assistance and cueing are allowed and if there is required training to do either action.

##### **Response**

A definition of basic cognitive services in § 2800.4 (relating to definitions) was added and includes intermittent cueing. ALRs are required to provide basic cognitive support as an assisted living service under § 2800.220(b)(11) (relating to service provision). The level of assistance and cueing required will be determined by a resident's assessments and support plans. See §§ 2800.224, 2800.225 and 2800.227 (relating to initial assessment and preliminary support plan; additional assessments; development of the final support plan).

In regards to training of direct care staff persons, § 2800.65(j)(5) (relating to staff orientation and direct care staff person training and orientation) requires that training be provided annually on assisted living service needs of the resident. Section 2800.65(j)(3) requires annual training on care for residents with dementia, cognitive and neurological impairments. Section 2800.65(g)(3) requires that training on the care of residents with mental illness, neurological impairments, mental retardation and other mental disabilities be completed prior to direct care staff persons being permitted to provide unsupervised assisted living services.

##### **C. Comment**

Two commentators noted there would be a financial burden to provide "adaptive devices" and recommended language allowing providers to charge for devices.

They requested clarification on "physical assistance" with eating, as the regulations should not require the ALR to feed residents.

### **Response**

There is no requirement in the regulations that an ALR pay for adaptive devices. It is the responsibility of the resident to either personally pay for adaptive devices or seek reimbursement through his third-party health insurance carrier or other health care coverage. In terms of clarification of the term "physical assistance," the Department intends the usual and common definition of the words as found in the tenth edition of the Merriam Webster's Collegiate Dictionary. "Physical" means pertaining of or relating to the body. "Assistance" means help. The amount of assistance required with meals and whether or not adaptive devices are needed is to be determined by each individual's assessment and support plan. While the Department recognizes that some residents may require assistance with eating, the regulations do not require "feeding" of individuals and § 2800.164(b) (relating to withholding or forcing of food prohibited) provides that residents may not be forced to eat food.

### **D. Comment**

Four commentators recommended the ALR have the ability to safely and effectively provide and meet the resident's health care needs. They recommended, consequently, that ALR have the ability to discharge a resident when the needs of the resident exceed the capabilities of the ALR, such as with feeding. They also stated, if additional staffing and services are necessary beyond what is defined in the resident/residence agreement, the ALR have the ability to charge for the additional services.

### **Response**

The overarching intent of the Department in Act 56 and in these regulations is to provide residents with an opportunity to age in place. 62 P.S. §1021(a)(1)(viii) requires that the Department create standards for transfer and discharge that require the ALR to make reasonable accommodation for aging in place that may include services from outside providers. As individuals age, they may need additional services. However, they may also develop needs that cannot be met by ALRs. Section 2800.228(h) (relating to transfer and discharge) recognizes this and establishes eight circumstances under which an ALR is permitted to transfer or discharge a resident. One of those reasons is if an ALR determines that a resident's functional level has advanced or declined so that the resident's needs cannot be met in the ALR under § 2800.229 (relating to excludable conditions; exceptions) or within the scope of licensure for an ALR.

The staffing requirements established in these regulations are minimum requirements and are dependent on the level of assistance required by each individual resident. The charges for all services provided by an ALR must be set forth in the resident-residence contract. § 2800.25(l) (relating to resident-residence contract).

**E. Comment**

One commentator noted total assistance with feeding is not possible with current staffing ratios.

**Response**

It is unclear to the Department what the commentator means by "total" assistance with "feeding." As stated above, while some residents may require assistance with eating, the regulations, under § 2800.164(b) (relating to withholding or forcing of food prohibited) provide that residents may not be forced to eat food. Also as noted above, the staffing requirements of the regulations are minimum requirements only. Section 2800.60(a) (relating to additional staffing based on the needs of the residents) requires that staffing be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

**F. Comment**

Three commentators suggested timeframes between meals should be provided by ALRs but that residents have the choice of eating at times other than scheduled meals. They stated that the restriction should be on the ALR to provide meals within those timeframes, but it should not limit the resident to those hours if they choose otherwise.

**Response**

This section mirrors that of the PCH regulations, which the Department is required to meet or exceed. Subsection (a) requires that there may not be more than 15 hours between the evening meal and the first meal of the next day and that there may not be more than 6 hours between breakfast and lunch and lunch and dinner. Additionally, in subsection (b), it is required that when a resident misses a meal, food adequate to meet daily nutritional requirements be available and offered to the resident. Nothing in the regulations precludes a resident from eating at times other than those scheduled by the ALR. Residents can also now opt-out of meal services as provided in § 2800.220(d) (relating to service provision).

**Section 2800.163  
Personal Hygiene for Food Service Workers**

**A. Comment**

One commentator stated that all food service workers and persons who provide personal care and supplemental health services should be required to have a current TB test (the proposed regulation requires this of residents as a condition of admission, but it is not required of residence staff). The commentator noted that staff with discharging or infected wounds, sores or lesions should not be providing direct personal care or serving food (in addition to not working in the kitchen area as specified in the proposed regulations).

**Response**

Subsection (d) of this section provides that a staff person, volunteer or resident who has a discharging or infected wound, sore lesion on hands, arms or any exposed portion of their body may not work in the kitchen in any capacity. Section 2800.54(a)(3) (relating to qualifications for direct care staff persons) contains the requirement that direct care staff must be free from medical conditions that limit them from providing necessary assisted living services with reasonable skill and safety. Supplemental health care providers must meet the requirements in § 2800.142 (relating to assistance with medical care and supplemental health care services).

### **Section 2800.171 Transportation**

#### **A. Comment**

Fifty-four commentators stated requiring every facility-owned vehicle to be handicapped accessible is extreme, burdensome and cost prohibitive. They noted this may cause ALRs to not provide transportation. In addition, they stated this would also raise costs to residents. They stated not all residents are in need accessible transportation and additional nursing staff may need to be hired to accompany residents to appointments.

#### **Response**

Based on comments received, the Department has amended § 2800.171(d) to require that a minimum of one vehicle be accessible to residents who use wheelchairs and any other assistive equipment the resident may need.

#### **B. Comment**

Six commentators recommended ALRs should be permitted the option to provide transportation at an additional charge.

#### **Response**

Nothing in the regulation requires that ALRs must provide transportation. Instead, subsection (a) requires that an ALR provide directly *or arrange for* transportation. (Emphasis added.) It is a business decision for an ALR whether it purchases its own vehicle or arranges for transportation for residents. Charges for transportation would depend on which core service package a resident has purchased. The cost of transportation is included in the enhanced core package.

#### **C. Comment**

Four commentators asked if ALRs are able to bill for providing or coordinating transportation.

#### **Response**

The Department submits that the answer to the commentators' question would depend upon what core package is chosen by the resident and what is in the resident-residence contract. As stated above, the enhanced core package

contains transportation services. ALRs may bill for transportation services that are not part of that core package.

**D. Comment**

One commentator recommended unlimited choice of providers but limited transportation to providers. The commentator noted ALRs could designate the mile-radius of medical transportation, but provide unlimited choice within the radius.

**Response**

Based on comments received, new language has been added to subsection (a) that requires ALRs to provide or arrange for transportation on a regular weekly basis that permits residents to schedule medical and social appointments within a reasonable local area. The Department submits that, while not identical to the commentator's recommendation, this new provision addresses the commentator's concern. As to unlimited choice of providers, this question has been addressed above in the discussion related to supplemental health care providers.

**E. Comment**

One commentator recommended the regulations refer to religious services. The commentator noted these cannot be referred to as "social appointments."

**Response**

The Department does not agree and finds that the change recommended by the commentator is unnecessary. The term "social appointments" covers a broad range of activities and may include religious services.

**F. Comment**

One commentator suggested a resident of the ALR should be permitted to drive an ALR's vehicle. In addition, the commentator stated the definition of "resident" should be changed to "assisted living resident."

**Response**

The Department has elected not to make this change. Subsection (b)(3) provides that the driver of the ALR vehicle cannot be a resident. This mirrors language in the PCH regulations, which the Department must meet or exceed. Regarding the request to change "resident" to "assisted living resident," the Department finds that adding the words "assisted living" would be redundant.

**G. Comment**

One commentator suggested that ALRs providing transportation, in addition to coordinating it, should be given 3 years to purchase an accessible vehicle. The commentator stated mandating this purchase within 1 year is extreme and cost prohibitive.

**Response**

There is no requirement in the regulation that a vehicle be purchased within 1 year. The effective date of the regulation is 6 months from the date of publication in the *Pennsylvania Bulletin*. Six months is an adequate timeframe to allow ALRs who seek licensure to obtain an accessible vehicle.

#### **H. Comment**

Six commentators stated ALRs should be required to transport or ensure transportation to medical and social appointments. They noted the ALR should ensure transportation and provide the transportation in a way that coordinates with the time/appointment needs of the resident.

#### **Response**

The Department agrees and has amended subsection (a) to require that an ALR provide or arrange for transportation on a regular weekly basis that permits residents to schedule medical and social appointments within a reasonable local area. Additional language has been added to require that the resident must be picked up and dropped off no later than 1 hour before the appointment and 1 hour after the appointment and that the ALR must make a reasonable effort to pick-up the resident within 15 minutes before or after the scheduled pick-up time.

#### **I. Comment**

Seven commentators suggested removing "social appointments" from this requirement. They stated an ALR should only be responsible for coordinating and providing transportation to medical appointments and residence-scheduled activity trips. They stated non-medical transportation could be provided as an additional fee service or otherwise arranged.

#### **Response**

Transportation is a required service in the enhanced core package under § 2800.220(c)(2)(iii) (relating to service provision). Additionally, in § 2800.171(a) as revised, ALRs must either provide or arrange for transportation services on a regular weekly basis that permits residents to schedule to and from medical and social appointments within a reasonable local area. The cost of transportation is included in the enhanced core service package. The Department submits that social appointments are an important aspect of resident well-being.

### **Section 2800.181 Self-Administration**

#### **A. Comment**

Seven commentators questioned how it is determined whether a resident is capable of self-administering medications. They stated a determination should be made if the resident is able to conduct the following: use the medication as prescribed, including being capable of placing medication in own mouth and swallowing completely; applying topical medications; placing drops in eyes; correctly and properly inhaling nasal therapies and other inhalants.

**Response**

The Department asserts that self-administration of medications is adequately addressed in subsections (c) and (e). Subsection (c) requires that a physician, physician's assistant, or certified registered nurse practitioner assess a resident who desires to self-administer regarding their ability to do so and the need for medication reminders. Subsection (e) establishes criteria to be used to decide if a resident is to be considered capable to self-administer medications. This consists of a resident being able to recognize and distinguish his medication; knowing how much medication is to be taken; and knowing when medication is to be taken. The Department submits that this criteria is sufficient to protect the health and safety of residents.

**B. Comment**

One commentator questions what "self-administration" of medication means.

**Response**

The Department intends the usual and customary dictionary definition of the term. The word "self," according to the Merriam Webster's Collegiate Dictionary, means "by means of oneself." The word "administration" means the act or process of administering. The word "administer" means to manage.

**C. Comment**

Two commentators recommended allowing the following medications that can be safely taught to family members to administer: oxygen therapy, nebulizer treatments, erythropoietin, B-12 injections, variable dose insulin, low-molecular weight heparin injections, and similar medications.

**Response**

The provisions of this section are based on the PCH regulations, which the Department is required to meet or exceed. The Department declines to regulate in this area.

**Section 2800.182  
Medication Administration**

**A. Comment**

Three commentators feel that any administration of medication should be done by an RN or other licensed health care provider. Any administration of medication by trained staff should be under the supervision of an RN or licensed health care provider.

**Response**

The Department submits that the State Board of Nursing has allowed trained staff to administer medications in long-term care settings for many years. The Department, therefore, maintains that, as provided in subsection (b)(4), allowing a

staff person who has completed the medication administration training as specified in § 2800.190 (relating to medication administration training) to administer oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies is consistent with existing state policy and practice for PCHs.

**B. Comment**

Four commentators requested clarification on the following points: Can an aide pass medications as long as they're certified to do so? What provisions are there when a person is sick and needs nursing judgment with regard to holding medications (diuretics, insulin, oral hypoglycemic agents) if medications are passed by direct care staff? Identify which staff members may help residents with medication administration.

**Response**

The answer to the commentator's inquiry would depend on the certification requirements of that individual. If an aide is appropriately certified under licensure requirements as provided under § 2800.18 (relating to applicable laws), the standards of that licensure category would be applied. With regard to the issue of a sick person and holding medications if medications are passed by direct care staff, the Department submits that this will depend on the individual circumstance related to the illness and what level of assistance is needed to meet the resident's needs. Regarding staff that are permitted to assist residents with medication administration, subsection (b) identifies those individuals.

**C. Comment**

One commentator stated medication administration training and testing should assure that "extended release" medications are never crushed or split. In addition, the commentator noted that crushing or splitting a medication should be deemed a medication error if the ALR does not have a written order from the resident's physician or written directive from the resident's pharmacist directing how to crush, split or otherwise alter the medication. The commentator recommended an ALR should never be given the authority to dispose of medication in any situation without first obtaining the written approval of the resident.

**Response**

The Department finds that subsection (c)(4) provides that the crushing or splitting of medication is to be done as ordered by the prescriber. An ALR is required to follow a prescriber's orders. While the regulations are silent on resident approval of disposal of the resident's medications, a resident has a right to file a complaint under § 2800.44 (relating to complaint procedures) if this occurs.

**Section 2800.183**

**Storage and Disposal of Medications and Medical Supplies**

**A. Comment**

One commentator asked for the following clarification: Does the regulation mean that medications must remain in bottles and that blister packs (packaged by a pharmacy) are no longer allowed? The commentator noted if bottles are required, medication errors are sure to increase.

**Response**

Medications must be kept in the original labeled container. There is no prohibition against blister packs or multiple pills packaged in the same "blister" or on the same "medi-set" page as long as packaging is compliant with Pennsylvania pharmacy laws and regulations. Blister packs are considered original containers provided they are packaged and individually labeled by the pharmacist.

**B. Comment**

One commentator and one legislator stated the ALR should be permitted to dictate the fashion in which prescription drugs are delivered/ packaged and able to ensure the integrity of the medication regimen. The commentator stated that if a pharmacy refuses to package medications in a manner consistent with the ALR's operations, the ALR should not be mandated to accept drugs from that source. The legislator noted an ALR should not be forced to accept drugs from a pharmacy if that pharmacy refuses to package prescription drugs in a manner consistent with the ALR's operation.

**Response**

Act 56 provides in 62 P.S. § 1057.3(a)(12) that to the extent prominently disclosed in a written admission agreement, an ALR may require residents to use providers of supplemental health care services designated by the ALR. With the agreement of industry stakeholders, consumers and other interested parties, § 2800.42(y) (relating to specific rights) of these regulations was added and requires that the actions and procedures utilized by a supplemental health care service provider chosen by a resident must be consistent with the ALR's systems for caring for residents. This includes the handling and assisting with the administration of resident's medications. The Department submits that this should address the commentator's concerns.

**C. Comment**

One commentator questioned the 2-hour restriction. The commentator noted that it seems preparing pills could be done by overnight staff. In addition, the commentator questioned if this prohibits the use of pill sorting boxes and blister packs?

**Response**

The Department submits that this requirement is the same as in the PCH regulations, which the Department is required to meet or exceed. Blister packs are considered original containers provided they are properly labeled as required.

**D. Comment**

One commentator noted requiring destruction of medicine does not allow for a recycling option, such as donating it to veterinary use or another country.

**Response**

The Department submits that § 2800.18 (relating to applicable laws) addresses this concern. Recycling of medications is an important issue and legislative proposals have been introduced in the General Assembly that would address it. The Department, therefore, declines to regulate on the issue.

**E. Comment**

One commentator requested the following clarification: Is it safe to assume that the resident's lockable living unit suffices as a safe and secure location for medications (those already being stored out of sight)?

**Response**

Pursuant to subsection (b), prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes unless kept in the resident's living unit.

**Section 2800.184  
Labeling of Medications**

**A. Comment**

One commentator noted that medications that are prepared for administration by packets of bubble wrap for individual patients must have the name, dose, route and administration schedule for each medication attached to each weekly packet. The commentator noted this information should not be removed until all of the medications in that packet are administered.

**Response**

Labeling and packaging is completed by the pharmacy. The Department has elected to maintain the language in subsection (a)(4) because it very clearly requires that the prescribed dosage and instructions for administration appear on the pharmacy label of prescription medications. This language mirrors the language in § 2600.184(a)(4) (relating to labeling of medications) which the Department must meet or exceed under Act 56.

**Section 2800.185  
Accountability of Medication and Controlled Substances**

**A. Comment**

One commentator stated there is not a nurse overseeing medication management and does not feel direct care staff would be able to identify problems related to use of narcotics (constipation, over-sedation, changes in gait, etc.). The commentator recommended a nurse for this purpose.

**Response**

This provision is in the PCH regulations, which the Department must meet or exceed. The Department-approved medication management administration training course, approved by the State Board of Nursing, has been utilized for several years in many types of facilities across the spectrum. This training includes monitoring for signs of adverse reaction.

**B. Comment**

One commentator requests clarification on what is meant by the requirement to "keep an adequate supply of resident medication on-hand at all times." The commentator noted the concern is that this could be interpreted to mean an on-site pharmacy is needed. Another commentator requested clarification on the supply storage implications of section (b)(5).

**Response**

It is not the intent of these regulations to require an on-site pharmacy. Regarding supply of medications, the Department finds that a resident's individual support plan, as specified in subsection (b)(5), will determine what an adequate supply of medications means for each individual resident based upon his needs.

**Section 2800.186  
Prescription Medications**

**A. Comment**

One commentator stated this regulation is a dangerous step toward preventing optimal medication management for residents as it will lead to an increase in medical errors. The commentator noted it is important that a resident's primary care physician be able to override, alter and adjust the medication orders of specialist physicians to avoid potential drug-drug and drug-disease interactions that can result from multiple prescribers.

**Response**

The Department has elected not to make this change. This provision mirrors that of the PCH regulations, which the Department is required to meet or exceed.

**B. Comment**

One commentator stated an appropriate health care professional should be able to make medication changes, not solely the prescriber.

**Response**

This provision mirrors that of the PCH regulations. The Department has elected not to make the recommended change.

**Section 2800.187  
Medication Records**

**A. Comment**

One commentator stated that food sensitivities to substances like wheat, soy or milk, should be included.

**Response**

The Department submits that food sensitivities or allergies are to be part of a resident's support plan and are to be noted along with other dietary restrictions. See §§ 2800.224(c)(3) and 2800.227(d) (relating to initial assessment and preliminary support plan; development of the final support plan).

**B. Comment**

One commentator noted that to assure the continuity of care for residents of an ALR, upon return of the resident to their ALR after a discharge from a hospital, nursing home, or rehab facility, staff should compare the discharge orders from the discharging facility with the prior standing orders for the resident. The commentator stated that within 24 hours the ALR should notify the resident's physician, with copies to the resident's family and agent under Power of Attorney, of differences between the medication administration record and the discharge orders.

**Response**

The provisions of this section mirror the PCH regulations, which the Department is required to meet or exceed. Section 2800.225(a)(2) (relating to additional assessments) requires an additional assessment if the condition of the resident significantly changes prior to the annual assessment. The Department maintains that return to the ALR after placement in a hospital, nursing home or rehab facility qualifies as a significant change. Section 2800.225(b)(4) requires that an additional assessment must include the resident's medical history, medical conditions and current medical status and how these impact with the individual's service needs. As to notification of the individual's listed, the final support plan must be revised within 30 days upon changes in the resident's needs as indicated on the current assessment. Section 2800.227(c). It must also be provided to the resident and his designated persons under § 2800.227(k). It must also be part of the resident-residence contract. These provisions should be sufficient to address the commentator's concerns and provide assurance that the continuity of care of the resident is being implemented.

**Section 2800.188  
Medication Errors**

**A. Comment**

One commentator stated that in addition to the documentation of medication errors, an incident report should be completed and investigated for corrective action.

**Response**

Prescription medication errors are included as a circumstance that requires the submission of an incident report under § 2800.16(a)(13) (relating to reportable incidents and conditions). In such a case, under § 2800.16(c) the ALR is required to report the incident to the Department's ALR office or the ALR complaint hotline within 24 hours in a manner designated by the Department. The ALR is required to immediately report the incident or condition to the resident's family and the resident's designated person. The primary goal of an incident management system is to ensure that when an incident occurs, the investigation and corrective action will protect the health, safety and well-being of the resident. The Department will review all reportable incidents and conditions and investigate as appropriate. Act 56 requires the Department to meet or exceed the PCH regulations. This provision mirrors the PCH language, which was based on a suggestion by the State Board of Nursing.

**B. Comment**

One commentator questioned who is reviewing records of medication administration.

**Response**

The Department finds that the ALR is responsible for complying with the provisions of this final-form rulemaking including medication administration requirements. The Department is responsible for enforcing the provisions of this Chapter and has access to records under § 2800.254 (relating to record access and security).

**C. Comment**

One commentator stated reports of medication errors should be made in writing to the resident, the resident's designated person, power of attorney, guardian and the prescriber (also to the pharmacist if the ALR has a house pharmacy).

**Response**

Subsection (b) requires the ALR to immediately report medication errors to the resident, the resident's designated person, and the prescriber. Nothing precludes a power of attorney or guardian from being notified if he is the resident's designated person. Subsection (b) mirrors the PCH regulations, which the Department is required to meet or exceed under Act 56. § 2600.188(b) (relating to medication errors).

**D. Comment**

One commentator stated medication errors should be of significant concern to the Department and providers. The commentator noted the proposed regulations do little to minimize the probability of medication errors and make no provision for reporting errors to the Department.

**Response**

The Department submits that these regulations contain provisions that address medication errors and protect the health and safety of residents in this regard. Section 2800.16(a)(13) (relating to reportable incidents and conditions) lists a prescription medication error as defined in this section as a reportable incident. As stated above, the ALR is required to report such incidents to the Department within 24 hours. This provision meets or exceeds the PCH regulations.

**E. Comment**

Three commentators stated the notification to the resident's designated person of a medication error should be made at the request of, or with the consent of, the resident rather than be automatic reporting. They noted to mandate otherwise removes the choice of the resident to maintain privacy.

**Response**

A designated person, under § 2800.4 (relating to definitions), is an individual who *may* be chosen by the resident (emphasis added). If a resident wants information kept private, he does not have to name a designated person. This provision mirrors that of the PCH regulations, which the Department is required to meet or exceed.

**Section 2800.190  
Medication Administration Training**

**A. Comment**

One commentator stated there is no mention of administration of other injectibles, such as epogen, which in home situations would be administered by family. The commentator noted this is beyond the scope of care of the direct care workers.

**Response**

The Department submits that entry into an ALR requires that certain conditions be met. ALRs are home-like environments but residents do not have total independence relative to having family members administer injections. A purpose of these regulations is to provide for the health and safety of ALR residents. As such, ALRs and their residents must comply with appropriate laws that dictate who may perform injections. Act 56 requires that the Department meet or exceed the PCH regulations, which permit administration of oral and topical prescription medications by trained staff persons. The injection of insulin for diabetes and epinephrine for insect bites and other allergies is also permitted by trained staff persons.

**B. Comment**

One commentator noted licensed health care providers administering medications must be skilled in administering safely to patients with dysphagia.

**Response**

The Department submits that an individual's support plan under §§ 2800.224(c) and 2800.227 (relating to initial assessment and preliminary support plan; development of the final support plan) would document that a resident has dysphagia and would provide for appropriate administration of medications to a person with a swallowing disorder.

**C. Comment**

One commentator wanted confirmation that staff may assist with self-administration of medications only as authorized by Pennsylvania's Nurse Delegation Act for health care providers.

**Response**

Section 2800.18 (relating to applicable laws) requires that ALRs comply with existing Federal, State and local laws, ordinances and regulations.

**Section 2800.191  
Resident Education**

**A. Comment**

One commentator stated that if the Department involves itself in the manner in which the ALR documents resident education, the Department should consult with the regulated community before issuing any directive.

**Response**

Should the Department decide to undertake involvement in the manner in which an ALR documents resident education, it will carefully consider and involve industry stakeholders, consumers and other interested parties.

**Section 2800.201  
Safe Management Techniques**

**A. Comment**

One commentator stated this statement does not go far enough to address the need for, and training of, staff about behavior management of persons with agitated dementia or longstanding mental health disorders.

**Response**

The language in this section is consistent with the provisions of the PCH regulations. Additionally, § 2800.65(g)(3)(iv) (relating to staff orientation and direct care staff person training and orientation) requires training on the care of residents with mental illness, neurological impairments, mental retardation and other mental disabilities and § 2800.65 (g)(3)(xvii) has been added to require training for direct care staff in behavioral management techniques. Additionally, administrative staff, direct care staff persons, ancillary staff persons, substitute personnel and volunteers are required to take additional dementia-specific training under

§ 2800.69 (relating to additional dementia-specific training). The Department maintains that these requirements address the commentator's concerns.

### **Section 2800.202 Prohibitions**

#### **A. Comment**

One commentator stated when a physician has made the clinical judgment a resident needs a PRN (pre re nata) medication for a specific condition (such as to alleviate anxiety), this should not be considered to be a chemical restraint.

#### **Response**

As specified in paragraph (4), the prohibition on the use of a chemical restraint does not include a drug ordered by a physician or dentist to treat the symptoms of a specific mental, emotional or behavioral condition, or a pretreatment prior to a medical or dental examination or treatment.

#### **B. Comment**

One commentator stated the regulation should not limit physician practice to treat patients. PRN medications are used to prevent anxiety, not control behavior. The commentator noted the Department does not have a license to practice medicine.

#### **Response**

This provision mirrors the language in the PCH regulations, which the Department is required to meet or exceed. As stated above, the prohibition on the use of a chemical restraint does not include a drug ordered by a physician or dentist to treat the symptoms of a specific mental, emotional or behavioral condition, or a pretreatment prior to a medical or dental examination or treatment.

#### **C. Comment**

One commentator stated PRN medications should be allowed if prescribed with specific instructions as determined by a physician. The commentator noted current language should be altered clarifying the difference in chemical restraint vs. PRN psychotropics.

#### **Response**

The Department finds the language is sufficiently clear. As noted above the prohibition on the use a chemical restraint does not include a drug ordered by a physician or dentist to treat the symptoms of a specific mental, emotional or behavioral condition, or a pretreatment prior to a medical or dental examination or treatment.

#### **D. Comment**

Two commentators noted strict documentation regarding the directed use and subsequent administration of PRN must be enforced.

**Response**

The provisions of § 2800.187(a)(12) (relating to medication records) clearly require maintenance of documentation related to the purpose for the medication, including pro re nata (PRN).

**E. Comment**

Three commentators recommend a revision to this section as follows: Medication ordered pro re nata for treatment of specific conditions is permitted to be administered by unlicensed staff if accompanied by specific instructions from the ordering physician stating in what circumstances it may be administered.

**Response**

The Department declines to make this change. Section 2800.182 (b) (relating to medication administration) lists those who are permitted to administer medication that is not self-administered by a resident. This provision mirrors the PCH regulations, which the Department is required to meet or exceed.

**Section 2800.203  
Bedside Rails****A. Comment**

Seven commentators stated the proposed regulations do not use the bedrail provision from the PCH system and the Federal Government recommendations. They noted half-length rails be permitted only if all of the following conditions are met: a physician has completed an assessment during the past 6 months and completed a signed, time-limited, written order for the use of the rails which specifies the specific medical symptoms that warrant the use of bedside rails; the rails meet FDA safety guidelines; staff persons complete a physical check of each resident who uses a half-length rail at least every 15 minutes during the time the bedside rail is in use. Another commentator believes this regulation should be dropped or modified due to it ultimately resulting in significant hardship and functional limitations for residents.

**Response**

The Department has determined that the language in the proposed regulations sufficiently protects the health and safety of residents. The Department does not see the use of bedside rails purely as restraints but sees them in many cases as a safety precaution for individuals who may otherwise suffer from falls. Consequently, the Department has reinserted § 2800.203(b) that permits half-length rails under certain conditions. Those conditions are if the resident's assessment or support plan, or both, addresses the medical symptoms necessitating the use of half-length rails and the health and safety protection necessary in order to safely use half-length rails; if the ALR has attempted to use less restrictive alternatives; and if the resident or legal representative consented to the use of half-length rails after the risk, benefits and alternatives were explained.

**B. Comment**

Three commentators stated subsection (b) should be deleted or modified as the language in the Chapter 2600 regulations is sufficient and appropriate. They note the language in § 2800.203(b) as drafted could be construed as a restraint.

**Response**

The Department submits that there is no language in the PCH regulations that address the issue of half-length bedside rails, although it was subsequently addressed through PCH policy. As stated above, the Department gave thoughtful consideration to this issue and determined that the provisions in the ALR final-form rulemaking meet the health and safety needs of residents.

**C. Comment**

One commentator stated the following conditions must be added to the proposed regulations: a physician has completed an assessment within the past 6 months and specified in writing that use of the half-length rail is appropriate to protect the health and safety of the resident; staff persons complete a physical check of each resident who uses a half-length rail at least every 15 minutes during the time the rail is in use; the rails and the space between the bed rails and the mattress meet FDA safety guidelines; the resident's assessment AND support plan completed within the past 6 months address the resident's needs and health and safety protections necessary for the use of half-length rails.

**Response**

The Department has chosen to retain the language of § 2800.203(b) and submits that it places sufficient qualifiers on the use of half-length rails to allow for their limited and medically-indicated use. These include the requirement that a resident's assessment and support plan document the medical symptoms necessitating the use of half-length rails and the health and safety protection necessary in order to safely use half-length rails.

**Section 2800.220  
Service Provision**

**A. Comment**

One commentator noted subsection (c)(7), which states that transportation to medical appointments is coordinated by the ALR, is contradictory to § 2800.171(b)(7) (relating to transportation), which states an assistant to the driver is necessary.

**Response**

Subsection (e)(7), formerly subsection (c)(7), has been amended to harmonize the two provisions by requiring escort service if indicated in the resident's support plan or requested by the resident.

**B. Comment**

One commentator stated ALRs should be required to provide cognitive support services to all of those who need it, not only those in special care units.

**Response**

The Department submits that subsection (b)(11) requires that all residents be provided with basic cognitive support services. Both the independent core package and the enhanced core package also require provision of basic cognitive support services. § 2800.220(c)(1)(vii) and (c)(2)(i).

**C. Comment**

One commentator feels that laundry and transportation services should be a supplemental service rather than a core service in these regulations. Making these core services would be cost prohibitive and raise costs to residents. The laundry charge should be absorbed by those residents who need the service. Transportation as a core service would be cost prohibitive and limit transportation opportunities. The regulations should be modified to clarify that payment for supplemental services by the residence is not implied.

**Response**

Based on comments received, a number of changes have been made to this section of the regulations. The Department has established two core service packages that include different services based on level of need. Additionally, residents will now be provided with the opportunity to opt-out of three core services: laundry, meals and housekeeping. The Department agrees that not all residents will need these services. Also based on comments received, transportation is now a required service in the enhanced core package only. Regarding payment for services, the Department maintains that the resident-residence contract will govern payment issues.

**D. Comment**

Twelve commentators noted many residents do not prefer staff accompaniment to or from medical appointments but rather choose to attend those appointments individually or with a friend or family member.

**Response**

The Department submits that subsection (e)(7) bases escort service on need as determined in an individual's assessment and support plan.

**E. Comment**

Thirty-two commentators requested clarification/had questions on the following points: While all ALRs are required to provide cognitive support, cognitive support services are described as including dementia-capable programming and crisis management, while not being clear whether this is for all ALRs or those with a special care designation? What exactly are "household services essential for health, safety and comfort of the resident?" How do facilities price supplemental health care? How would this be part of an agreement if a third party is involved?

Does "escorting" mean a driver takes them to and from an appointment or does it mean that the escort accompanies the resident into the office when the resident sees the physician? Define "core packages", including hours of care, services and costs. An additional commentator stated escort service and/or providing additional staff while transporting should not be required, but should be available as needed for the safety of the resident.

### **Response**

The Department directs the commentators to the core packages described in subsection (c)(1) and (c)(2) and notes that basic cognitive support services are included in both the independent core package and the enhanced core package. These services are also incorporated by reference into §§ 2800.231 through 2800.239. The services referred to by the commentators are defined in § 2800.4 (relating to definitions) as cognitive support services and are services specifically provided in special care units. The services that a resident in a special care unit receives is determined under § 2800.231(a)(1).

In regards to household services, subsection (b)(6) has been amended to replace "household services" with "housekeeping services." This change provides uniformity in the definition of the service, which is clearly defined in § 2800.4. Regarding the pricing of supplemental health care services, Act 56 clearly states that these services are to be packaged, contracted and priced separately from the resident agreement. See 62 P.S. § 1021(a)(2)(iii). This is further provided for in § 2800.25(l) (relating to resident-residence contract). As to how this would be handled if a third party is involved, the contract between the ALR and a third-party provider would govern, or the contract between a resident and a third-party provider would govern. Whether or not a resident is accompanied by an escort into a physician's office is an issue determined by a resident's assessment and support plan. See §§ 2800.224, 2800.225 and 2800.227 (relating to initial assessment and preliminary support plan; additional assessments; development of the final support plan). Regarding hours of care, services and costs, the Department submits that hours and services are to be determined by a resident's assessment and support plan and that cost is governed by the resident-residence contract under § 2800.25 (relating to resident-residence contract).

### **F. Comment**

Six commentators noted the language in this section suggests the ALR is responsible for providing escort services to and from every medical appointment that the residence coordinates. They stated this would be impractical and add significantly to staffing needs and operating costs. They noted pulling one or more staff persons "off the floor" to escort residents to appointments leaves the ALR vulnerable from a staffing perspective. They continued this would also raise costs to residents, regardless of whether or not they even use it.

### **Response**

Subsection (e)(7) has been revised to clarify that escort service, as a supplemental health care service, is to be provided if indicated in resident's support plan or requested by the resident.

#### **G. Comment**

One commentator stated that access to behavioral health and cognitive support services should not be an add-on to the list of provided services. The commentator noted there should be an escort knowledgeable about the patient on the core list of provided services.

#### **Response**

The Department has identified cognitive support as a critical service for ALR residents and, as noted above, cognitive support services are included in both the independent core package and the enhanced core package. Additionally, specialized cognitive support service is a supplemental health care service under subsection (e)(8). The Department submits that the availability of these services, in addition to those provided in special care units, reflects a significant level of attention to the cognitive needs of residents.

Under subsection (e)(7), escort services are a supplemental health care service that ALRs are required to provide or arrange for. Section 2800.142 (relating to assistance with medical care and supplemental health care services) requires that each ALR demonstrate the ability to provide or arrange for the provision of supplemental health care services in a manner protective of the health, safety and well-being of its residents. The Department maintains that provision of escorts who have appropriate skill and are knowledgeable about a resident is necessary to meet this requirement.

#### **H. Comment**

One commentator stated the listing of supplemental health care services should not include the following: home health, hospice & home care agency and home care registry. The commentator noted these services must be delivered by health care facilities licensed under the Health Care Facilities Act.

#### **Response**

Act 56 defines "supplemental health care services" as "the provision by an assisted living residence of any type of health care service, either directly or through contractors, subcontractors, agents or designated providers, except for any service that is required by law to be provided by a health care facility pursuant to the act of July 19, 1979 (P.L. 130, No. 48), known as the "Health Care Facilities Act." 62 P.S. § 1001. Subsection (e) of § 2800.220 provides that the residence shall provide or arrange for the provision of various supplemental health care services, including hospice services and home health services. Having these types of services provided in an ALR, however, does not transform the ALR into a health care facility. "Hospice" as defined in the Health Care Facilities Act, includes the provision of hospice services in an independent living environment, such as an

ALR. Specifically, "hospice" is defined as "[a]n organization licensed under this act to provide a coordinated program of palliative and supportive services provided in a home, independent living environment or inpatient setting which provides for physical, psychological, social and spiritual care of dying persons and their families. Services are provided by a medically directed interdisciplinary team of professionals and volunteers, and bereavement care is available to the family following the death of the patient. The term shall also be deemed to refer to the services provided by such organization." 35 P.S. § 448.802a. Likewise, the definitions of "home care agency" and "home care registry" also encompass the provision of services in the consumer's place of residence or other independent living environment. See 28 Pa.Code § 611.5 (relating to definitions).

Further, Act 56 requires these regulations to meet or exceed the PCH regulations. Both the PCH regulations at §2600.29 (relating to hospice care and services) and § 2800.29 (relating to hospice care and services) provide that hospice care and services that are licensed by the Department of Health as hospice may be provided in the PCH or ALR.

#### **I. Comment**

Fourteen commentators feel that each residence must provide a base core package of services that residents must purchase and can trust they will receive. It is recommended that the following services be added to the list of services that ALRs must provide: financial management; 24-hour supervision, monitoring and emergency response; activities and socialization; space and equipment for activities; development of an individualized care plan; bi-weekly housekeeping services; weekly laundry; medication administration and cognitive support services.

#### **Response**

Based on input by industry stakeholders, consumers and other interested parties, the Department has amended this section to include two core packages that meet different levels of resident need. Financial management, 24-hour supervision, monitoring and emergency response, activities and socialization, basic cognitive support services, housekeeping services and laundry area included in both core packages. Assistance with medications is included in the enhanced core package. To provide additional flexibility, the Department has provided residents with the choice of opting out of ALR provided meals, laundry and housekeeping services. Space for activities is addressed in § 2800.221(a) (relating to activities program). Development of individualized support plans is addressed in §§ 2800.224 and 2800.227 (relating to initial assessment and preliminary support plan; development of the final support plan).

#### **J. Comment**

One commentator noted the nature of the care plan is a crucial concern for a resident and the waiver program might provide a useful model to characterize what the service packages should look like. The commentator stated consumer choice is

a concern where the regulations appear to restrict choice to a single provider for supplemental health care.

### **Response**

The Department concurs that development of support plans is crucial. The regulations provide for both a preliminary support plan under § 2800.224 (relating to initial assessment and preliminary support plan) and a final support plan under § 2800.227 (relating to development of the final support plan). In regards to residents being able to choose their own supplemental health care providers, these regulations cannot conflict with Act 56, which requires that to the extent prominently disclosed in a written admission agreement, an ALR may require residents to use providers of supplemental health care services designated by the ALR. See 62 P.S. § 1057.3(a)(12). If, however, an ALR does not designate a supplemental health care provider, a resident may choose his own so long as the actions and procedures utilized by a supplemental health care service provider chosen by a resident are consistent with the ALR's systems for caring for residents. See § 2800.42(y) (relating to specific rights). The Department finds that waiver programs are outside the scope of these regulations.

### **K. Comment**

One commentator stated that the proposed regulations do not adequately ensure the competent and safe delivery of care to Pennsylvania seniors. The commentator stated that formal attention to ethics is absent from the proposed regulations and that requirements for providers to incorporate ethics into their structures and policies, initial and ongoing training, orientation programs and facility handbooks should be established. The commentator added that the regulations do not contain any language related to provider responsibilities to educate consumers about assisted living or to ethical marketing practices.

### **Response**

The Department will consider and evaluate the ethical education and marketing issues raised by the commentator for future rulemaking. Although the regulations do not specifically address ethical education and marketing requirements, consumer protections are available. The regulations require ALRs to provide numerous written disclosures to each potential resident or designated person upon application and prior to admission. These written disclosures include the list of nonwaivable resident rights, a copy of the resident-residence contract, a copy of the residence rules and handbook, and information regarding the services and core packages (including costs), offered by the residence. See § 2800.22(e) (relating to application and admission). Further, in order to distinguish facilities, Act 56 prohibits any person, organization or program from using the term "assisted living" in any name or written material unless it is licensed under these regulations. 62 P.S. § 1057.3(i). Finally, the General Assembly has also addressed consumer protection concerns by enacting the Unfair Trade Practices and Consumer Protection Law (73 P.S. §§ 201-1 – 201-9.3).

## **L. Comment**

Four commentators noted that the proposed regulations do not reflect the clear intent of Act 56. The commentators stated that the regulations do not specify the kinds of services that ALRs can provide, how they should function, the requirements for staffing and training and other critical information that consumers need to have in order to make informed decisions.

### **Response**

The Department finds that this rulemaking reflects the intent of Act 56. Specifically, the regulations are designed to specify how ALRs should operate, as well as the kinds of services offered. Assisted living services are detailed under subsection (b). Independent core package services are outlined in subsection (c)(1). Enhanced core package services are outlined in subsection (c)(2). Supplemental health care services are detailed in subsection (e). Activities programs are described in § 2800.221 (relating to activities program). Services in special care units are listed in § 2800.237 (relating to program). Training requirements for staff and administrators are outlined in § 2800.63 (relating to first aid, CPR and obstructed airway training), § 2800.64 (relating to administrator training and orientation), § 2800.65 (relating to staff orientation and direct care staff person training and orientation), 2800.66 (relating to staff training plan) and § 2800.69 (relating to additional dementia-specific training). Staffing requirements are located in § 2800.51 (relating to criminal history checks), § 2800.52 (relating to staff hiring, retention and utilization), § 2800.53 (relating to qualifications and responsibilities of administrators), § 2800.54 (relating to qualifications for direct care staff persons), § 2800.55 (relating to portability of staff training), § 2800.56 (relating to administrator staffing), § 2800.57 (relating to direct care staffing), § 2800.58 (relating to awake staff persons), § 2800.59 (relating to multiple buildings), § 2800.60 (relating to additional staffing based on the needs of residents) and § 2800.61 (relating to substitute personnel). In regards to information needed by residents in order to make informed decisions, these provisions are spread throughout the regulations and include, but are not limited to § 2800.25 (relating to resident-residence contract), § 2800.41 (relating to notification of rights and complaint procedures), § 2800.42 (relating to specific rights), § 2800.43 (relating to prohibition against deprivation of rights) and § 2800.44 (complaint procedures).

## **Section 2800.221 Activities Program**

### **A. Comment**

Six commentators stated the ALR should provide verbal cueing and reminders of activities to include start times and locations

### **Response**

Section 2800.221(c) (relating to activities program) has been revised to include cueing.

**B. Comment**

One commentator stated since the word "encourage" is not defined and subject to various (and different) interpretations, the ALR should "offer the opportunity" to participate rather than "encourage."

**Response**

Subsection (a) has been amended to substitute the words "offer the opportunity" for the word "encourage."

**C. Comment**

One commentator suggested residents be encouraged to walk to the dining room, toilet or activities. The commentator stated seniors can become disabled because they're encouraged to use a diaper and a wheelchair. The commentator noted these residents need to be assisted to walk to maintain optimal function, maintain dignity and quality of life.

**Response**

The Department submits that § 2800.1 (relating to purpose) establishes that these regulations are to provide ALR residents with an environment in which they can age in place, develop maximum independence and exercise decision-making and personal choice. A resident's assessment and support plan would determine the amount of assistance a resident needs with ADLs and IADLs and with mobility needs. See §§ 2800.224(a)(5)(i) and 2800.224(a)(5)(ii) (relating to initial assessment and preliminary support plan). These regulations are intended to support the maintenance of dignity and quality of life of all residents.

**Section 2800.222  
Community Social Services**

**A. Comment**

One commentator noted the word "encourage" is not defined and subject to various (and different) interpretations. The commentator stated the ALRs "offer the opportunity" to participate rather than "encourage."

**Response**

The Department intends the usual and ordinary definition of the word "encourage" as found in the tenth edition of the Merriam Webster's Collegiate Dictionary, which is "to inspire, spur on and give help." The Department submits that the current language is sufficient in this instance and declines to make the recommended change.

**Section 2800.223  
Description of Services**

**A. Comment**

One commentator stated the terms "admission" and "discharge" relate to medical facility settings and are used to describe the facility's choices and actions in regards to the patient. The commentator noted ALRs should apply the principle of resident choice and the regulations should use terminology in regards to the resident choosing to establish and terminate residency.

**Response**

The Department declines to make this change since the terms "admission" and "discharge" are used in Act 56. See 62 P.S. § 1057.3(a)(i) and §1021(a)(2)(viii).

**Section 2800.224  
Initial Assessment and Preliminary Support Plan**

**A. Comment**

Twenty commentators stated it is not customary to inform every potential resident in writing they are not accepted into the ALR. They noted this is time-consuming, potentially creates liability for the provider and is in direct conflict with both the Fair Housing Act and the Americans with Disabilities Act. They stated a decision not to admit may not be appropriate to document and the applicant may consider it insulting. They continued it could be demoralizing and harmful to the resident's mental well-being. In addition, they stated this could cause providers to be accused of discrimination. They noted providers not be directed by regulation to submit written decisions why needs cannot be met. They stated it is recommended the potential resident be informed of the decision and then referred to an appropriate local assessment agency.

**Response**

The Department finds that the General Assembly has directed the Department to regulate admission policy and procedures and further finds that individuals should be informed why they were not accepted into an ALR. 62 P.S. § 1057.3(a)(1)(i) and (iii) require that a screening be done to determine whether a potential resident requires the services provided by an ALR. Section 2800.22(b.3) (relating to application and admission) requires that a potential resident whose needs cannot be met by the ALR be provided with a written decision denying his admission and provided with a basis for the denial. It further requires that the decision be confidential and only be released with the consent of the potential resident or his designated person. In regards to referrals, § 2800.22(b.3) requires that a potential resident shall be referred to a local appropriate assessment agency if the ALR cannot meet the needs of the potential resident.

**B. Comment**

One commentator suggested the potential resident be provided a means for challenging a denial.

**Response**

Article X of the Public Welfare Code does not grant jurisdiction to the Department to adjudicate applicant or resident appeals of actions taken by an ALR.

**C. Comment**

One commentator noted the determination of the pre-admission screening form used should not be left to the discretion of the Department, but rather be part of a stakeholder process which includes the regulated community.

**Response**

The Department submits that the development of the initial and additional assessment forms will include input from industry stakeholders, consumer and other interested parties. However, Act 56 clearly requires that the screening form "be developed by the department." 62 P.S. § 1057.3(a)(1)(i).

**D. Comment**

Six commentators recommended deleting the entire section (d) and replacing it with "a potential resident need not require supplemental health care services to qualify for admission to an assisted living residence." They stated "safe emergency evacuation" of section (g) should be replaced with "them to be safely served in the residence."

**Response**

The provisions of subsection (d) referenced by the commentators have been moved to § 2800.22(c) (relating to application and admission). The provisions of subsection (g) have been moved to § 2800.22(d). These provisions are based on the language of Act 56 under 62 P.S. § 1057.3(a)(1)(iii) and §1057.3(b).

**E. Comment**

One commentator stated written notice of a decision to deny admission be provided to the resident within 15 days of the date of the pre-admission screening.

**Response**

Neither PCHs nor nursing facilities specify a timeframe for admission denials. The Department declines to regulate in this area in order to provide ALRs with flexibility in managing their admissions process.

**F. Comment**

One commentator stated pre-admission assessments of all individuals should include a cognitive screen such as the Mini Mental State Examination and a depression screen such as the Geriatric Depression Scale. The commentator noted these would identify pre-admission cognitive and emotional care needs. Another commentator suggested that use of this tool could identify dementia sooner and allow for earlier treatment which could delay nursing home placement and reduce costs.

**Response**

The Department submits that it has provided for an assessment of mobility needs under subsection (a)(5)(ii). The definition of a "resident with mobility needs" is one who is unable to move from one location to another or who has difficulty in understanding and carrying out instructions without the continued full assistance of other individuals under § 2800.4 (relating to definitions). Additionally, subsection (a)(5)(iv) requires that an individual's medical history, medical conditions and current medical status be included in the assessment. The Department maintains that these provisions will identify the cognitive and emotional needs of a resident. Identification of specific assessment tools will be done by the Department with input from industry stakeholders, consumers and other interested parties.

**G. Comment**

One commentator urged consideration of the complications an ALR considers when determining if an applicant is appropriate while ensuring the well-being of their current population.

**Response**

Act 56, as specified in 62 P.S. § 1057.3(a)(3), provides that an applicant whose needs cannot be met by the ALR shall be referred by the ALR to an appropriate assessment agency.

**H. Comment**

One commentator suggested clarification of payment source for supplemental health care and that it be defined as the responsibility of the resident.

**Response**

There is nothing in this final-form rulemaking to suggest that an ALR is responsible for payment of supplemental health care services. Indeed, as required by Act 56, supplemental health care services must be packaged, contracted and priced separately from the resident agreement. 62 P.S. § 1021(a)(2)(iii). The Department has provided this in § 2800.25(l) (relating to resident-residence contract).

**I. Comment**

One legislator commented 30 days is too long to complete initial assessments.

**Response**

The Department has enhanced the assessment process. An initial assessment must be conducted within 30 days prior to admission. A preliminary support plan must also be developed within that 30 day period. This will benefit both consumers and ALRs by giving each an accurate, "upfront" picture of the individual's needs. Once a resident is admitted to an ALR, a final support plan is to be developed and implemented within 30 days after admission. These revised provisions in the final-form regulation exceed the PCH assessment process and should address the concerns raised.

**J. Comment**

One commentator stated that residents entering ALRs should have a baseline evaluation completed within 30 days of their admission of their physical, medical and psycho-social needs and a detailed review of all medications completed by a qualified licensed practitioner experienced in the care of older adults. The commentator stated that the baseline evaluation should be the basis of the development of the care plan.

**Response**

The Department concurs that residents should have a baseline evaluation. This final-form rulemaking contains provisions under § 2800.22(a)(1) (relating to application and admission) for a medical evaluation to be completed 60 days prior to admission or 15 days after admission under certain circumstances; and, under § 2800.224(a)(2), for an initial assessment to be completed 30 days prior to admission or 15 days after admission under certain circumstances. These will form the basis of both the preliminary support plan under this section and the final support plan under § 2800.227 (relating to development of the final support plan). In regards to the commentator's desire to have a practitioner perform evaluations who is experienced in the care of older adults, the Department declines to make this change since ALRs are not designed only for older individuals but for anyone in need of ALR services, including persons with disabilities and individuals with acquired brain injury.

**K. Comment**

Three commentators recommended the regulations allow the initial support plan to be completed within 14 days of admission.

**Response**

Section 2800.224 (c)(1) and (c)(2) (relating to initial assessment and preliminary support plan), has been amended to allow for the initial support plan to be completed either within 30 days prior to admission or within 15 days after admission in the case of a resident being admitted directly to the ALR from an acute care hospital, a resident being admitted to escape from an abusive situation or any other situation where a resident has no alternative living arrangement. This is in addition to a medical evaluation performed within 60 days of admission and the development of a final support plan within 30 days after admission. The Department maintains that these provisions should address the commentators' concerns.

**L. Comment**

One commentator noted there be some accommodation made for assistance offered to persons who have cognitive challenges in the pre-admission screening process.

**Response**

Under subsection (a)(1), an initial assessment is conducted by the ALR administrator, administrator designee, or licensed practical nurse, under the

supervision of a registered nurse, or a registered nurse. This assessment, under subsection (a)(5)(ii) is to include the mobility needs of the potential resident. As noted above, the definition of a "resident with mobility needs" includes an individual who is unable to move from one location to another or who has difficulty in understanding and carrying out instructions without the continued full assistance of other individuals. Thus, the initial assessment will identify the cognitive issues this comment addresses. After the initial assessment, a preliminary support plan is developed.

**M. Comment**

One commentator stated that the assessment should be performed prior to admission unless an urgent admission from a hospital makes this unworkable. They noted in that case, the assessment should be performed after admission.

**Response**

Under subsection (a)(3)(i), the initial assessment is required to be completed within 30 days of admission except in certain circumstances, which include admission directly from an acute care hospital. In those cases, initial assessments are permitted 15 days after admission to the ALR.

**N. Comment**

One commentator recommended a cognitive assessment of all residents at the time of admission over the age of 65, as well as anyone under 65 with a diagnosis of a cognitive dysfunction. The commentator also stated there is a need for ongoing assessment of cognitive decline (perhaps every 6 months).

**Response**

Regarding cognitive assessments, subsection (a)(5)(ii) details an enhanced assessment process that includes an assessment of a resident's mobility needs. As defined in § 2800.4 (relating to definitions), a "resident with mobility needs" includes an individual who has difficulty in understanding and carrying out instructions without the continued full assistance of other individuals. The Department submits that these provisions should address the commentator's concerns.

As to the frequency of assessments for residents who exhibit cognitive decline, for those residents not in special care units, § 2800.225 (relating to additional assessments) requires that in addition to annual assessments, additional assessment may be provided if a resident's condition changes significantly or at the request of the Department. Under § 2800.231 (relating to admission) it is required that residents in Alzheimer's and dementia special care units be assessed quarterly and that those in special care units for people with brain injury be assessed semi-annually or more frequently if needed.

**Section 2800.225**  
**Additional Assessments**

**A. Comment**

Fifty-three commentators stated it is not clinically necessary to have an RN complete assessments and support plans. They noted this will also significantly increase costs associated with operations. They continued, having an RN review plans and assessments could be reasonable, but requiring the direct supervision of an RN is not needed. They stated this could also reduce the amount of charitable care an ALR can provide. Two additional commentators stated that an RN is needed to complete assessments as LPNs are not trained in assessment skills.

**Response**

This provision meets or exceeds the PCH regulations. The Department finds that it is appropriate to have an RN supervise assessments and support plans performed by LPNs due to the acuity levels of some ALR residents. It furthermore finds that the resultant cost is outweighed by the health and safety benefits to residents.

**B. Comment**

One commentator stated the initial and annual assessments should include questions about brain injury (a validated screening instrument to assure accurate and complete information). The commentator noted where there is evidence of a brain injury, a neuropsychological evaluation and treatment plan occur. The commentator continued, this is an important issue because of the high rate of brain injury rehabilitation in seniors and because there is generally no other source of funding for brain injury.

**Response**

Based on stakeholder input, the Department, in § 2800.4 (relating to definitions), has added a definition for *INRBI* as "intense neurobehavioral rehabilitation after brain injury." For admission to INRBI special care units, it has also added in § 2800.231(c)(2)(i) (relating to admission) a requirement for a written cognitive, physical, behavioral (CPB) preadmission screening to be completed in collaboration with a physician, neuropsychologist or cognitive, physical, behavioral assessment team. The Department submits that this should address the commentator's concerns. In regards to funding for brain injury, this issue is outside the scope of these regulations.

**C. Comment**

Two commentators noted the intent of this regulation was not clearly stated. They asked is it the intent that all assessments be done under the supervision of an RN. They continued, also, the regulation does not define what qualifications a designee must have when completing an assessment and this needs clarification.

### **Response**

It is not the intent of the Department to have all assessments done under the supervision of an RN. Section 2800.224(a)(1) (relating to initial assessment and preliminary support plan) and § 2800.225(c) require only that LPNs complete assessments under the supervision of an RN. Regarding administrator designees, the Department finds that authority is provided by the PCH regulations under § 2600.224(c) (relating to preadmission screening) to permit administrator designees to perform assessments. Section 2800.56(b) (relating to administrator staffing) has been amended at the recommendation of industry stakeholders to provide for the qualifications of administrator designees, one of which is passage of the Department-approved competency-based administrator training test under § 2800.56(b)(3) (relating to administrator training and orientation).

### **D. Comment**

One commentator requested clarification as to the specific requirement for the "supervision of a registered nurse." The commentator questioned if this implies an RN on staff or a contractual agreement with a nurse to be available to come into the ALR on an as-needed basis? The commentator noted a 24-hour on-call arrangement with an RN would be costly.

### **Response**

The Department has elected not to specify in the regulations the manner in which an ALR employs an RN for the purpose of assessments (whether the nurse is an employee or a contractor). Instead, it defers the specifics of the employment status of RN supervisors to the individual ALR.

## **Section 2800.226 Mobility Criteria**

### **A. Comment**

Fifteen commentators stated it is sufficient to keep a list of residents admitted with mobility needs or those who develop mobility needs instead of notifying the Department within 30 days of developing an issue.

### **Response**

The 30-day notification language is consistent with the language contained in the PCH regulations, which the Department is required to meet or exceed. This provision will provide the Department with needed information about the populations entering ALRs as well as the changing status of those living there.

### **B. Comment**

One commentator noted in § 2800.238 each resident "shall be considered to be a resident with mobility needs." The commentator questioned is it necessary to notify the Department of each admission?

**Response**

The language in subsection (c) requires that the ALR notify the Department within 30 days after a resident with mobility needs is admitted to the ALR and compile a monthly list of when a resident develops mobility needs.

**C. Comment**

One commentator noted that Chapter 2600's Licensing Measurement Instrument has been interpreted recently by the Department's Adult Residential Licensing Division to mean that written notice to the Department is not required.

**Response**

The language in subsection (c) of this final-form rulemaking was agreed to by industry stakeholder, consumers and other interested parties.

**Section 2800.227**

**Development of the Final Support Plan**

**A. Comment**

Twenty-one commentators stated the requirement for quarterly updates of the support plan is excessive, time-consuming, redundant and serves to increase costs. It is recommended that support plans be updated semi-annually or upon a significant change in a resident's condition.

**Response**

As noted previously, ALRs are intended to provide an environment in which residents may age in place, which is defined in § 2800.4 (relating to definitions) as receiving care and services at a licensed ALR to accommodate changing needs and preferences in order to remain in the ALR. As such, the Department finds that requiring revision of support plans on a quarterly basis does not place an undue burden on ALRs and that the benefits to residents outweigh the costs.

**B. Comment**

Twelve commentators suggested a copy of the support plan be given to the resident and/or the resident's designated person only upon request.

**Response**

The Department finds that subsection (d), which requires the ALR to give a copy of the final support plan to the resident and the resident's designated person benefits the resident by allowing his specific needs to be documented. It also allows residents and their families to monitor resident care and well-being. The Department finds that the benefits of this provision outweigh its costs.

**C. Comment**

Thirteen commentators and one legislator stated the support plan should be completed and implemented prior to admission, not within 30 days after admission.

**Response**

The Department submits that although a support plan must be developed within 30 days prior to admission, it cannot be implemented until the resident is actually admitted to an ALR.

**D. Comment**

Six commentators recommended the support plan be attached to or incorporated into and serve as a part of the resident/ALR agreement. They stated each ALR have a written support plan developed prior to admission and implemented within 7 days. They further stated the support plan should be revised within 30 days of completion of the quarterly assessment.

**Response**

Section § 2800.227(k) has been revised to require that the final support plan be attached to or incorporated into and serve as part of the resident-residence contract. Additionally, § 2800.224 (relating to initial assessment and preliminary support plan) has been revised to include the development of a preliminary support plan 30 days prior to admission or 15 days after admission under a limited number of circumstances. Under § 2800.227 (relating to development of the final support plan), a final support plan is to be developed and implemented within 30 days of admission. Subsection (c) requires that the final support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment. It, furthermore, provides that the residence shall review each resident's final support plan on a quarterly basis and modify as necessary to meet the resident's needs.

**E. Comment**

One commentator noted completing the support plan prior to admission is unrealistic. The commentator stated staff needs time to spend with residents to know their needs and interests.

**Response**

Section 2800.224 (relating to initial assessment and preliminary support plan) requires that a preliminary support plan be *developed* prior to admission (emphasis added). The Department submits that the preliminary support plan will provide potential residents with valuable information about the services they would need and the cost of those services charged by the ALR.

Section 2800.227(a) (relating to development of the final support plan) requires that each resident requiring services have a written final support plan developed *and implemented* within 30 days after admission to the ALR (emphasis added). During this time, appropriate adjustments can be made as the staff becomes acquainted with the resident.

**F. Comment**

One commentator stated that direct care staff of an ALR should be given easy access to the resident's support plan at all times. The commentator stated that not be a violation of the Department's regulations and sanctions should be imposed. The commentator noted the ALR should provide the name, address and phone number of the RN required to review and approve the support plan. The commentator stated support plans for ADLs and IADLs should be separate documents.

**Response**

The Department points the commentator to subsection (i), which requires that the final support plan be accessible by direct care staff persons at all times. Violations of this requirement will be cited by the Department through the annual licensing survey or through complaint investigations, or both. Regarding the information required on the support plan and the formatting of that form, subsection (a) requires that support plans be documented on the Department's support plan form. The Department will give consideration to the commentator's requests when developing that form.

**G. Comment**

Three commentators requested clarification on the following points: Will the person conducting the assessment have to have any training in dealing with acquired brain injury?

**Response**

Under § 2800.18 (relating to applicable laws), ALRs are required to comply with applicable Federal, State and local laws, ordinances and regulations. As such, the extent of an RN's or LPN's training and whether the training includes dealing with acquired brain injury will depend on their licensure requirements. Administrators, under § 2800.64(b)(10) (relating to administrator training and orientation) are required to receive training in the care of residents with cognitive and neurological impairments. Under § 2800.56 (relating to administrator staffing) administrator designees must pass the same Department-approved competency-based administrator training test that must be passed by administrators. With respect to admission into INRBI special care units, § 2800.231(c)(2)(ii) (relating to admission) requires that a cognitive, physical, behavioral specialist with brain injury experience is to assist in developing a rehabilitation and support plan by working with a resident's physician, neuropsychologist, and, when appropriate, the resident's designated person or the resident's family, or both to develop the resident's rehabilitation and support plan. These provisions should satisfy the commentators' concerns.

**Section 2800.228**  
**Transfer and Discharge**

**A. Comment**

Forty commentators and three legislators questioned the fact that transfers and discharges need to be called to the ombudsman. They stated involvement of the ombudsman as an active participant is inappropriate and unnecessary. They noted the ombudsman should provide a counseling role for the resident if needed/requested, not act as a legal advisor. They continued it is believed a team approach is more effective than relying on an ombudsman for determining the transfer of a resident. They stated there should not be any delay if a transfer or discharge needs to occur by adding the ombudsman and asked if anyone has spoken with the Area Agency on Aging about this requirement. They continued, if a resident is deemed to be incompetent, the resident should have a Power of Attorney and if they do not, only then should the ombudsman have a role. One commentator recommended the language be modified to include the resident and their designated person but provide contact information for the ombudsman. The commentator continued the involvement of the ombudsman in every transfer and discharge would require additional ombudsman staff hours and an increase in funding.

**Response**

Section 2800.228 has been revised to no longer require the local ombudsman to be notified of all transfers or discharges.

**B. Comment**

Twenty-four commentators stated ALRs should be permitted to maintain control over the transfer and discharge of its residents to ensure that residents are appropriately cared for. Another commentator stated that the transfer and discharge requirement exceed the statutory requirement of Act 56.

**Response**

Under Act 56, ALRs are required to make a reasonable accommodation for aging in place, including services from outside providers. 62 P.S. §1021(a)(2)(viii). However, there are certain circumstances when an ALR cannot accommodate a resident and a resident has to be transferred or discharged. It is not a reasonable accommodation if meeting a resident's needs would create an undue financial or programmatic burden on the ALR, or if the resident's needs cannot be met by the ALR. See subsections (h)(3) and (4).

Subsection (h) specifically enumerates the only grounds for transfer and discharge. The foundation for this transfer and discharge language is the PCH regulations at § 2600.228 (relating to notification of termination), which the Department is required to meet or exceed under Act 56. Further, under subsection (a), ALRs are required to ensure that a transfer or discharge is safe and orderly and that the transfer or discharge is appropriate to meet the resident's needs.

Act 56 further prohibits the admittance, retention and serving of an individual when the individual has a certain excludable condition or health care need. See 62 P.S. § 1057.3(e) and (g). The Department mirrored this language at § 2800.229 (relating to excludable conditions; exceptions). If an individual has one of these excludable conditions, the ALR may choose to submit a written exception request to the Department to admit, retain or serve this individual. See subsections (b), (c)(1), (e) and (f). However, the facility is under no obligation to do so.

Taken together, these provisions meet the needs of residents and recognize that the ALR has the ability to meet those needs.

### **C. Comment**

Four commentators noted that the requirement for an ALR to ensure a transfer or discharge is appropriate to meet the needs of the resident is not always possible. They stated a competent resident, a designated person, Power of Attorney or guardian may be the person making this choice. They continued, it is suggested the wording be changed to place the burden on the ALR to fully inform the resident, designated person, or other individual of the possible consequences and to inform the local Protective Services.

### **Response**

Subsection (a) requires that the ALR shall ensure that a transfer or discharge is safe and orderly and appropriate to meet the resident's needs. As stated above, an ALR is required under Act 56 to make reasonable accommodation to allow a person to age in place. Subsection (b)(2) provides that, if agreed to by the resident and ALR, supplemental services may be provided by the resident's family, residence staff or private duty staff as agreed to by the resident and residence. If an ALR initiates a transfer or discharge of a resident, subsection (b)(iv) requires that it provide an explanation of the measures the resident or the resident's designated person can take if they disagree with the ALR's decision to transfer or discharge. Subsection (b)(1)(v) requires that notice of transfer or discharge must include the resident's transfer or discharge rights. In regards to assurances that a transfer or discharge is appropriate, subsection (h) enumerates the only grounds on which a transfer or discharge may occur. If the transfer or discharge is due to a resident being a danger to himself or others, or if an ALR determines that a resident's functional level is such that the resident's needs can no longer be met in the ALR due to the excludable conditions specified in 2800.229 (relating to excludable conditions; exception), a certification to that effect is required. The certification must be provided either by the administrator in consultation with supplemental health care providers, the resident's physician or certified registered nurse practitioner or the medical director of the ALR. While the specific language of the commentator has not been adopted, the Department submits that these provisions offer ample protections for residents in the transfer and discharge processes. Additionally, the Department will monitor the requirements of this section as a condition of licensure.

#### **D. Comment**

One commentator stated allowing the resident to participate in the decision-making process for a transfer/discharge situation be based on the resident's cognitive ability to make sound decisions. The commentator noted this could put a heavy burden on the ALR in placement of care, transfer or discharge.

#### **Response**

The Department submits that the legislative intent of Act 56 is for ALRs to allow people to age in place, maintain their independence and exercise decision-making and personal choice. It further submits that it would be contrary to the spirit of the Act to exclude residents from participating in transfer and discharge processes because of cognitive impairment. While the involvement of a resident's designated person is included in these processes, the Department does not see this as a reason to exclude the resident himself. As far as resident involvement being a burden to an ALR, the Department submits that the benefits to the resident outweigh the burden on the ALR.

#### **E. Comment**

One commentator stated in instances where exceptions have been granted and the ALR determines it can no longer provide services to a resident, the resident should be entitled to an independent assessment from the Area Agency on Aging.

#### **Response**

The requirements in this section exceed the PCH regulations. While recognizing that an external evaluation could be of assistance in some situations, the Department has no authority to compel Area Agencies on Aging or any other external agencies to perform the independent assessment the commentator recommends.

#### **F. Comment**

One commentator noted if dual licensure is permitted, it is important to clarify whether the notice requirements and processes outlined apply to an internal transfer (it is believed they should not apply). The commentator stated the regulations appear to deny the ALR fair notice and the opportunity for a hearing concerning action taken against them by the Department. The commentator noted since "licensure action" would be contemplated, the ALR should be assured appropriate due process and an opportunity to give its view of the ombudsman's report.

#### **Response**

"Transfer" is defined in § 2800.4 (relating to definitions) as movement of a resident within the ALR or to a temporary placement outside the ALR. It is clear, therefore, that with respect to internal transfers, they are covered by notice requirements. Regarding appeals of actions taken by the Department, § 2800.12 (relating to appeals) outlines appeal avenues available to ALRs. As to ombudsmen, they are

no longer involved in issuing notification and reports related to transfer and discharge under this final-form rulemaking.

#### **G. Comment**

One commentator noted paragraph (b)(2) is one-sided towards the resident and does not allow the ALR to have a say in the type of care it will provide. The ALR cannot be placed in a position which jeopardizes the care and safety of residents. The commentator continued this could also lead to liability issues for the ALR by not referring a resident to a higher acuity resource than it can provide. The commentator noted the paragraph suggests an ALR would have to keep a resident regardless of their condition.

#### **Response**

As stated above, Act 56 requires that ALRs make reasonable accommodation to provide residents with an opportunity to age in place. However, subsection (h)(4) provides that if meeting a resident's needs would require a fundamental alteration in the ALR's program or building site, or would create an undue financial or programmatic burden on the ALR, the ALR is permitted to transfer or discharge the resident. Consequently, the Department does not concur with the commentator's broad interpretation and characterization that an ALR is being forced to keep a resident regardless of his condition.

#### **H. Comment**

Two commentators recommended an ALR ensure that residents who are discharged will have their medications, durable medical equipment and personal belongings go with them. They stated the regulations should also require tracking of admissions, discharges and transfers by the ALR, including those involving excludable conditions.

#### **Response**

Subsection (a) requires that an ALR ensure that a resident is transferred or discharged with all his medications, durable medical equipment and personal property. Regarding tracking, subsection (e) requires that an ALR record the date and reason for the transfer or discharge in the resident record and that it be tracked in a transfer and discharge tracking chart that the residence shall maintain and make available to the Department.

#### **I. Comment**

One commentator recommended the following changes in wording: the term "appropriate local authorities" should be changed to "appropriate local entities" and defined in the definitions section, the term "documented repeated violation of the residence rules" should be deleted entirely as a legal reason for discharge and the language of "practicable notice" should be replaced with "30 day advance written notice to the resident and the legal representative, if one exists."

#### **Response**

The Department is required to be consistent with Act 56 in which the term "appropriate local authorities" is used. See 62 P.S. § 1057.2(a). The ALR rules are designed to ensure the health and safety of residents. Repeated violation of the rules can jeopardize resident health and safety. Further, the grounds for transfer or discharge for ALRs mirror the current grounds for transfer or discharge for PCHs, including documented, repeated violation of the ALR rules. Therefore, the Department did not make the requested change.

If an ALR initiates a transfer or discharge of a resident, subsection (b) requires a 30-day advance written notice to the resident, the resident's family or designated person. However, if a delay in transfer or discharge would jeopardize the health, safety or well-being of a resident or others, as certified by a physician or the Department, a shorter notice period, a practicable notice, is required.

Regarding use of the term "practicable notice," the Department intends the common and usual definition of the word "practicable," which according to the tenth edition of the Merriam Webster's Collegiate Dictionary means "feasible." Notice would depend on the feasibility of providing notice in the individual circumstances of a case.

#### **J. Comment**

One commentator stated in the event of a planned closure, residents and the Department of Public Welfare both be notified 60 days in advance.

#### **Response**

This provision mirrors that of the PCH regulations, which the Department is required to meet or exceed. The Department has elected not to make the recommended change.

#### **K. Comment**

One commentator recommended the addition of a new subsection to this section: (i) notwithstanding anything in this section or in this Chapter, discharge, transfer and eviction shall be addressed through existing subsidized residence rules if the operations of the ALR must comply with the requirements of one or more federal housing subsidies. The commentator stated that in the event of a conflict, the subsidized residence rules should prevail over the requirements of this Chapter.

#### **Response**

The Department finds that the commentator's recommendation is beyond the scope of this rulemaking since the rulemaking addresses ALR licensing, not federal housing subsidy issues.

#### **L. Comment**

Four commentators asked if the certification by the Department or the physician can be verbal, and not written.

**Response**

62 P.S. § 1057.3(f) gives the Department authority to regulate the standards required for certification. Based on comments received, the Department has amended subsection (b)(3) to require that the certification be in writing.

**M. Comment**

Two commentators noted this section severely limits the ALR's ability to ensure the protection of resident rights. They stated ALRs cannot approve or assume the responsibility to allow non-trained family members or care providers to provide care the ALR has already determined is beyond their trained abilities. They questioned why a provider would choose to assume this liability as an ALR. They recommended this language be removed from the proposed regulations.

**Response**

Subsection (b)(2) allows for the provision of supplemental services by the resident's family if it is agreed to by the resident and the ALR. Based on comments received, the Department has deleted language from the notice of proposed rulemaking prohibiting a resident's transfer or discharge if the resident or his designated person arranges for the needed services.

**N. Comment**

One commentator stated notification to DPW be made prior to the ALR beginning the relocation of residents to ensure this section can be implemented. The commentator noted this will prevent situations that have occurred in PCH closures where DPW is notified of a closure after the facility has begun relocating residents, making it difficult for DPW to ensure residents are protected. The commentator recommended the regulations identify DPW as the lead agency who is responsible for relocation assistances and the coordination of assistance regardless of age.

**Response**

This provision mirrors that in the PCH regulations, which the Department is required to meet or exceed. The role of the Department in relocations is set out in Act 56, which provides that the Department work "in conjunction with" appropriate local authorities when an ALR closes. See 62 P.S. § 1057.2.

**O. Comment**

Three commentators stated discharged residents, regardless of which party initiated the discharge, have the ultimate say in where they relocate. They noted an ALR can work to ensure a smooth transfer or discharge but should not be held accountable as to the appropriateness of placement. They stated it is not reasonable to place the onus of this on the provider, as the resident can and should have free will regarding discharge and transfer.

**Response**

The Department finds that an ALR is in the best position to ensure a smooth transfer or discharge as provided in subsection (a) because it is knowledgeable

about other possible placements for a resident. The Department does not see this as an onerous burden on ALRs but, indeed, maintains that the health and safety benefits to residents outweigh potential costs. 62 P.S. § 1057.2 specifies that the Department, in conjunction with appropriate local authorities, shall relocate ALR residents if an ALR is either operating without a license or is voluntarily closing and relocation is necessary for the health and safety of the residents. Nevertheless, regarding resident involvement, subsection (f), which is similar to the language of the PCH regulations, provides that, except in the case of an emergency, each resident may participate in planning the transfer, and shall have the right to choose among the available alternatives after an opportunity to visit the alternative ALRs before relocation or following temporary emergency relocation. Residents shall choose their final placement and shall be given assistance in transferring to such place 62 P.S. § 1057.2(b). This provides the "free will" provided by law to residents.

**P. Comment**

Six commentators stated the regulations should include two rights: the right to appeal a discharge to the Department's Bureau of Hearings & Appeals and the right to continue to reside in the ALR pending the outcome of the appeal.

**Response**

The Department does not have jurisdiction to adjudicate cases involving resident involuntary transfer and discharge unless such authority is granted by statute. Article X of the Public Welfare Code does not grant authority to the Department to adjudicate disputes related to resident appeals of actions taken by an ALR. Instead, it is a matter of contract law between the home and the resident. Concerning a resident being able to reside in an ALR pending the outcome of any legal action they may take, the regulations provide for a 30-day advance notice under subsection (b).

**Section 2800.229  
Excludable Conditions; Exceptions**

**A. Comment**

Two commentators stated that if a resident is not capable of self-care of a gastric tube and a nurse is not required to be on-site, then individuals using gastric tubes that are not capable of self-care should not remain in the ALR.

**Response**

The language in this provision mirrors that in Act 56 under 62 P.S. §1057.3(g)(1). This provision permits an ALR to admit, retain or serve an individual who requires a gastric tube under two conditions. One condition is if the consumer is capable of self-care of the gastric tube or a licensed health care professional or other qualified individual cares for the tube. In this case, the ALR does not have to seek the Department's determination to serve the individual. If, however, the individual is not capable of self-care of the gastric tube and there is not a licensed health care

professional or other qualified individual to care for the gastric tube, the ALR may admit, retain or serve the consumer only if it provides a written request to the Department and the Department provides a determination that the individual's needs can be met by the ALR. The ALR is, however, not required to submit this request.

**B. Comment**

One commentator stated if a resident requires 24-hour nursing care for more than 15 days the resident should not remain in the ALR.

**Response**

The statute under 62 P.S. §1057.3(e)(vii) provides that an ALR may not admit, retain or serve an individual who needs continuous skilled nursing care twenty-four hours a day unless an exception is granted by the Department. Section 2800.229(a)(7) mirrors this provision. The Department finds it is not appropriate to establish a timeframe for this provision because to do so would potentially prevent such residents from aging in place. Nor has the General Assembly placed any restriction on the length of time that an individual needing such care may remain in the ALR. As a result, no change has been made to this subsection.

**C. Comment**

One commentator noted that this section should clarify what services are required by law to be provided by a health care facility. The commentator questioned whether the provisions that permit exceptions to these excludable conditions are in violation of Senate Bill 704. The commentator noted subsection (c) should also include the criteria that any exception request cannot place other residents, visitors or ALR staff at risk.

**Response**

The services that a health care facility may provide are found in the Health Care Facilities Act. (35 P.S. § 448.101-448.901.) The language regarding the exceptions process is taken directly from Act 56, which was Senate Bill 704 PN 1272 (2007-2008 Session). The Department finds that the existing provisions under subsection (c) provide adequate assurances that an ALR will be able to provide the care that a resident needs. The question of its impact on other residents, visitors and ALR staff is one that each ALR will have to consider when contemplating an exception request and whether to seek an exception from the Department.

**D. Comment**

Three commentators recommend the regulations specify the number of years' experience required for any professional making any medical/clinical determination. Another recommended 5 years' experience caring for the elderly or people with disabilities.

**Response**

The Department maintains that the requirements for medical professionals are beyond the scope of these regulations. Licensure qualifications are set by the Department of State, not the Department of Public Welfare.

**E. Comment**

One commentator stated the term "qualified individual" explicitly include trained family members or other representatives of choice. The commentator noted a number of excludable conditions should not require request for exemption from the Department, including MRSA, C difficile and VRE colonization, which may persist for years without functional impact on the resident. Another commentator asked what is the definition of a qualified person to administer oxygen? The commentator said that assisting with oxygen is something a layperson can be taught and does not require any specific level of qualification. What is the definition of a qualified person to administer inhalation therapy? The commentator stated that assisting with inhalation therapy is something a layperson can be taught and does not require any specific level of qualification.

**Response**

The Department has amended the regulation by adding subsection (e)(10), which provides that "qualified individuals" for the purpose of this section are persons so designated by any of the people listed in subsection (d). These individuals are: (1) The administrator acting in consultation with supplemental health care providers; (2) The individual's physician or certified registered nurse practitioner; or (3) The medical director of the residence.

**F. Comment**

One commentator noted there is no provision for an independent panel to determine whether a resident with an excludable condition can, in fact, be admitted or retained.

**Response**

Act 56 places the responsibility and authority on the Department to determine whether an exception is to be made in cases where there is an excludable condition and the ALR seeks an exception. Requests will be reviewed on a case-by-case basis by the Department. Act 56 does not require formation of an independent panel. Instead, Act 56 provides that certain individuals may certify that a consumer may not be admitted or retained in and ALR: 1) the ALR administrator in consultation with supplemental health care providers; 2) a consumer's physician or certified registered nurse practitioner; or 3) the medical director of the ALR.

**G. Comment**

Two commentators stated that allowing for the request of exception to conditions prohibiting admission can and will affect appropriate admissions into the skilled care setting. They noted the regulations should not allow for the request of these exceptions.

**Response**

Act 56 provides the ALR with the authority to seek exceptions for certain excludable conditions. The Department cannot deviate from that statutory language.

**H. Comment**

Five commentators stated the Department's response time guideline of within 5 days is too long. They stated "within 48 hours" would be a more reasonable delay time. One commentator stated the Department should grant exception requests if all requirements of the exception request application are adequately submitted.

**Response**

The Department maintains that the 5 business day response time is needed to ensure a thorough review to include review by the medical director. A review time of 48 hours is not realistic or practicable. As to the comment that the Department should grant exception requests if all requirements on the application are "adequately" submitted, the Department will exercise discretion and will weigh the factors outlined in subsection (c) and consult with appropriate health care professionals in subsection (b) in rendering a decision.

**I. Comment**

One commentator noted this regulation will result in current residents of an ALR who are hospitalized or who are residents of a nursing facility, to wait unnecessarily in another care setting while waiting for response from the Department. The commentator stated this will result in financial hardship for ALRs, residents, providers and insurers. The commentator noted an interim plan be allowed so the application for exception can be made from the ALR while the resident is receiving appropriate care.

**Response**

The Department cannot assume that residents who have been admitted to hospitals and nursing facilities will ultimately be re-admitted to an ALR. Act 56 does not provide authority for the Department to approve an interim plan based on a pending exception request. Instead, the words of the statute are clear: An ALR may not admit, retain or serve a consumer with an excludable condition unless an exception is granted by the Department. 62 P.S. §1057.3(e).

**J. Comment**

One commentator noted that the care needs listed in subsection (e)(1-9) are currently served in PCHs. The commentator questioned, does their inclusion in ALRs indicate they will be excluded from PCH admission?

**Response**

This regulation is intended to address licensure requirements for ALRs. PCHs are not addressed in the Chapter.

**K. Comment**

The commentator noted it is unclear if a resident could return to an ALR if they were colonized or infected with organisms such as staphylococcus. The commentator stated it is also possible as a resident's condition changes, hospice or palliative care will become an option. The commentator stated although an ALR can apply for an exception to keep the resident, the resident has no appeal if the ALR wishes to discharge them.

**Response**

As required by Act 56, § 2800.229(a)(4)(relating to excludable conditions; exceptions) provides that an ALR may not admit, retain or serve an individual with a reportable infectious disease in a communicable state that requires isolation of the individual or requires special precautions by a caretaker to prevent transmission of the disease unless the Department of Health directs that isolation be established within the ALR. Reportable infectious diseases can be found at 28 Pa.Code § 27.21a (relating to reporting of cases by health care practitioners and health care facilities).

In response to whether a resident with an excludable condition can appeal a discharge from an ALR, this is a matter of contract law between the ALR and the resident. Article X of the Public Welfare Code does not grant jurisdiction to the Department to adjudicate disputes related to discharge or transfer of residents.

**L. Comment**

One commentator asked if having a medical director is the decision of the ALR or will the regulations require it?

**Response**

The Department submits that there is nothing in the regulations to require an ALR to have a medical director to certify determinations under §§ 2800.22(b.2), 2800.228(i) and 2800.229(d) (relating to application and admission; transfer and discharge; excludable conditions; exceptions). A medical director is one of the individuals authorized to certify determinations related to excludable conditions. Whether to have a medical director is a business decision to be made by an ALR.

**M. Comment**

One commentator recommended flexibility with respect to a resident's ability to die in an ALR, even when his or her condition has deteriorated to a point that exceeds the excludable conditions criteria. The commentator stated a mutual decision by the provider and the resident should be reached. The commentator noted not all providers have access to the hospice support necessary to permit this.

**Response**

Act 56 establishes that residents of ALRs will receive the assistance they need to "age in place," which is defined in 62 P.S. § 1001 as receiving care and services at

a licensed ALR to accommodate changing needs and preference is order to remain in the ALR. By definition, an ALR must provide or arrange for the provision of supplemental health care services. (Id.) This includes hospice care, which is included as a supplemental health care service that ALRs are required to provide under § 2800.220(e)(1) (relating to service provision).

**N. Comment**

One commentator thinks a regulatory distinction should be made between those excludable conditions which develop among residents and those individuals who have not been admitted. For many, the excluded conditions are part of the natural course of illness. The regulations should be written to make a presumption of acceptance and to exclude a resident for those conditions only if it is shown that the resident's needs cannot be met with facility or supplemental resources.

**Response**

The Department submits that Act 56 provides, in 62 P.S. §1057.3(e)(3), that an ALR may not admit, retain or serve a consumer with the excludable conditions enumerated in the statute, unless an exception is requested by the ALR and approved by the Department.

**O. Comment**

One commentator stated a physician should review the exception request in consultation with the Department. The commentator stated the exception request process allows ALRs to provide care traditionally provided in nursing homes without the degree of oversight by the Department of Health. The commentator continued it is important that residents have an understanding of any medical risks that may exist in requesting the exception. In addition, the commentator stated this should be outlined in the written alternate care plan.

**Response**

The legislature, in Act 56, provided that exception requests may be reviewed by a certified registered nurse practitioner "or" a physician. (Emphasis added.) See 62 P.S. § 1057.3(f). The Department cannot substitute its judgment for the legislature's on this issue. The Department submits that there are numerous consumer protections built into this section in subsection (c)(4)(i)-(v), which provide that the Department will review an exception request; that the request must be desired by the resident; that the resident will benefit from the approval of the request; the ALR demonstrate to the Department's satisfaction that it has the ability to care for the resident related to the excludable condition; the ALR will demonstrate to the Department's satisfaction that any necessary supplemental health care provider is able to care for the resident's needs related to the excludable condition; and that the ALR provides a written alternate care plan that ensures the ALR can care for the resident in the event the supplemental health care provider is unavailable. Nothing in these regulations would prohibit a resident from having a risk assessment performed.

**P. Comment**

Six commentators recommended adding the following language to subsection (d): the following persons may certify that an individual may not be admitted or retained in a residence "and must certify that an individual may be safely served in a residence where the residence follows its proposed plan to meet the resident's needs"; "The residence provides a written alternate care plan that ensures the availability of staff with the skills and expertise necessary to care for the resident's needs related to the excludable condition in the event the supplemental healthcare provider is unavailable."; "The residence shall record the following decisions made on the basis of this section: all admission denials; transfer or discharge decisions that are made on the basis of this section."

**Response**

The Department submits that the language in subsection (d) was taken from Act 56 at 62 P.S. § 1057.3(f). It further submits that § 2800.229(c)(4)(v) requires that an ALR provide a written alternate care plan that ensures the availability of staff with the necessary skills and expertise to care for a resident's needs in the event that a supplemental health care provider is not available. Section 2800.229(h) requires the ALR to record decisions on admission denials and transfer or discharge that are made based on this section.

**Q. Comment**

One commentator said that there should be a requirement that residents who have been granted exception requests be assessed quarterly (as they are in special care units). The concern is that a resident may not be receiving sufficient care and would be better served in a nursing facility, but the family is trying to preserve assets.

**Response**

The Department submits that the purpose of these regulations, as stated in § 2800.1 (relating to purpose), is to protect the health, safety and well-being of ALR residents. As licensed entities, ALRs are required by law to conform to the provisions of this final-form rulemaking. In the case of an individual for whom an ALR has requested and been granted an exception request by the Department, the ALR would be required to conduct assessments as provided in § 2800.225 (relating to additional assessments). These assessments are to be conducted as follows: annually; *if the condition of the resident significantly changes* prior to the annual assessment; and *at the request of the Department upon cause to believe that an update is required.* (Emphasis added.) The Department submits that this flexible requirement is more appropriate than a quarterly assessment because it provides for additional assessments based on changing circumstances of the individual resident rather than a fixed timetable.

**Section 2800.231  
Admission**

**A. Comment**

Three commentators stated this section is not congruent with the definition of special care designation. The commentator noted the definition includes those with severe cognitive impairments, including dementia or Alzheimer's. The commentator continued brain injury may result in severe cognitive impairment, but is not a form of dementia. The commentator stated the Commonwealth has every incentive to rehabilitate those with severe cognitive impairment due to brain injury.

**Response**

The Department has amended § 2800.231 to include units for individuals in need of intense neurobehavioral rehabilitation (INRBI) and to differentiate the Alzheimer's and dementia special care designation from the brain injury special care designation. This was added at the request of the Acquired Brain Injury Network of Pa, Inc. The language in Act 56 clearly defines a special care designation to mean "care for residents with severe cognitive impairments, including, but not limited to, dementia or Alzheimer's disease..."

**B. Comment**

Nine commentators stated that requiring a resident with dementia or other cognitive impairment to document agreement to admission to a specialized unit is not logical. They noted the nature of dementia (or any cognitive impairment) makes it impossible to truly consent, so the signature is meaningless.

**Response**

In response to comments received, the Department has amended § 2800.231(a)(1)(i) and (a)(2)(iii) to include language related to the involvement of the resident's designated person or the resident's family in the resident's admission or transfer to the special care unit. These individuals, when appropriate, are also required to agree to admission or transfer to the special care unit.

**C. Comment**

Six commentators stated the assessment should be completed semi-annually rather than quarterly as the cost involved and amount of time spent detracts from the quality time spent caring for residents.

**Response**

The Department did not decrease the frequency of assessments for residents with Alzheimer's disease and dementia in special care units based on their higher acuity level. However, at the request of advocates for those with brain injury, assessments for those in INRBI special care units are required to be completed at least semi-annually.

**D. Comment**

Two commentators recommended the written cognitive pre-admission screening be conducted 15-30 days prior to admission, not within 72 hours of admission.

**Response**

This provision mirrors the PCH regulations, which the Department is required to meet or exceed.

**E. Comment**

One commentator questioned if consumers will understand the meaning of "special care designation" and what that means in terms of ALRs and what they can and cannot offer. The commentator questioned how and in what arrangement services to cognitively-impaired residents will be delivered.

**Response**

The Department finds that the term "special care designation" is the definition used in 62 P.S. § 1001. In addition, the statute provides that in order to hold itself out to the public as providing services or housing for consumers with cognitive impairments, the ALR must make certain disclosures. 62 P.S. § 1057.3(c). These disclosures are quite comprehensive and should provide guidance to consumers and their families concerning how the care needs of an individual with cognitive impairments will be met. Specifically, § 2800. 234(a)(1) (relating to resident care) requires that within 72 hours of the admission, or within 72 hours prior to the resident's admission, a support plan be developed, implemented and documented in each resident's record. The support plan determines what services are to be provided and the manner in which they are to be provided.

**F. Comment**

One commentator stated admission to a special care unit should not be granted without a physician diagnosis of dementia and MMSE.

**Response**

Subsection (b)(1) requires that documentation for a special care unit for residents with Alzheimer's disease or dementia must include the resident's diagnosis of Alzheimer's disease or dementia and the need for the resident to be served in a special care unit. The requirement for a diagnosis mirrors the PCH regulations, which the Department is required to meet or exceed. New language has been added to this section creating special care units for those with INRBI. Subsection (b)(2) requires documentation for a special care unit for INRBI must include the resident's or potential resident's diagnosis of brain injury and need for residential services to be provided in a special care unit for INRBI.

**G. Comment**

One commentator noted subsection (d) should be removed and the term "geriatric assessment team" should be included under definitions.

**Response**

The language that was formerly in subsection (d) has been relocated to subsection (c)(1)(ii). The Department submits that because the term is used only in this section it is not necessary to place it in the definition section of the regulations.

#### **H. Comment**

One commentator noted these regulations as written would discourage them from offering a special care unit for residents with dementia due to the requirements being so onerous.

#### **Response**

It is at the discretion of a provider to elect to be licensed as an ALR offering special care units.

#### **I. Comment**

One commentator recommended removing the final sentence in subsection (a) as it is vague, too open to interpretation and would create unnecessary delays in admissions for those needing services. Six other commentators stated this section needs to be stronger and recommended the following language: "Admission of a resident to a special care unit should be recommended to the resident and the resident's family or designated person following completion of the medical evaluation, cognitive pre-admission screening, assessment and proposed support plan." They noted that prior to admission into a special care unit, other service options available to a resident should be considered. They noted the discussions with the resident and family or designated person should be documented in the resident's record. They continued, saying it is recommended that a resident who has objected or whose designated person has objected to the transfer to a special care unit not be transferred. Additionally, they recommended a spouse, significant other, friend or family member of a resident who does not have a primary diagnosis of Alzheimer's or other dementia may reside in the special care unit if desired by the resident or their designated person. Two other commentators stated the statement "Prior to admission into a special care unit, other service options that may be available to a resident shall be considered" requires further explanation. They noted it suggests some type of liability on the provider for actions of family members prior to moving the resident into the ALR.

#### **Response**

The Department has elected not to amend the language in subparagraphs (a)(1)(ii) and (a)(2)(iv) relating to other service options and submits that consideration of other service options provides enhanced consumer choice and decision-making. Concerning medical evaluations, the Department notes that subsection (b) requires that a resident or potential resident of a special care unit have a medical evaluation completed within 60 days prior to admission. Concerning screening, subsection (c) provides for preadmission screening for both Alzheimer's and dementia special care units and INRBI units. Regarding support plans, subsection (c) provides for development of support plans. Regarding involvement of designated persons, subparagraphs (a)(1)(i) and (a)(2)(iii) require that admission into a special care unit be done in consultation with the resident's family or designated person. As to documentation, subsection (d) requires that each resident record must have documentation that the resident, and when appropriate his designated person or

the resident's family, has agreed to admission or transfer to the special care unit. The Department also notes that subsection (g) allows for a spouse, friend or family member who does not have a primary diagnosis of Alzheimer's disease or dementia or brain injury to reside in the special care unit if desired by the resident or his designated person.

Regarding the issue of liability vis à vis exploration of other service options, as noted above, the Department has elected to retain this language and maintains that if there are other more appropriate service options available to the resident or potential resident, they should be explored.

**J. Comment**

Two commentators stated a resident's designated person should be involved in the admission decision and enter into the contract as a representative of the resident. Two other commentators stated the consultation with a family member or legal representative is a more effective and secure manner to make a decision concerning the admission of a resident to a special care unit.

**Response**

Subsection (a)(1)(i) requires consultation with the resident's family or designated person in the case of special care units for residents with Alzheimer's disease or dementia. Similarly, subsection (a)(2)(iii) requires such involvement, when appropriate, in the case of special care units for INRBI. As defined in § 2800.4 (relating to definitions), a resident's designated person may be the resident's legal representative.

**K. Comment**

One commentator noted subsection (c) is a repetitive and costly process as a physician should already be documenting a diagnosis of dementia on the medical evaluation as stated in § 2800.22 and § 2800.141.

**Response**

This provision is contained in the PCH regulations, which the Department is required to meet or exceed. The Department has elected not to change the language.

**L. Comment**

One commentator noted the terminology used in this section would allow individuals with cognitive disabilities other than dementia to be serviced within the dementia program. The commentator stated this be justified through documentation and regulations require individuals be served according to specific needs.

**Response**

Act 56 provides that special care designation is defined as "capable of providing cognitive support services to residents with severe cognitive impairment, including

*but not limited to, dementia or Alzheimer's disease...* (Emphasis added.) See 62 P.S. § 1001. In addition to special care units for people with dementia, based on recommendations by the Acquired Brain Injury Network of Pa, Inc., the Department has elected to also provide for special care units for INRBI as detailed in § 2800.231 through § 2800.239. The regulation does require appropriate documentation of the individual's cognitive impairment as recommended by the commentator as well as a support plan.

**M. Comment**

One commentator questioned whether persons with all stages of dementia are admitted to special care units and if so, what protections are instituted to keep them safe. The commentator stated language such as the "least restrictive manner" is of concern as some persons with dementia are at greater risk for wandering. The commentator noted these persons should be evaluated for history of wandering and ALRs institute tools to help protect them, such as wander guard bracelets.

**Response**

An individual's needs are assessed prior to admission to a special care unit to determine if this level of care is necessary. Other options are also to be considered. Section 2800.233 (relating to doors, locks and alarms) contains provisions to ensure the safety of residents.

**N. Comment**

One commentator noted further explanation is required with reference to the geriatric assessment team. The commentator questioned who is part of this team and when is this required.

**Response**

The language in subparagraph (c)(1)(ii) defines a geriatric assessment team as a group of multidisciplinary specialists in the care of adults who are older that conducts a multidimensional evaluation of a resident. Subparagraph (c)(1)(i) requires that the geriatric assessment team be involved in the preadmission screening that is to occur within 72 hours prior to admission to the special care unit on the Department's cognitive preadmission screening form.

**O. Comment**

One commentator stated families should be provided written information from the Commonwealth about state laws which govern the rights of the patient and families. The commentator suggested a detailed booklet be provided from each county giving the name and phone number of the ombudsman and should contain the procedure if there is an issue with the care given at an ALR. In addition, the commentator noted the family should sign a form stating they have received the information. The Department of Aging should go to senior centers, libraries and other locations to educate the senior population about their rights.

### **Response**

The Department submits that all regulations contained in the previous sections of this final-form rulemaking are incorporated by reference in §§ 2800.231 through 2800.239. This includes information that is to be provided to residents or their designated persons under § 2800.25 (relating to resident—residence contract), § 2800.30 (relating to informed consent process), § 2800.42 (relating to specific rights), § 2800.44(a) (relating to complaint procedures), which includes information about contacting the ombudsman, and Appendix A, which contains a list of resident rights. Disclosure of specific information is required in special care units under §§ 2800.231(i) and (j). Requirements related to the Department of Aging are outside the scope of this rulemaking.

### **P. Comment**

One commentator recommended safeguards be in place for elopement due to resident wandering. The commentator further recommended a dementia screening and Mini Mental State Examination (MMSE) be performed at admission and semi-annually. The commentator also suggested the Department require that the ALR have a plan for rescue in the event of a successful elopement.

### **Response**

Act 56 in 62 P.S. § 1057.3(d)(2), requires that ALRs identify measures to address residents with cognitive impairments who have tendencies to wander. Additionally, § 2800.239(8) (relating to application to Department) requires that an ALR in its application to the Department include its policies and procedures on resident elopement, which would include policies concerning rescue in the case of elopement. Furthermore, § 2800.16(a)(5) (reportable incidents and conditions) provides that an unexplained absence of a resident for 24 hours or more, or less time if a support plan so defines, or an absence of a resident from a special care unit is a reportable incident. A number of dementia and cognitive impairment-related staff training provisions are included in §§ 2800.64 (relating to administrator training and orientation), 2800.65 (relating to staff orientation staff person training and orientation, and 2800.69 (relating to additional dementia-specific training). The Department finds that these measures should allay the commentator's concerns. In regards to administration of a dementia screening and Mini Mental State Examination (MMSE), as stated above, subsection (b)(1) requires that documentation for a special care unit for residents with Alzheimer's disease or dementia must include the resident's diagnosis of Alzheimer's disease or dementia and the need for the resident to be served in a special care unit. The requirement for a diagnosis mirrors the PCH regulations, which the Department is required to meet or exceed.

### **S. Comment**

One commentator stated that the regulations do not clearly state the circumstances under which currently licensed PCHs that offer head injury rehabilitation must apply for licensure as an ALR. The commentator stated that it seems that the regulations would not apply to those residences that are not serving

aging people with degenerative conditions. The commentator suggested that the regulations use general terms and imply that people with cognitive disabilities other than dementia residing in the facility and receiving services are subject to the regulations. The commentator said that the regulations should not apply to facilities that do not conform to the type of program that could be more properly and effectively regulated under the PCH regulations. The commentator expressed concern that the regulations would allow many people with cognitive disabilities to be placed in programs that will not serve them and may in fact diminish their capacity.

#### **Response**

As stated above, the Department has construed Act 56 to allow special care units to care for individuals with severe cognitive impairments, including, but not limited to, Alzheimer's disease and dementia. In response to comments received from the Acquired Brain Injury Network of Pa, Inc, the Department has added a provision to the final-form regulations to allow for special care units for those with intense neurobehavioral rehabilitation needs (INRBI). It is not the intent of these regulations to displace current PCH residents who are safely being served there.

### **Section 2800.232 Environmental Protection**

- A. One commentator noted that while special arrangements are required for more than one resident in a room, two residents per room are permitted without any special arrangements in a facility with a special care designation. The commentator noted there is a risk in having two residents per room. The commentator stated those with dementia, Alzheimer's or brain injuries must be carefully evaluated for the risk to a roommate. The commentator noted that, generally, the rule should be single rooms unless there are special circumstances which are documented.

#### **Response**

The requirements for special care units incorporate by reference all the other requirements in Chapter 2800, including § 2800.101 (relating to resident living units), which requires that the rule is that a resident shall be given his own living unit, unless two residents voluntarily agree to share one living unit. Documentation of that voluntary sharing must be in the residence-resident contract and no one may be forced to share a living unit. The Department also submits that language in subsections (d) and (e) has been added to provide that the environment is appropriate to each resident's behavior and needs. Those needs are determined by a resident's assessments and support plans.

### **Section 2800.233 Doors, Locks and Alarms**

- A. Comment

One commentator noted there is no provision to prevent unsafe egress by those who maintain the cognitive ability to read, yet are not cognitively safe to be out of an area, which could occur by posting the directions.

**Response**

Resident assessments and support plans would identify those at risk of elopement and their cognitive and safety needs. See § 2800.234(b)(1) (relating to resident care). Section 2800.239(c)(8) (relating to application to Department) requires that facilities applying for ARL licensure must provide in their application their policy and procedures to be implemented for emergency egress and resident elopement.

**B. Comment**

One commentator recommended observing the least restrictive alternative principle in behavioral health, encouraging residents to interact with general resident population at all opportunities and not unduly restrict egress from the unit. The commentator noted it is unrealistic to expect residents with significant dementia to be capable of operating a keypad.

**Response**

The Department finds that the regulations maintain a sufficient balance between resident independence and the safety of other residents and staff. A resident's support plan will address the individual's social and interactive needs. Keypads are a standard mechanism used to deter wandering of individuals with Alzheimer's disease and dementia.

**C. Comment**

One commentator noted the physical plant needs to be carefully designed so Alzheimer's clients are not harmed. The commentator stated the clients should not be able to leave unless escorted. The commentator continued, saying the following conditions should be prevented: eliminate exit doors that open automatically, reduce loud buzzers that go off whenever anyone leaves or enters the unit, an Alzheimer's client should be prevented from access to the elevator when a guest is leaving, dishes, glasses and cups should be made out of non-breakable materials, and knives should not be given to Alzheimer's clients.

**Response**

Each resident's need will be determined through the assessment process and development of their support plans. In § 2800.232(d) (relating to environmental protection), language has been added to require that an ALR provide a full description of the measures implemented to enhance environmental awareness, minimize environmental stimulation and maximize independence of the residents in public and private spaces based on the needs of the individuals being served. The Department finds that this language provides the type of procedures needed to ensure the health and safety of residents with Alzheimer's disease.

**Section 2800.234**

## Resident Care

### A. Comment

One commentator noted the support plan does not address functional status/needs evaluation and treatment. The commentator also noted there is no mention of who participates in the review of the support plan.

### Response

The Department points to language that was added at the request of consumers to § 2800.231(a) (relating to admissions), which requires preadmission screening to be conducted within 72 hours prior to admission to a special care unit. Section 2800.231(a)(1)(ii) requires that a geriatric assessment team be involved in conducting a multidimensional evaluation for special care units for residents with Alzheimer's disease or dementia and that the team assist in the development of resident support plans. Section 2800.231(c)(2)(ii) requires that a physician, neuropsychologist or cognitive, physical, behavioral (CPB) specialist with brain injury experience be involved in the completion of a CPB preadmission screening for special care units for INRBI and that they assist in developing resident support plans. Additional assessments are required quarterly for residents in special care units for residents with Alzheimer's disease or dementia and semi-annually for residents in special care units for INRBI.

These provisions are in addition to other sections of the regulations related to assessments and support plans, which are incorporated by reference into provisions for special care units. Section 2800.231(a) (relating to admission).

## Section 2800.235 Discharge

### A. Comment

Seven commentators noted they would delete this section, as the discharge section of § 2800.228 should also apply here. They stated this section would give consumers with cognitive impairments fewer protections.

### Response

Subsection (a) mirrors the PCH regulations, which the Department is required to meet or exceed. Additionally, the provisions contained in § 2800.228 (relating to transfer and discharge) are incorporated by reference and also apply to residents in special care units. See § 2800.231(a) (relating to admission). The provisions of § 2800.235 are in addition to the provisions in § 2800.228 (relating to transfer and discharge).

### B. Comment

One commentator noted that this section does not address how the ALR would handle involuntary discharge.

**Response**

In § 2800.4 (relating to definitions) the term "discharge" means termination of an individual's residency in an ALR. It is used to mean both voluntary and involuntary discharge. As noted above, the provisions contained in § 2800.228 (relating to transfer and discharge) are incorporated by reference and also apply to residents in special care units. The provisions of § 2800.235 are in addition to those general provisions. As an enhanced consumer protection, § 2800.228(b) requires that 30 day advance written notice be given to the resident, the resident's family or designated person and the referral agent citing the reasons for the transfer or discharge.

**C. Comment**

One commentator suggested a clarifying statement be added: "In an emergency or based on clinical needs, the discharge or transfer can be done based on consent of the resident and the resident's designated person."

**Response**

Nothing in this final-form rulemaking forces a resident to stay in an ALR.

**Section 2800.236  
Training**

**A. Comment**

One commentator noted the proposed regulations do not require special care units for residents with dementia to have additional staffing or additional training for staff.

**Response**

Section 2800.238 (relating to staffing) defines all residents in special care units as having mobility needs. Section 2800.57 (relating to direct care staffing) provides for 2 hours a day minimum staffing for residents with mobility needs. This provision mirrors the PCH regulations, which the Department is required to meet or exceed.

Regarding staff training in care of residents with dementia, § 2800.69 (relating to additional dementia-specific training) requires that administrative staff, direct care staff persons, ancillary staff persons, substitute personnel and volunteers receive at least 4 hours of dementia-specific training within 30 days of hire and at least 2 hours of dementia-specific training annually thereafter in addition to the training requirements of this Chapter. Similarly, § 2800.236(a) adds additional training requirements for direct care staff persons working in special care units for individuals with Alzheimer's disease and dementia. This is in addition to the dementia-specific annual training for direct care staff persons in § 2800.65(i)(3) (relating to staff orientation and direct care staff person training and orientation).

**B. Comment**

One commentator stated this section should be deleted since according to a requirement in § 2800.65, trainings are to be delivered any time a new population is served.

**Response**

The Department submits that the commentator misconstrued the requirements pertaining to annual training in § 2800.65(i)(6) (relating to staff orientation and direct care staff person training and orientation). The training in that section is required annually of direct care staff persons, ancillary staff persons and substitute personnel on new population groups served at the ALR who were not previously served, if applicable. By contrast, § 2800.236(a) (relating to training) requires that each direct care staff person working in a special care unit for residents with Alzheimer's disease or dementia shall have 8 hours of initial training related to dementia care and services, in addition to the 16 hours of annual training.

**C. Comment**

One commentator stated well-trained, compassionate staff is the single most important factor that determines the quality of the Alzheimer client's experience. The commentator noted ALRs have as their main goal the constant striving to provide the highest quality of care. The commentator continued, noting legislation should be in place to constantly monitor Alzheimer's units so the desire for the highest profit does not replace the goal of providing quality care. The commentator stated the background of staff should be carefully investigated. The commentator noted staff training should be provided constantly and visitors should be welcomed and encouraged.

**Response**

The Department appreciates these comments. It is the intention of the Department, through these regulations, to provide quality care, services and supports to all individuals residing in ALRs, including those with Alzheimer's disease.

**Section 2800.237  
Program**

**A. Comment**

One commentator stated self-care activities should be offered more than once a week in a special care unit. The commentator noted special care units should emphasize the need to require self-care at least twice per week.

**Response**

The Department has elected to retain the language in subsection (a)(2), which provides that self-care activities be offered at least weekly to residents in special care units for residents with Alzheimer's disease or dementia. This provision mirrors that in the PCH regulations, which the Department is required to meet or exceed. For those in special care units for INRBI, as specified in subsection (c),

the individual's rehabilitation and support plans will determine the types and frequency of individual and group activities.

**B. Comment**

One commentator noted activities should include those that are meaningful to each resident and acknowledge each resident's personal or professional interests.

**Response**

The purpose of these regulations, as stated in § 2800.1(b) (relating to purpose) is to provide an environment in which ALR residents can maintain maximum independence, exercise decision-making and personal choice. Aging in place, in § 2800.4 (relating to definitions), is defined as receiving care and services at a licensed ALR to accommodate changing needs and preferences in order to remain in the ALR. The Department maintains that these provisions, combined with §§ 2800.237(b) and (c) respect the individual's age and cognitive abilities and support the retention of those abilities.

**C. Comment**

One commentator stated that the description of the program does not reflect many aspects of cognitive therapy rehabilitation services. The commentator noted that the regulations are not appropriate to those existing programs operating under PCH licensure that offer head injury services to people with cognitive disabilities who are progressing and improving cognitive function for living in the community with or without supports.

**Response**

The Department has revised subsection (c) to provide that the types and frequency of activities for individuals with brain injury are to be based on a resident's support plan rather than listing activities. The Department submits that the regulation provides another choice to consumers in the array of long-term care options and is not intended to disrupt care that is safely being provided in a PCH.

**Section 2800.238  
Staffing**

**A. Comment**

Seven commentators recommended mobility/immobility language be removed. They noted the Commonwealth continues to label consumers as "mobile" or "immobile".

**Response**

The Department has based the use of the term "resident with mobility needs" on the term "immobile person" used in the Public Welfare Code at 62 P.S. § 1001. Furthermore, it has adopted the same definitions of the term "mobile resident" and "resident with mobility needs" as are used in the PCH regulations, which the

Department is required to meet or exceed. Additionally, the term immobile person is used in 62 P.S. § 1057.3(b).

**B. Comment**

One commentator recommended that special care units for residents with dementia should have additional staff that is specifically trained in how to care for individuals with dementia. The commentator recommended prohibiting volunteers from providing direct care services.

**Response**

As noted above, the Department added § 2800.69 (relating to additional dementia-specific training), which requires that administrative staff, direct care staff persons, ancillary staff persons, substitute personnel and volunteers receive at least 4 hours of dementia-specific training within 30 days of hire and at least 2 hours of dementia-specific training annually thereafter in addition to the training requirements of this Chapter. Similarly, the Department added the language in § 2800.236(a), which provides for additional training requirements for direct care staff persons working in special care units for individuals with Alzheimer's disease and dementia. This is in addition to the dementia-specific annual training for direct care staff persons in § 2800.65(i)(3) (relating to staff orientation and direct care staff person training and orientation). Regarding volunteers, § 2800.54 (b) (relating to qualifications for direct care staff persons) provides that a volunteer who performs or provides ADLs is required to meet the direct staff person qualifications and training requirements specified in this Chapter. This provision mirrors the PCH regulations, which the Department is required to meet or exceed. See § 2600.54(c).

**Section 2800.239**  
**Application to Department**

**A. Comment**

Six commentators recommended deleting subsection (c)(16) and replacing it with "A description of the dementia care and programming the ALR provides, pursuant to 2800.237 and otherwise."

**Response**

The Department finds that it is not necessary to add the recommended language. Section 2800.237(a) (relating to program) already lays out specific programs that are to be offered in special care units for individuals with Alzheimer's disease and dementia. The language in subsection (c)(16) mirrors the language in the PCH regulations, which the Department must meet or exceed. See §2600.239(c)(16). Therefore, the Department declines to delete it.

**Section 2800.251  
Resident Records**

**A. Comment**

Three commentators recommended adding language for written notification and specifying timeframes for compliance of request (such as "within 48 hours of receipt of written request"). Another commentator recommended records be made available within 10 business days. Another requested some clarification on the timelines needed for ALRs to comply. Six commentators also recommended that resident records be made available to residents and family members following transfer, relocation or death of a resident.

**Response**

The Department did not make changes to this provision and maintains that "during working business hours" mirrors the language of the PCH regulations, which the Department is required to meet or exceed. Additionally, subsection (e) requires that resident records be made available upon request to the resident and the resident's designated person. The Department does not find it necessary to make further changes in this area.

**B. Comment**

One commentator stated that records should be made available to the agencies and representatives named in § 2800.5, which include representatives of the Area Agency on Aging.

**Response**

Section 2800.5(a) (relating to access) clearly provides *immediate* access to resident records to a number of individuals, including representatives of the area agency on aging. Since § 2800.5(a) provides such access, the Department finds it unnecessary to amend the regulations further on this issue.

**C. Comment**

One commentator recommended the essentials of choice (advance directives and designated powers of attorney for health care and finance) be placed at the front of the medical chart in plastic sleeves, easily sent out to hospitals. All staff should be trained on their content/importance.

**Response**

Section 2800.143(b) (relating to emergency medical plan) addresses the issue of what information must be available related to a resident at all times for each resident and which must accompany the resident when the resident needs emergency medical attention, including a power of attorney for health care or health care proxy, if applicable.

**D. Comment**

One commentator recommended the deletion of the requirement that records go with a resident when they see a consultant or go to the hospital. The commentator recommended a suggested list of items would be better.

**Response**

Section 2800.251 does not require that a resident's record accompany him when he sees a consultant or goes to the hospital. Instead, § 2800.143(b) (relating to emergency medical plan) contains a requirement that certain information accompany the resident when the resident needs *emergency* medical attention. (Emphasis added.)

**Section 2800.252  
Content of Resident Records**

**A. Comment**

Six commentators stated the proposed regulations do not identify key items that should be retained in the resident's record to track needs and progress such as: monthly weight checks, medication administration, unusual incidents involving the resident and monitoring of restraints. They recommended race, height and weight at time of admission should be part of the record. They recommended any language, speech, hearing and/or vision need that requires accommodation and/or awareness of during oral and/or written communication (such as needing an interpreter for a particular language or American Sign Language) be included in the record.

**Response**

Paragraph (2) requires that race, height, and weight at time of admission be part of resident records. Paragraph (4) has been amended to include a requirement that a language, speech, hearing or vision need which requires accommodation or awareness of during oral or written communication be part of resident records. Section 2800.187(a) (relating to medication errors) specifically requires that medication records be kept by each ALR. ALRs are required to keep copies of reportable incidents or conditions under § 2800.16(f) (relating to reportable incidents and conditions). Additionally, mechanical restraints under § 2800.202(5) (relating to prohibitions) are prohibited under this final-form rulemaking. An ALR cannot keep a record of something that is prohibited. The Department finds that the issue of monthly weight checks would depend on the individual resident's needs as outlined in his assessment and support plan.

**B. Comment**

One commentator noted there is no mention or discussion of advanced directives, living wills or durable powers of attorney for medical or financial decisions.

**Response**

While there is no specific mention of these documents in § 2800.252, § 2800.143 (b)(9) and (b)(11) (relating to emergency medical plan) require that the power of attorney for health care or health care proxy, if applicable, as well as instructions regarding advance directives, be available at all times for each resident and accompany the resident when the resident needs emergency medical attention.

**Section 2800.253  
Record Retention and Disposal****A. Comment**

Six commentators recommended that, in addition to the resident's discharge, the resident's entire record should be maintained for a minimum of 3 years following the resident's death.

**Response**

The Department agrees and notes that at the request of commentators this change has been incorporated into the regulations in subsection (a).

**Section 2800.261  
Classification of Violations****A. Comment**

Six commentators recommended critical steps be taken to improve the provisions on plans of correction and the Department's expectations. They recommended the following language for (a)(1): Class I violations "have resulted in or" have a substantial probability of resulting in death or serious mental or physical harm to a resident.

**Response**

Based on comments received, the Department has amended the language in subsection (a)(1) as requested.

**B. Comment**

One commentator recommended a defined, written appeal process be made available to providers if they disagree with a violation.

**Response**

A citation for a regulatory violation, without a penalty or licensure action, is not an appealable action. Only penalties and licensure actions may be appealed since they are adverse actions. See §§ 2800.12 and 2800.263 (relating to appeals; appeals of penalty).

**C. Comment**

One commentator noted no steps were taken to improve enforcement provisions. Another commentator noted no penalty is available for Class III violations, which are defined as "minor violations, which have an adverse effect upon the health, safety or well-being of a resident." The commentator recommended the amount of penalties for all classes be increased and penalties for Class III violations authorized. The commentator continued, noting the Department should impose larger penalties for deficiencies that are not corrected or repeated.

**Response**

The proposed regulations regarding Class III penalties mirror the existing PCH regulations, which the Department is required to meet or exceed. The Department points out, however, that although Class III violations do not result in an immediate penalty, a fine is triggered if an ALR fails to correct the violation. The Department further notes that with the last revision of the PCH regulations in 2005, the Department received comments requesting stronger enforcement provisions and has implemented many of those suggestions. For example, § 2600.269 (relating to ban on admissions) was added because a licensee that cannot care for its current residents in compliance with the regulations should not be allowed to take new residents and expose them to the risks resulting from the regulatory violations. This provision is mirrored in § 2800.269 of this Chapter.

**Section 2800.262  
Penalties and Corrective Action**

**A. Comment**

Six commentators recommended the following language for this provision: (a) upon finding violations of this Chapter or other applicable laws, the Department will issue a notice of violations to the ALR. (b) The ALR shall submit a written plan of correction indicating how it will correct the violation, how it will address the cause of the violation, and how it will prevent recurrence of the violation. (c) The Department will promptly determine whether the plan of correction will bring about meaningful compliance and approve or deny the plan accordingly. (e) Penalties will be assessed on a daily basis from the date on which the citation was issued until the date the ALR proves that the violation is corrected, except in the case of Class II and Class III violations. In addition, they required Class II violations will be cited for failure to comply with a plan of correction or for false documentation of compliance with a plan of correction.

**Response**

The Department finds that provisions of this section, which are consistent with the PCH regulations, are sufficient in that they clearly provide a gradation of penalties based on the severity of the offense. These penalties range from monetary fines to ban on admissions to revocation of license.

**B. Comment**

One commentator stated the penalty amounts specified in the regulation are nominal in nature and do not provide adequate consequence for the most serious of violations. The commentator noted it is recognized, however, that a ban on admissions is a powerful incentive for correction.

**Response**

The penalty amounts for listed violations are legislatively determined penalties as set forth in 62 P.S. § 1086. The Department, therefore, has no authority to increase these penalties.

**C. Comment**

One commentator recommended requiring the Department to establish a protocol for choosing which remedies to impose in particular situations. The commentator stated enforcement is more likely to occur and is more likely to be effective and consistent when the Department uses an enforcement protocol.

**Response**

62 P.S. § 1086 (relating to penalties) prescribes the penalty amount per day for the classification of violation. Further, the categories for the classification of violations are determined at 62 P.S. § 1085 (relating to classification of violations). Currently, the Department uses a "totality of circumstance" basis, not a "per se" basis to classify violations for PCHs. That is, the circumstances for each single violation are assessed in determining the appropriate classification and amount of the fine, rather than pre-classifying each regulation and each possible circumstance of the violation.

**Section 2800.266  
Revocation or Nonrenewal of Licenses**

**A. Comment**

One commentator noted the enforcement scheme is too limited and enforcement is imposed essentially for failure to correct deficiencies, not for the existence of deficiencies. The commentator recommended the types of available remedies be expanded to include monitors, directed plans of correction, temporary management and receivership.

**Response**

The Department submits that the provisions of this section mirror the PCH regulations, which the Department is required to meet or exceed.

**B. Comment**

One commentator recommended the regulations be amended to include provisions which address the issuance of a provisional license. The commentator suggested amending the text to provide if an ALR is in substantial compliance, then the ALR

shall be entitled to receive a provisional license. The commentator recommended the following language: "If the Department elects to initiate an enforcement action, then if the ALR is in substantial compliance with the applicable statutes, ordinances and this Chapter and have taken appropriate steps to correct the violation(s), the Department may not revoke or refuse to renew the license of an ALR, but rather shall issue the ALR a provisional license for a specified period of not more than six months which may be renewed three times. Upon the ALR achieving full compliance, the Department shall issue a regular license immediately." The commentator noted this language clarifies the grounds upon which a provisional license may be issued.

#### **Response**

The Department did not make this change. Section 2800.266 mirrors the PCH regulation at § 2600.266 (relating to revocation or nonrenewal of licenses), which the Department is required to meet or exceed under Act 56. Further, state statute at 62 P.S. § 1008 (relating to provisional license) already addresses the circumstances of when the Department can issue a provisional license.

### **Section 2800.268 Notice of Violations**

#### **A. Comment**

One commentator stated the timeframe for providing written notification of violation to the responsible party (48 hours) is unrealistic.

#### **Response**

For Class I violations, subsection (a) provides that the resident and the resident's designated person must be notified within 24 hours. This provision mirrors the PCH regulations, which the Department must meet or exceed.

#### **B. Comment**

One commentator noted the notice of violation is one of the most demoralizing and intimidating sections of the proposed regulations. The commentator stated the impact automatically finds the ALR guilty before it has a chance to appeal the Department surveyor's opinion. The commentator continued, saying this is a form of abuse to the elderly residents because they are now concerned about a finding that may not be appropriate and may cause additional stress to the staff.

#### **Response**

This provision mirrors the PCH regulations, which the Department is required to meet or exceed.

#### **C. Comment**

One commentator recommended rewriting the section to make it a collaborative effort on behalf of the Departmental and staff to correct the deficiency, help the ALR develop (or revise) policies and assist in recommendation of training that, in

combination, will heighten the level of care and services to the residents. The commentator noted this would be a win-win situation rather than the facility vs. the Department with the resident in the middle. The commentator recommended informing the residents of the findings and solutions in a way that they are well informed.

**Response**

The Department submits that, as part of its enforcement role, it will provide technical assistance to facilities as necessary and appropriate to the extent that staffing is available. However, ultimate responsibility for ensuring compliance with the regulations resides with the ALR.

**Section 2800.269  
Ban on Admissions**

**R. Comment**

One commentator stated the Department must ban admissions under certain circumstances and the enforcement scheme is too limited.

**Response**

This provision mirrors the PCH regulation, which contains a ban on admissions.

**S. Comment**

The commentator stated the wording of this section is confusing. "...has maintained regulatory compliance for a period of time sufficient to permit a conclusion that the compliance will be maintained for a prolonged period" does not make sense. The commentator questioned how a "prolonged period" is defined. The commentator recommended the Department be held to a time standard for the return deficiency visit.

**Response**

The Department maintains that there cannot be a rigid and inflexible approach in determining at what point an ALR is going to maintain compliance. As a result, the Department declines to establish a definition of "prolonged period" and instead notes the usual and customary meaning of the term, which according to the tenth edition of the Merriam Webster's Collegiate Dictionary is a "continued" or "extended portion of time."

Shawn Barndt  
120 W 5th Street  
Boyertown, PA 19512

Barbara Dively  
2275 Glenview Drive  
Lansdale, Pennsylvania 19446-6082

E. Jill Hirt  
7727 Carlton Road  
Coopersburg, Pennsylvania 18036

Clifford Rieders  
161 West Third Street  
Williamsport, PA 17703-0215

Dana Rider  
4825 Matts Drive  
Bethlehem, PA 18017

Linda Harding  
364 Little Walker Road  
Shohola, Pa 18458

Lisa Schultz  
227 N Ruch St  
Coplay, PA 18037

Tonya Stephens  
421 N. 31st Street  
Allentown, PA 18104

Tim Johnson  
2075 Scotland Avenue  
Chambersburg, PA 17201

Kevin Williams  
1220 West Street Road  
Warminster, PA 18974

Pattiann Rohrbach  
405 Green Pond Road  
Bethlehem, PA 18020

Michael Miller  
334 State Street  
Towanda, PA 18848

Daniel Merrick  
858 Route 446  
Smethport, PA 16749-5536

Jane Taylor  
Willowbank Office Building  
Bellefonte, PA 16823-1488

Monica Trilli  
1718 Spring Creek Rd  
Macungie, PA 18062

Robert Bickerton  
5130 Tuscarawas Road  
Beaver, PA 15009

Eva Bering  
1001 East Oregon Rd  
Lititz, PA 17543-9206

Danielle Kilchenstein  
418 Parkwood Road  
Pittsburgh, PA 15210

Tracey Flynn  
1430 Dekalb Street  
Norristown, PA 19404

Lorraine Lardani  
801 Ridge Pike  
Lafayette Hill, Pa 19444-1799

Lisa Fichera  
1925 Turner Street  
Allentown, PA 18104

Sandra Massetti  
1925 Turner Street  
Allentown, PA 18104

Kenneth Daniel  
1925 Turner Street  
Allentown, PA 18104-5551

Joan Matura  
1925 Turner Street  
Allentown, PA 18104-5551

Rob Khanuja  
1 Reading Drive  
Wernersville, PA 19565

Cynthia Bonney  
1925 Turner Street  
Allentown, PA 18104-5551

Joseph Carr  
627 N. Leh St  
Allentown, PA 18104

Scott Stevenson  
1925 Turner Street  
Allentown, PA 18104-5551

Deborah Yowler  
2011 Scotland Avenue  
Chambersburg, PA 17201

Beth Byler  
1 Heidelberg Drive  
Wernersville, PA 19565

William Hacker  
1605 N Cedar Crest Blvd  
Allentown, PA 18104-2351

Robert Rundle  
1050 Pennsylvania Avenue  
York, Pa 17404

Karen Russel  
809 Deep Lake Drive  
Cranberry Twp, Pa 16066

Joseph Vincent  
1210 S. Cedar Crest Blvd.  
Suite 2300  
Allentown, PA 18103-6252

Justine Hall  
1200 Tel Hai Circle  
Honey Brook, PA 19344

Alvin Allison, Jr.  
489 Castle Shannon Boulevard  
Pittsburgh, PA 15234-1482

Debra Carbaugh  
55 S Second St.  
Chambersburg, PA 17201

Linda Sell  
Garvey Manor  
Hollidaysburg, PA 16648

Star High  
1 Heidelberg Drive  
Wernersville, PA 19565

Kendra Leffler  
1 Heidelberg Drive  
Wernersville, PA 19565

Robin Shappell  
1 Heidelberg Drive  
Wernersville, PA 19565

Charlene Kleman  
1 Heidelberg Drive  
Wernersville, PA 19565

David Heilman  
P.O. Box 455  
Southampton, PA 18966

Karen Zbruzzese  
1200 Spring Street  
Bethlehem, PA 18018

Daniel Snyder  
200 Bellann Court  
Annville, PA 17003-9012

Kathleen Krick  
2425 Lower State Road  
Doylestown, PA 18901

Mary Fromknecht  
4855 West Ridge Road  
Erie, PA 16506

Erin Garcia  
1 Heidelberg Drive  
Wernersville, Pennsylvania 19565

Nancy Luke  
360 Westminster Drive  
Huntingdon, Pennsylvania 16652

Renea Kreamer  
210 Big Spring Road  
Newville, Pennsylvania 17241-9486

Richard Leonard  
535 McFarland Road  
Latrobe, Pennsylvania 15650

Zainab Jama  
2 North Second Street  
Suite 100  
Harrisburg, Pennsylvania 17101

Alissa Halperin  
437 Chestnut Street  
Suite 900  
Philadelphia, Pennsylvania 19106

Kristen Santangelo  
101 East State Street  
Kennett Square, Pennsylvania 19348

Daniel Krieger  
100 Dogwood Drive  
Phillipsburg, Pennsylvania 16866

Diane Burfeindt  
One Trinity Drive East  
Dillsburg, Pennsylvania 17019

Jean LaFuria  
5416 East Lake Road  
Erie, Pennsylvania 16511

Anita Martin  
200 Luther Lane  
Columbia, Pennsylvania 17512

Patty Curtin  
5416 East Lake Road  
Erie, Pennsylvania 16511

Rodney Williams  
642 North Broad Street  
Philadelphia, Pennsylvania 19130

Paul Cercone  
1022 Northampton Street  
Easton, Pennsylvania 18042

Paul Taylor  
7 E. Locust Street  
Oxford, Pennsylvania 19363

Ray Landis  
30 North 3rd Street  
Harrisburg, Pennsylvania 17101

Joseph Mraz  
3026 Mt. Hope Home Road  
Manheim, Pennsylvania 17545

Sherry Andreo  
100 Bristol Lane  
Irwin, Pennsylvania 15642

A. Terri Weitzel  
300 St. Mark Avenue  
Lititz, Pennsylvania 17543

Winona Kissinger  
10 Tranquility Lane  
Reading, Pennsylvania 19607

Antoinette Manley  
Box 370  
Dallas, Pennsylvania 18612

Kathy Forrest  
30 E. Oakland Avenue  
Doylestown, Pennsylvania 18901

Deborah Frazier  
606 W. Upsal Street  
Philadelphia, Pennsylvania 19119

Dana Kunzman  
1 Smithfield Street  
Pittsburgh, Pennsylvania 15222

Michele Brague  
810 Louisa Street  
Williamsport, Pennsylvania 17701

C. Dale McClain  
100 South Street  
Harrisburg, Pennsylvania 17108

Thomas Prickett  
500 Wittenberg Way  
Mars, Pennsylvania 16046

Brian Hortert  
134 Marwood Road  
Cabot, Pennsylvania 16023

Zenta Benner  
P.O. Box 498  
Frederick, Pennsylvania 19435

Clare Schiefer  
223 North Street  
Harrisburg, Pennsylvania 17105

Brinda Penyak  
P.O. Box 60769  
Harrisburg, Pennsylvania 17106

Patricia Johnston  
745 R. S. 5th Street  
Philadelphia, Pennsylvania 19147

Curt Evans  
600 East Main Street  
Lititz, Pennsylvania 17543

Carol Cirka  
308 Bomberger Hall  
Collegetown, Pennsylvania 19426

Jennifer Strayer  
2040 Linglestown Road  
Harrisburg, Pennsylvania 17110

Susan Collins  
1215 Hulton Road  
Oakmont, Pennsylvania 15139-1196

Richard Stefanacci  
600 South 43rd Street  
Philadelphia, PA 19104-4495

Maureen Benson  
1595 Gregory Drive  
Warrington, Pennsylvania 18976

Philip DeBaun  
P.O. Box 100  
Kennett Square, Pennsylvania 19348

Cecile Shocket  
1750 Quarry Road  
Yardley, Pennsylvania 19067

William Davis, Jr.  
One Masonic Drive  
Elizabethtown, PA 17022-2199

Sally Jo Snyder  
650 Smithfield Street  
Pittsburgh, Pennsylvania 15222

Thomas Conlin Jr.  
875 Montour Blvd.  
Danville, Pennsylvania 17821

Carol Berster  
800 Maple Avenue  
Harleysville, Pennsylvania 19438

Dana Breslin  
3305 Edgemont Avenue  
Brookhaven, PA 19015-2801

Elizabeth Jensen  
One Kirkland Village Circle  
Bethlehem, PA 18017-3846

Elaine Swyer  
9 South Bryn Mawr Avenue  
Bryn Mawr, Pennsylvania 19010

Lesley Carson, M.D.  
3615 Chestnut Street  
Philadelphia, PA 19104-2676

Michael Hays  
500 Route 909  
Verona, Pennsylvania 15147-3863

Harold Yoder  
810 Louisa Street  
Williamsport, Pennsylvania 17701

Jay Laff  
31 Fairfax Lane  
Annville, Pennsylvania 17003

Robert Kocent  
1000 Masonic Drive  
Sewickley, PA 15143-2359

Adrienne Staudenmayer  
801 Ridge Pike  
Lafayette Hill, PA 19444-1799

Nancy Murray  
711 Bingham Street  
Pittsburgh, PA 15203-1007

Julia Regan  
1616 Huntingdon Pike  
Meadowbrook, Pennsylvania 19046

Joy Bodnar, Ph.D.  
500 East Marylyn Avenue  
State College, Pennsylvania 16801

Robin Farber, NHA  
8580 Verree Road  
Philadelphia, Pennsylvania 19111

Laurence Lane  
101 East State Street  
Kennett Square, Pennsylvania 19348

Denise Bower  
1900 Ravine Road  
Williamsport, Pennsylvania 17701

Joseph Corey  
50 West Tioga Street  
Tunkhannock, Pennsylvania 18657

Robert Goyette  
9510 Ormsby Station Toad  
Louisville, Kentucky 40223

Carson Ritchie  
801 North Hanover Street  
Carlisle, Pennsylvania 17013

Laura Roy  
401 South Main Street  
Zelienople, Pennsylvania 16063

Sister Phyllis McCracken  
607 East 26th Street  
Erie, Pennsylvania 16504

Robin Knight  
133 Laurelbrooke Drive  
Brookville, Pennsylvania 15825

Audry Urban  
607 East 26th Street  
Erie, Pennsylvania 16504

Eleonore Shay  
945 Duke Street  
Lebanon, Pennsylvania 17042

James Pieffer  
1215 Hulton Road  
Oakmont, Pennsylvania 15139-1196

Shirley Walker  
1007 North Front Street  
Harrisburg, Pennsylvania 17102

Stuart Shapiro  
315 North Second Street  
Harrisburg, Pennsylvania 17101

Dan Lytle  
3952 Columbia Avenue  
Columbia, Pennsylvania 17512

Gene Bianco  
2400 Park Drive  
Harrisburg, PA 17110-9357

Thomas Lawrence  
777 East Park Drive  
Harrisburg, PA 17105-8820

W. Russell McDaid  
1100 Bent Creek Boulevard  
Mechanicsburg, Pennsylvania 17050

Lynn Warner  
890 Grantley Road  
York, Pennsylvania 17403

Leslie Grenfell  
305 Chamber Plaza  
Charleroi, Pennsylvania 15022-1607

David Parkhill  
3001 Lititz Pike  
Lancaster, Pennsylvania 17606-5093

Richard Grimes  
1650 King Street  
Alexandria, Virginia 22314-2747

Robert Meek  
1315 Walnut Street  
Suite 400  
Philadelphia, Pennsylvania 19107

Marielle Hazen  
2000 Linglestown Road  
Harrisburg, Pennsylvania 17110

David Leader  
830 Cherry Drive  
Hershey, Pennsylvania 17033

Gene Bishop  
3400 Spruce Street  
Philadelphia, Pennsylvania 19104

Eric Carlson  
3434 Wilshire Boulevard  
Los Angeles, CA 90010-1938

Jean Bryan  
300 Strode Avenue  
Coatesville, Pennsylvania 19320

Daniel Haimowitz  
1 Gardenia Road  
Levittown, Pennsylvania 19057

Crystal Lowe  
525 South 29th Street  
Harrisburg, Pennsylvania 17104

Tim Coughlin  
1625 Lowell Avenue  
Erie, Pennsylvania 16505

Terri Middleton  
505 Antenor Avenue  
Pittsburgh, Pennsylvania 15210

Bruce Kinoshian MD  
3400 Spruce Street  
Philadelphia, Pennsylvania 19104

Cyndee Wallgren  
207 Laurel Lane  
Broomall, Pennsylvania 19008

Gail Inderwies  
8765 Stenton Avenue  
Wyndmoor, Pennsylvania 19038

Judith Anderson  
P.O. Box 17497  
Pittsburgh, Pennsylvania 15235

Kimber Latsha  
1700 Bent Creek Boulevard  
Mechanicsburg, Pennsylvania 17050

Toby Edelman  
1025 Connecticut Avenue NW  
Washington, DC 20036

Brian Gralnick  
1735 Market Street  
Philadelphia, Pennsylvania 19103

Pamela Walz  
3638 North Broad Street  
Philadelphia, Pennsylvania 19140

Daniel Grant  
200 Lothrop Street  
Pittsburgh, PA 15213-2582

Stephanie Pastula  
12 South 23rd Street  
Philadelphia, Pennsylvania 19103

Teresa Long  
1200 Tel Hai Circle  
Honey Brook, Pennsylvania 19344

Lynette Killen  
99 Barclay Street  
Newtown, Pennsylvania 18940

Vicky Wittuck  
5416 East Lake Road  
Erie, Pennsylvania 16511-1496

Diane Gergal  
300 W. Lemon Street  
Lititz, Pennsylvania 17543

John Bartko  
143 Cherry Blossom Lane  
Newville, Pennsylvania 17241

Barbara Keyser  
701 Main Street  
Peckville, Pennsylvania 18452-2305

Cathy Berkheiser  
803 North Wahneta Street  
Allentown, PA 18109-2491

Allison Guthertz  
7900 Westpark Drive  
McLean, Virginia 22102

J. Carol Hanson  
700 North Franklin Street  
West Chester, PA 19380-2334

Gary Johnson  
100 Mt. Allen Drive  
Mechanicsburg, PA 17055-6100

Sarah Hughes  
14 Ridge Lane  
Newville, Pennsylvania 17241

John Schwab  
400 North Walnut Street  
West Chester, PA 19380-2487

Diane Menio  
100 South Broad Street  
Philadelphia, PA 19110-1088

Wilmarie Gonzalez  
555 Walnut Street  
Harrisburg, PA 17101-1919

Cynthia Trimmer  
145 Lafayette Manor Road  
Uniontown, Pennsylvania 15401

Vicki Hoak  
20 Erford Road  
Lemoyne, Pennsylvania 17043

Norma Malek  
1155 Indian Springs Road  
Indiana, Pennsylvania 15701

Robert Warren  
25 W. Fornance Street  
Norristown, Pennsylvania 19401

Anne Maher  
850 Norristown Road  
Warminster, Pennsylvania 18974

Lee Ann Prince  
519 Penrose Lane  
Warminster, Pennsylvania 18974

Barbara DeWilde  
2249 Valley Hill Road  
Malvern, Pennsylvania 19355

Edward Corbeil  
336 South State Street  
Clarks Summit, Pennsylvania 18411

Rebecca Weber  
433 South Kinzer Avenue  
New Holland, Pennsylvania 17557

Denise Hoak  
433 South Kinzer Avenue  
New Holland, Pennsylvania 17557

Teresa Nellans  
854 Dorseyville Road  
Pittsburgh, Pennsylvania 15238

Nancy Grundahl  
231 Conway Avenue  
Narberth, Pennsylvania 19072

Mary Knapp  
1120 Meetinghouse Road  
Gwynedd, Pennsylvania 19436

Donna Eaves  
601 Westtown Road  
West Chester, Pennsylvania 19380

Natalie Tssario  
5416 East Lake Road  
Erie, Pennsylvania 16511

Brad Roae  
PO Box 202006  
Harrisburg, Pennsylvania 17120

Mike Folmer  
Senate Box 203048  
Harrisburg, Pennsylvania 17120

Catherine Harper  
PO Box 202061  
Harrisburg, Pennsylvania 17120

Melissa Golden  
1821 Shawan Lane  
York, Pennsylvania 17406

Sandra Raudenbush  
9896 Bustleton Avenue  
Philadelphia, Pennsylvania 19115

Linda McCurto  
9896 Bustleton Avenue  
Philadelphia, Pennsylvania 19115

Bridget McGinn  
9896 Bustleton Avenue  
Philadelphia, Pennsylvania 19115

Elmer Heiland  
1001 S. Valley Forge Road  
Lansdale, Pennsylvania 19446

Barbara McIlvane Smith  
25B East Wing  
Harrisburg, Pennsylvania 17120

Michael Fleck  
159-A East Wing  
Harrisburg, Pennsylvania 17120

Chris Ross  
B-16 Main Capitol Building  
Harrisburg, Pennsylvania 17120

Phyllis Mundy  
P.O. Box 202120  
Harrisburg, Pennsylvania 17120

RoseMarie Swanger  
P.O. Box 202102  
Harrisburg, Pennsylvania 17120

Tim Hennessey  
209 Ryan Office Building  
Harrisburg, Pennsylvania 17120

Michele Brooks  
P.O. Box 202017  
Harrisburg, Pennsylvania 17120

Sam Smith  
Room 423  
Main Capitol Building  
Harrisburg, Pennsylvania 17120

Robert Freeman  
207 Irvis Office Building  
Harrisburg, Pennsylvania 17120

Charles McIlhinney Jr.  
Senate Box 203010  
Harrisburg, Pennsylvania 17120

Katrina Wise  
9896 Bustleton Avenue  
Philadelphia, Pennsylvania 19115

Stewart Greenleaf  
Senate Box 203012  
Harrisburg, Pennsylvania 17120

Victor Rose  
207 West Summit Street  
Souderton, Pennsylvania 18964

Curt Schroder  
Room 41A, East Wing  
Harrisburg, Pennsylvania 17120

Nancy Woodbury  
2200 West Liberty Avenue  
Pittsburgh, Pennsylvania 15226

Nancy Twomey  
250 N. Bethlehem Pike  
Ambler, Pennsylvania 19002

Kim Biletz  
250 N. Bethlehem Pike  
Ambler, Pennsylvania 19002

Don White  
Senate Box 203041  
Harrisburg, Pennsylvania 17120

Tiffany Rife  
1425 Philadelphia Ave  
Chambersburg, PA 17201

Angela L. Dohrman  
1050 Pennsylvania Ave  
York, PA 17404

Toni McClay  
2000 Greenbrier Lane  
West Grove, PA 19390

Tracy A. Leja  
1000 Masonic Dr  
Sewickley, PA 15143-2328

Nancy L. Spears  
1382 Newtown-Longhorn Rd  
Newtown, PA 18940-2401

Gloria Boring  
2101 Belmont Ave  
Philadelphia, PA 19131-1628

Orla Nugent  
105 North Front St. Suite 106  
Harrisburg, PA 17101

Beth McMaster  
2100 UTZ Terrace  
Hanover, PA 17331

Katherine E. Saidis  
1802 Folkemer Circle  
York, PA 17404

Mary Snyder  
800 Bollinger Dr  
Shrewsbury, PA 17361

Julie A. Hull  
2990 Carlisle Pike Box 128  
New Oxford, PA 17340-0128

Betty Bebian  
250 N. Bethlehem Pike  
Ambler, PA 19002

Anne M. Wantz  
315 N. Second St  
Harrisburg, PA 17101

Susan Bower  
801 N. Hanover St  
Carlisle, PA 17013

Mary Jane Mertz  
1460 Renton Ave  
Pittsburg, PA 15239

Nancy Dickson  
220 Newry Street  
Hollidaysburg, PA 16648-1626

Carol C. Cirka  
207 Bamberger Hall  
Collegetown, PA 19426

Mary K. Kender  
2000 Joshua Rd.  
Lafayette Hill, PA 19444

Margie Adelman  
2040 Linglestown Rd. Suite 104  
Harrisburg, PA 17110

John Scott  
1 Reed St. Suite 200  
Philadelphia, PA 19147

Colleen McGuire  
1501 Reedsdale St. Suite 105  
Pittsburg, PA 15233

Nicole M. Sarver  
100 Mt. Allen Dr.  
Mechanicsburg, PA 17055-6100

Gary N. Clouser  
3001 Lititz Pike  
Lititz, PA 17543

Tim Johnson  
2075 Scotland Ave  
Chambersburg, PA 17201

Anthony DeCarolis  
400 N. Walnut St.  
West Chester, PA 19380-2487

Marilee Mohr  
400 N. Walnut St  
West Chester, PA 19380-2487

Kathleen M. Jeffers  
400 S. Main St.  
Zelienople, PA 16063

Rodney E. Mason  
2011 Scotland Ave  
Chambersburg, PA 17201

Karen Picking  
1425 Philadelphia Ave  
Chambersburg, PA 17201

David Riegsecker  
2075 Scotland Ave  
Chambersburg, PA 17201

Tiffany Rife  
1425 Philadelphia Ave  
Chambersburg, PA 17201

Tim Johnson  
2075 Scotland Ave  
Chambersburg, PA 17201

Dixie Kiehl  
3001 Lititz Pike  
Lancaster, PA 17606-5093

Clifford Haines  
100 South Street Box 186  
Harrisburg, PA 17108-0186

Katherine C. Pearson  
100 South St. P.O. Box 186  
Harrisburg, PA 17108-0186

Cathy Himes  
133 Laurel Brooke Dr  
Brooksville, PA 15825

Tara L. Stock  
1075 Old Harrisburg Rd  
Gettysburg, PA 17325

The Honorable Andrew Dinniman  
Pennsylvania Senate  
Senate Box 203019  
Harrisburg, PA 17120-3019

David Riegsecker  
2075 Scotland Ave  
Chambersburg, PA 17201

Karen Picking  
1425 Philadelphia Ave  
Chambersburg, PA 17201

Angela L. Dohrman  
1050 Pennsylvania Ave  
York, PA 17404

Toni McClay  
2000 Greenbrier Lane  
West Grove, PA 19390

Tracy A. Leja  
1000 Masonic Dr  
Sewickley, PA 15143-2328

Nancy L. Spears  
1382 Newtown-Longhorn Rd  
Newtown, PA 18940-2401

Gloria Boring  
2101 Belmont Ave  
Philadelphia, PA 19131-1628

Orla Nugent  
105 North Front St. Suite 106  
Harrisburg, PA 17101

Beth McMaster  
2100 UTZ Terrace  
Hanover, PA 17331

Katherine E. Saidis  
1802 Folkemer Circle  
York, PA 17404

Mary Snyder  
800 Bollinger Dr  
Shrewsbury, PA 17361

Julie A. Hull  
2990 Carlisle Pike Box 128  
New Oxford, PA 17340-0128

Betty Bebian  
250 N. Bethlehem Pike  
Ambler, PA 19002

Anne M. Wantz  
315 N. Second St  
Harrisburg, PA 17101

Susan Bower  
801 N. Hanover St  
Carlisle, PA 17013

Mary Jane Mertz  
1460 Renton Ave  
Pittsburg, PA 15239

Nancy Dickson  
220 Newry Street  
Hollidaysburg, PA 16648-1626

Dixie Kiehl  
3001 Lititz Pike  
Lancaster, PA 17606-5093

Mary K. Kender  
2000 Joshua Rd.  
Lafayette Hill, PA 19444

Margie Adelman  
2040 Linglestown Rd. Suite 104  
Harrisburg, PA 17110

John Scott  
1 Reed St. Suite 200  
Philadelphia, PA 19147

Colleen McGuire  
1501 Reedsdale St. Suite 105  
Pittsburg, PA 15233

Nicole M. Sarver  
100 Mt. Allen Dr.  
Mechanicsburg, PA 17055-6100

Gary N. Clouser  
3001 Lititz Pike  
Lititz, PA 17543

Clifford Haines  
100 South Street Box 186  
Harrisburg, PA 17108-0186

Anthony DeCarolis  
400 N. Walnut St.  
West Chester, PA 19380-2487

Marilee Mohr  
400 N. Walnut St  
West Chester, PA 19380-2487

Kathleen M. Jeffers  
400 S. Main St.  
Zelienople, PA 16063

Rodney E. Mason  
2011 Scotland Ave  
Chambersburg, A 17201

Hon. Dave Reed  
145A East Wing  
PO Box 202062  
Harrisburg, PA 17120-2062

Hon. Curtis G. Sonney  
149B East Wing  
PO Box 202004  
Harrisburg, PA 17120-2004

Hon. Andrew Dinneman  
Senate Box 203019  
Harrisburg, PA 17120-3019

Hon. Shirley Kitchen  
Senate Box 203003  
Harrisburg, PA 17120-3003

Eleanor Lavin  
341 FoxHound Drive  
Lafayette Hill, PA 1944

Distribution List Name: Assisted Living Regulations

Alissa Halperin  
Bill Davis  
Cheri Rinehart  
Dave Evans  
Diane Kauffman  
Glenda Knight  
Karen Buell  
Karen Kulp  
Karen Russell  
Kathleen Spagnola  
Kathy Cubit  
Lauren Brinjac  
Linda Lindeman  
Lynn Geller  
Rosslyn Vanderlyke  
Sister Phyllis McCracken  
Stuart Shapiro  
Terry Kolaz

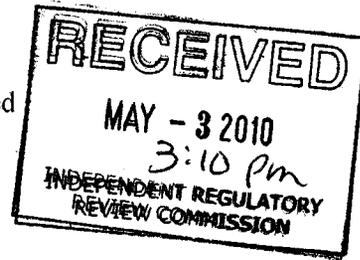
[AHalperin@phlp.org](mailto:AHalperin@phlp.org)  
[BDAVIS@masonicvillagespa.org](mailto:BDAVIS@masonicvillagespa.org)  
[CRINEHART@haponline.org](mailto:CRINEHART@haponline.org)  
[Devans@phfa.org](mailto:Devans@phfa.org)  
[dkauffman@thehickman.org](mailto:dkauffman@thehickman.org)  
[gknight@bv.org](mailto:gknight@bv.org)  
[Kbuell@lutheranseniorlife.org](mailto:Kbuell@lutheranseniorlife.org)  
[karen.kulp@hcapa.com](mailto:karen.kulp@hcapa.com)  
[krussell@stbarnabashealthsystem.com](mailto:krussell@stbarnabashealthsystem.com)  
[kspag@sharpaccess.com](mailto:kspag@sharpaccess.com)  
[cubit@carie.org](mailto:cubit@carie.org)  
[Lauren.Brinjac@pabar.org](mailto:Lauren.Brinjac@pabar.org)  
[lindal@bv.org](mailto:lindal@bv.org)  
[lkgeller@aol.com](mailto:lkgeller@aol.com)  
[rvanderlyke@churchofgodhome.org](mailto:rvanderlyke@churchofgodhome.org)  
[pmccracken@stmaryshome.org](mailto:pmccracken@stmaryshome.org)  
[sshapiro@phca.org](mailto:sshapiro@phca.org)  
[tdkolaz@lctelford.org](mailto:tdkolaz@lctelford.org)

TRANSMITTAL SHEET FOR REGULATIONS SUBJECT TO THE REGULATORY REVIEW ACT

I.D. NUMBER: 14-514
SUBJECT: ASSISTED LIVING RESIDENCES
AGENCY: DEPARTMENT OF PUBLIC WELFARE

TYPE OF REGULATION

- Proposed Regulation
X Final Regulation
Final Regulation with Notice of Proposed Rulemaking Omitted
120-day Emergency Certification of the Attorney General
120-day Emergency Certification of the Governor
Delivery of Tolled Regulation
a. With Revisions b. Without Revisions



FILING OF REGULATION

Table with 3 columns: DATE, SIGNATURE, DESIGNATION. Includes entries for House Committee on Aging and Older Adults, Senate Committee on Public Health & Welfare, and Independent Regulatory Review Commission.