#2712

From: Pam Walz [PWalz@clsphila.org]
Sent: Monday, September 15, 2008 4:30 PM Rec'd IRRC
To: IRRC
Cc: Sharon Dietrich
Subject: Reg. No. 14-514 Assisted Living
Attachments: Assisted Living Comments.pdf; Attachments.pdf

Dear Mr. Coccodrilli:

Attached please find Community Legal Services' comments on Regulation Number 14-514, concerning assisted living residences. A hard copy has been sent under separate cover. Thank you for your consideration.

Sincerely,

Pamela Walz, Director
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COMMUNITY LEGAL SERVICES
OF PHILADELPHIA

September 15, 2008

Gail Weidman
Department of Public Welfare
Office of Long Term Living
P.O. Box 2675
Harrisburg, PA 17105

Arthur Coccodrilli, Chair
Independent Regulatory Review Committee
33 Market Street, 14th Floor
Harrisburg, PA 17101

Re: Regulation No. 14-514

Dear Ms. Weidman and Mr. Coccodrilli:

These comments on the proposed rulemaking concerning assisted living residences are submitted by two units of Community Legal Services ("CLS"), both of which serve clients who will be greatly affected by the implementation of these proposed regulations. CLS provides free legal representation to low-income Philadelphia residents. Our clients include elderly and disabled individuals who need assisted living services, as well as low-wage workers whose livelihood is providing long term care services.

All but the last of the comments that follow were prepared by CLS's Elderly Law Project. These comments concern quality of care and residents' rights provisions. The Elderly Law Project ("ELP") is member of the Personal Care Home Reform Coalition, which has worked for the past seven years to increase quality standards in personal care homes and to improve the enforcement of licensing regulations. ELP is also a member of the Pennsylvania Assisted Living Consumer Alliance (PALCA), and we endorse PALCA's comments to the regulations, which were separately submitted. The last of our comments were prepared by CLS's Employment Unit. Their comments address the adoption by reference of the criminal background provisions of the Older Adult Protective Services Act, which would incorporate unconstitutional law into the proposed regulations.

1. 2800.25 Resident-residence contract

We are puzzled and disturbed by subsection (d), which prohibits a residence from seeking or accepting payments from any rent rebate funds received by *non-SSI* residents. The personal care

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home regulations contain a nearly identical provision at 55 Pa. Code §2600.25(d) which prohibits a home from keeping more than half of a resident's rent rebate. This protection applies whether the resident receives SSI or not. It is a very important provision for residents who may have only $60 per month in personal needs allowance to buy clothing, personal items, medication copayments, newspapers, transportation, and additional food. We cannot understand why the proposed assisted living regulations would extend such protection only to non-SSI residents, and we wonder whether this was an error. SSI recipients are poorer than other residents and are equally, if not more, in need of this protection. Moreover, since the assisted living regulations are required by Act 56 to meet or exceed the personal care home regulation requirements, we do not see how the proposed regulations can exclude the poorest residents from this financial protection. We see no reason why payments intended to provide a rebate for rent paid by low-income elderly and disabled renters should be converted into an additional rental payment for an SSI recipient's landlord (in this case, the assisted living residence). Accordingly, we recommend that "non-SSI" be deleted from the first sentence of this section.

2. 2800.28 Refunds

The 30 day time frames referenced in subsections (a), (d) and (f) within which a residence must refund previously paid charges when a resident moves out of the facility are entirely too long. When an assisted living resident moves out of a residence, he or she usually needs any funds owed as a refund in order to secure a new residence. We have repeatedly seen instances where a resident moves because of poor quality care or the closure of a facility, but has no money to pay the first month's charges to a new facility because he has already paid his whole month's income to the old facility and has to wait 30 days for a refund. The 30 day time frames in the personal care home regulations were based in part on the often-tenuous financial stability of small personal care homes. There is no reason that a facility with the resources to provide assisted living services should not be able to refund overpaid charges within one or two business days of request.

3. 2800.30 Informed Consent

This section concerns us greatly. We do not view this process as conferring any advantage on consumers. Assisted living residents, like all other individuals, have the common law right to refuse medical treatment and to make decisions about their care. If the goal of the informed consent process is to discuss concerns about whether those decisions are placing the resident at risk and to arrive at mutually-agreeable methods of mitigating those concerns, the support planning process should be the vehicle for this. If the resident continues to insist on exercising independence in directing the manner in which she receives care, the residence can mitigate its own liability by documenting the resident's decisions and its attempts to educate the resident about the possible negative outcomes. And in extreme circumstances, the residence can discharge the resident.

We are concerned that the informed consent process has great potential for abuse, and that residences will routinely require consumers to sign informed consent agreements to try to limit

the residence's liability in case of negligence. We also believe that there are too many unanswered questions about how this process will work. For example, a residence can initiate the informed consent process where a consumer's behavior is placing other residents at risk, but the process cannot result in an agreement which places other residents at risk. It is understandable that a consumer does not have the right to place other residents at risk, but what then is the point of using an informed consent process in this situation?

In light of these concerns, we support PALCA's recommendations for changes to this section.

4. 2800.42 Specific rights

We make the following recommendations for changes to this section (suggested edits are italicized):

Subsection (i) should be amended to read "A resident shall receive assistance in accessing health care services *and securing transportation to these services.*"

Subsection (k) should have the following language added to it: "Access to records shall be provided immediately. A resident, the resident's designated person, and other individuals upon the resident's written approval shall have the right to purchase, at a cost not to exceed the community standard, photocopies of the resident's records or any portions of them within 24 hours or a request, excluding weekend days." The reason for this suggested language is that personal care home residents, their family members and their advocates have encountered great delays and obstacles in accessing records in order to address quality of care or resident's rights concerns.

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 assisted living residence is the resident's home, and is a setting which is intended to support resident independence and autonomy. He or she 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.

We strongly recommend the addition of the following rights:

- A resident has the right to choose healthcare providers, subject to limitations on the choice of supplemental healthcare providers pursuant to §2800.142(a).
- A resident has the right to refuse treatments or services prescribed or recommended.
- A resident has the right to manage his or her own financial affairs.
- A resident has the right to reside and receive services with reasonable accommodation of individual needs and preferences, except where the health or safety of other residents would be endangered.

The latter right is one enjoyed by nursing home residents under federal and state law, and has been crucial in improving resident quality of life by requiring facilities to let residents make choices about their own daily routines and preferences rather than allowing the facility to dictate, for example, what time a resident must bathe or go to bed based on the facility's institutional schedule.

5. 2800.56 Administrator staffing

We strongly support the requirements that the administrator be present an average of 40 hours or more per week and that a designee who has completed administrator's training supervise the residence in the administrator's absence. When quality of care and other problems have arisen in personal care homes in the past, it has often become clear that the administrator was spending insufficient time in the facility and leaving less-trained personnel in charge most of the time. This problem should be corrected in the assisted living regulations, especially since assisted living will serve a higher acuity population.

6. Direct Care Staffing

We are very disappointed that the proposed regulations continue to tie staffing levels to residents' status as "mobile" or "immobile". These terms were included in the personal care home licensing regulations in the 1980s as a way of gauging the numbers of staff needed to safely evacuate the facility in case of fire. The terms are archaic and there is no evidence that they are a good indicator of the number of hours of care needed by a resident. The proposed regulations require staffing levels at the same level as personal care homes, despite the fact that assisted living facilities will serve a higher acuity population, including nursing home eligible individuals. Staffing levels should be tied instead to the actual needs of the residence's population, as determined by their support plans and unscheduled needs. This could be achieved by creating a tool to compute the numbers of staff hours needed to implement support plans.

7. 2800.60 Additional staffing based on the needs of the residents

We agree strongly with the requirements that residences have a nurse on call at all times and a dietician on staff or under contract. This professional expertise is needed to meet the needs of a population with substantial health needs living in a setting staffed mainly by non-professional staff. We have seen numerous cases in which residents' dietary needs (for example, for low sodium diets) were not met by meals provided by their personal care home because the staff did not know how to prepare meals that met those needs or understand the importance of doing so.

8. 2800.63 First Aid, CPR and obstructed airway training

All staff (particularly direct care staff) should be training in these techniques so that there is no possibility of the trained staff not being readily available in the event of emergency. We also recommend that subsection (d) be amended as follows in order to clarify that procedures not contraindicated by a resident's do not resuscitate order should be provided: "A staff person who is certified in first aid or certified in obstructed airway techniques or CPR shall provide those services in accordance with his training, except for procedures contraindicated by a resident's do not resuscitate order, if the resident has as do not resuscitate order issued by an attending physician."

9. 2800.64 Administrator training and orientation

We support PALCA's recommendation to increase the number of hours required for Department-approved administrator training to 150. Given the higher acuity level of the population to be served in assisted living, training requirements should be higher than for personal care home administrators and the number of hours must be sufficient to cover the many areas of training involved. We also feel very strongly that training requirements should not be waived for any personal care home administrator whose employment predated October 25, 2005, the date the most recent personal care home administrator training requirements went into effect. Administrators hired prior to that date were required to have only 40 hours of (often poor quality) training with no testing requirements. This training was wholly insufficient and is still more so in the assisted living context.

10. 2800.65 Direct care staff person training and orientation

Although we are pleased to see that a wide range of important subject areas must be covered in direct care staff training, it is unacceptable that no minimum number of staff training hours is set. This is crucial to ensure that topics are covered in a meaningful, non-superficial way. The personal care home industry has been beset for decades by regular scandals about poor care, resulting largely from the extremely low level of staff training in this setting. It is essential that this tragedy not be repeated in assisted living, where residents have even greater health and care needs.

The Direct Care Workforce Workgroup was convened by the Pennsylvania Workforce Investment Board and the Governor's Office of Health Care Reform to make policy recommendations to address the major issues facing the direct care workforce. The Workgroup has recommended 77 hours of initial training for direct care workers in order to professionalize this workforce and create a career ladder that will improve the quality of both jobs and care. This number would be an appropriate number to set for assisted living direct care staff.

11. 2800.83 Temperature

We strongly support the requirement that air conditioning be provided in all assisted living residences. Elderly people, especially those with respiratory and cardiovascular ailments, are particularly vulnerable to heat-related sickness and death. Facilities which cannot afford to provide air conditioning should remain licensed as personal care homes, not assisted living.

12. 2800.101 Resident Living Units

We applaud the proposed provision which would require that living unit size in new construction be at 250 square feet. We also agree with PALCA with there should be no exception allowing existing construction to contain only 175 square feet of living space.

The room size of personal care homes are not a good model for assisted living. Personal care home rooms are often tiny, with a minimum of just 80 square feet, or are shared with up to three other residents. As a result, residents' rooms in personal care homes are places to sleep rather than actual living spaces, and most personal care home residents spend much of their waking time in common areas or day programs. Assisted living is viewed by consumers and envisioned in Act 56 as a very different model which affords its residents a much greater measure of privacy and autonomy than personal care homes' congregate living model. Act 56 provides that the assisted living regulations must require that living units contain living and bedroom space as well as kitchen capacity and adequate space for storage. In order to make this a reality, living units must be large enough to be a true home to their residents, rather than simply a place to sleep. In addition, spaces smaller than 250 square feet are not large enough for wheelchair users to maneuver in. Many states require at least 200 square feet per single bedroom living unit in assisted living, and the Pennsylvania Housing Finance Agency and the Philadelphia Housing Authority recommend that living units contain no less than 250 square feet of space. These provisions will not cause harm to existing facilities which cannot meet their requirements, as these facilities can continue to operate as personal care homes.

We feel strongly that section 2800.101(j)(8), which would permit a residence to require residents who share rooms to share storage area, their bedside table, mirror and lamp, is inappropriate. Even in college dormitory rooms, roommates do not share these items. These amenities are still more important to assisted living residents, for whom these living units are their permanent home.

We also consider it essential that living units contain at least the kitchen capacity provided for in the proposed regulations, so that residents have the ability to store and keep food refrigerated, cook in a microwave and wash dishes in a sink (which must be separate from their bathroom sink). We feel that existing construction should afford the same cooking capacity to its residents, but at a minimum each unit must contain a small refrigerator and microwave and access to a sink, food preparation area and stovetop.

13. 2800.142 Assistance with health care and supplemental health care services

We recognize that Act 56 permits an assisted living residence to require residents to use supplemental health care providers designated by the residence, to the extent that this is prominently disclosed in the written admission agreement. However, it is essential that the regulations make clear that residents retain the right to freely choose all of their other health care providers. Some industry representatives have expressed an interest in limiting this choice and have interpreted the statute as not precluding this possibility.

Assisted living residents should have the same rights as other citizens, including nursing home residents, to choose their health care providers. The practice, common in certain personal care homes, of having the residents use a "house doctor" employed by the facility has often resulted in terrible medical care. CLS clients with severe disabilities and health care needs have told us of house doctors who never met with them except very quickly in the hallway to complete forms. After moving from such facilities, residents have been diagnosed with life-threatening illnesses which were probably long-standing but had never been detected. We strongly recommend that a provision be added in this section or the residents' rights section stating that with the exception of supplemental health care services in the circumstances outlined in this section, residents have the right to freely choose their health care providers and pharmacists.

14. 2800.181 Self-administration

We support PALCA's recommendation that the following language be added to subsection (e), which defines when a resident will be considered capable of self-administering medications:

> "Be able to use to the medication as prescribed in the manner prescribed, including but not limited to being capable of placing medication in own mouth and swallowing completely, applying topical medications, properly placing drops in own eyes, correctly inhaling inhalants, and properly inhaling nasal therapies."

We have had clients who received assisted living-type services in their own homes and were considered capable of self-administering their medications because they understood which medication to take but who were unable to, for example, accurately get eye drops into their eyes. This put them at risk for progression of their medical conditions.

15. 2800.203 Bedside rails

We are very concerned about the safety risks created by subsection (b), which is less protective than requirements concerning bedside rail use issued by the Department's Adult Residential Licensing (ARL) office for personal care homes (see Attachment 1, pages 3-7). These requirements were issued in January 2007 after four Pennsylvania personal care home residents died from bedrail entrapment during a 90 day period. ARL noted that between 1995

and 2005, 691 incidents were reported to the U.S. Food and Drug Safety Commission of individuals being caught, trapped, entangled and strangled in beds with rails. Of these, 413 people died. As a result, the FDA issued guidelines on the use of bedside rails and recommends that most personal care home residents can be in bed safely without bedside rails. Where bedside rails are used, the FDA recommended that residents be monitored frequently and that staff anticipate the reasons individuals get out of bed (such as hunger, thirst, needing to go to the bathroom, restlessness and pain), and meet these needs by offering food and fluids, scheduling ample toileting and providing calming interventions. The FDA also urged that staff perform frequent assessments and support plan updates.

Based on the FDA's safety recommendations and Pennsylvania's own recent experience, the ARL issued restrictions on the use of bedside rails in personal care homes, prohibiting the use of full-length bedrails and permitting half-length rails only where certain conditions are met. Subsection (b) omits several of these conditions, which 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 bedside rail is in use;
- The rails and the space between the bed rails and the mattress meet Food and Drug Administration safety guidelines; and
- The resident's assessment *and* support plan completed within the past six months addresses the resident's needs and health and safety protections necessary for the use of half-length rails.

The Department should heed the experience of the ARL, which currently licenses and regulates many of the facilities which will seek assisted living licensure. In addition, Act 56 requires that the assisted living regulations be at least as protective as the Chapter 2600 personal care home regulations.

16. 2800.225 and 2800.227 Initial and Annual Assessment and Development of the Support Plan

The assessment and support plan development requirements are crucial to the provision of quality care. Through this process, the individualized needs of each resident are identified and a written plan is developed which sets out how the residence will meet these needs. These requirements were added to the personal care home licensing regulations after innumerable incidents of residents receiving inadequate care – sometimes with tragic results – because the facility had not identified care needs or lacked a plan for how to meet them. We are very concerned that the time frames for these two processes – which give residences 15 days to perform an assessment and 30 days to develop a support plan - are inadequate to meet the needs of new residents. How will residents' needs be identified or met during this initial time period?

Individuals who are so frail that they qualify for nursing home level care will be among the residents served by assisted living residences. In recognition that this population requires prompt commencement of care, the regulations governing nursing homes require that a facility have physician orders for the resident's immediate care upon admission, an assessment within 15 days of admission, and a care plan developed within 7 days after the completion of the assessment. 42 C.F.R. § 483.20.

Having to wait 30 days for a care plan is also problematic because consumers will be forced to move in, sign a contract and begin paying the residence weeks before it would be required to identify her needs, explain whether and how it will meet those needs and how much this package of services will cost. We support PALCA's recommendation that the assessment be performed prior to admission unless an urgent admission from a hospital makes this unworkable, in which case the assessment should be promptly performed after admission. Pre-admission assessments can be amended as needed based on any additional information gained during the initial weeks of residency. We also agree that the support plan should be developed prior to admission and implemented within 7 days of admission.

Finally, we strongly support the requirement that a licensed nurse review and approve the support plan. Many assisted living residents will have substantial health-related needs, and the input of staff with at least the training of a licensed nurse is essential to ensure that these residents' needs are adequately planned for. Care plans for nursing home eligible individuals who receive care through the PDA waiver or in a nursing facility are either prepared or reviewed by licensed nurses, and this is equally necessary in the assisted living setting.

17. 2800.228 Transfer and discharge

We strongly support the requirement that facilities ensure a safe and orderly discharge that is appropriate to meet the resident's needs. Similar requirements exist in nursing facilities and hospitals, and they are important to ensure that frail and ill individuals are not sent to settings which cannot meet their needs or discharged without vital equipment or medications.

We also feel strongly that there must be an outside neutral appeal process for residents to challenge involuntary discharges. National experience has shown that there will be many instances where residences will decide that they cannot safely serve residents, that it is not cost-effective to do so, or that a resident is otherwise undesirable. For these residents, being told that they have to move is devastating. Assisted living residents usually sell or otherwise give up their own homes to move to assisted living, often with encouragement from the assisted living residence to believe that they can remain there for the rest of their lives. Many assisted living residences charge admission fees, which may consume the bulk of consumers' life savings. As a result, residents may have nowhere else to go and insufficient assets to enter another quality facility. Moving is also unusually traumatic for frail elderly people. It is not unusual for an involuntary move from a nursing home to result in a resident's decline in health or even death. Because of this, federal law requires states to provide appeal mechanisms for nursing home residents who are being involuntarily discharged. Assisted living residents need the same

protection. We therefore endorse the language recommended by PALCA setting out an appeals process and notice requirements.

18. 2800.235 Discharge

It is not clear why there is a separate provision for discharges from special care units, especially since this section does not contain many of the features of section 2800.228. The latter section should apply to all discharges and this section should be deleted.

19. 2800.239 Application to Department

We agree with PALCA that a facility's application to the Department to operate a special care unit should include a description of the dementia care and programming to be provided in the unit.

20. 2800.51 Criminal Background Provisions for Assisted Living Workers

Proposed Section 2800.51 provides:

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

However, the criminal record provisions of the Older Adults Protective Services Act ("OAPSA") have been found by the courts to be unconstitutional, and that deficiency has not yet been corrected by the legislature. We object to the incorporation of the unconstitutional provisions of OAPSA into the assisted living regulations; rather, the state should apply its OAPSA interim policy to assisted living facilities until OAPSA is amended.

OAPSA contains a chapter governing the employment by covered facilities (which include nursing homes and other long-term care facilities) of persons with criminal convictions. 35 P.S. §§ 10225.501 – 10225.508. The statute's general rule is that any worker who has ever been convicted of a crime on a list of 35 enumerated offenses – ranging on a continuum of seriousness from murder at one extreme to two theft misdemeanors at the other – is permanently prohibited from working in facilities covered by OAPSA. 35 P.S. § 10225.503. (See Attachment 2 for a complete list of offenses that bar employment under OAPSA). However, this rule does not apply to "grandfathered" workers who had been employed by a covered facility for at least a year as of July 1, 1998. 35 P.S. § 10225.508(1).

When the OAPSA criminal record provisions went into effect in July1998, scores of people sought legal assistance from CLS as a result of being rendered unemployable in their care-giving occupations. Many of these clients had old, minor or unrelated convictions and had made careers working on OAPSA-covered facilities.

In response to this overwhelming client need, CLS and co-counsel filed suit in August 2000 on behalf of five workers and a nonprofit organization with facilities covered by OAPSA. We challenged the legality of the OAPSA criminal record provisions under Article I, Section 1 of the Pennsylvania Constitution, which guarantees the right to pursue a lawful occupation. OAPSA's criminal record provisions ultimately were found unconstitutional, first by the Pennsylvania Commonwealth Court, and then by the Pennsylvania Supreme Court. Nixon v. Commonwealth, 789 A.2d 376 (Pa. Commw. 2001), aff'd on different grounds, 839 A.2d 277 (Pa. 2003).

The State Supreme Court applied a rational basis test to OAPSA's criminal record provisions – a rational basis test that it characterized as being more restrictive under the Pennsylvania Constitution than the United States Constitution. Nixon, 839 A.2d at 401-02. The Court concluded that the statute did not have a rational basis, because it failed to have "a real and substantial relationship to the interest the General Assembly is seeking to achieve." Id. at 403. Specifically, the Court indicated that the legislature's distinction between the exempt "grandfathered" workers and the non-exempt new applicants for employment made no sense, because if the grandfathered workers could rehabilitated themselves, there was no reason by the others could not do the same. Id. at 403-04. The Court concluded:

> Accordingly, we hold that the criminal records chapter, particularly with regard to its application to the Employees, does not bear a real and substantial relationship to the Commonwealth's interest in protecting the elderly, disabled, and infirm from victimization, and therefore unconstitutionally infringes on the Employees' right to pursue an occupation.

Id. at 404.

Following the State Supreme Court's decision in Nixon, the Pennsylvania Department of Aging announced an "interim policy" that would apply pending legislative action to conform OAPSA's criminal record provisions to the State Constitution (see Attachment 3). The interim policy permits covered facilities to hire people who have at least five years of work experience in care-giving jobs since the date of their conviction or release from prison, whichever is later.

While the interim policy remains in effect, CLS's experience with it is that the interim policy is little known by covered facilities and that those which do know about it lack confidence in it to hire people who are covered by the legislative provision. Moreover, CLS recently learned that the Pennsylvania Department of Health apparently has not been applying the interim policy to the OAPSA-covered facilities that it regulates.

Since the Nixon litigation concluded, there has been a great deal of discussion about a legislative amendment to the criminal records provisions of OAPSA, but until recently, there was wide disagreement over such an amendment's form. As a result, legislative action to modify OAPSA's criminal record provisions has long been stymied. But recently, interested legislators, the Rendell Administration, and numerous stakeholders reached agreement on the language

contained in Senate Bill 667, as amended on June 3, 2008.[1] Unfortunately, there is virtually no hope that this bill will be enacted during the current legislative session, which is quickly nearing its close.

Because most of the interested parties now agree on the language and concepts for the reform of OAPSA's criminal record provisions, CLS is hopeful that a successor version of SB 667 will be enacted relatively early in the next legislative session and that the amendments will mitigate the constitutional problems with the current law. However, as is always is true with proposed legislation, the successor bill's fate in the next legislative session remains unknown and uncertain.

Given that the OAPSA statute and regulations remain unconstitutional in their current form, CLS strongly objects to their incorporation by reference into the assisted living regulations. We propose that until OAPSA is modified so that it is no longer unconstitutional, the Pennsylvania Department of Aging's OAPSA interim policy be applied to assisted living facilities.

As noted above, the OAPSA interim policy has been far from a panacea. However, the other constitutional alternative would be to incorporate into the assisted living regulations a scheme similar to that set forth in SB 667, which CLS recognizes is probably not practical pending legislative action on that bill's successor.

The IRRC could help facilitate legislative action in SB 667's successor by emphasizing that the General Assembly's failure to act in response to the Nixon decision has had unintended consequences in the assisted living arena as well. In addition, it should recommend the adoption of the OAPSA interim policy, so that assisted living facilities will not be deprived of workers who have demonstrated themselves to be appropriate caregivers notwithstanding old criminal records.

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[1] SB 667 would significantly modify OAPSA's criminal record provisions by creating a three-tiered categorization of the 35 enumerated offenses.

- Offenses in the first tier, which constitute the most serious offenses, would forever bar employment in covered facilities, without exception.
- Offenses in the second tier would presumptively bar a worker for life; however, the person could be employed if able to obtain a "certificate of employability" by demonstrating fitness and rehabilitation in an administrative hearing.
- Offenses in the third tier, which constitute the least serious offenses, would presumptively bar a worker for ten years, but with the possibility of obtaining a certificate of employability after five years.

Grandfathering would be eliminated under SB 667; however, our expectation is that the vast majority of grandfathered workers who are still employed will be able to qualify under the second or third tier.

Thank you for the opportunity to provide input on the proposed regulations governing assisted living in Pennsylvania. For more information on OAPSA or the criminal record provisions, please contact CLS employment attorneys Sharon Dietrich (215-981-3719) or Janet Ginzberg (215-981-3745). If there are any questions about the non-OAPSA related comments, please contact Pamela Walz at (215) 227-2400, extension 2431. Thank you for your consideration of these comments.

Sincerely,

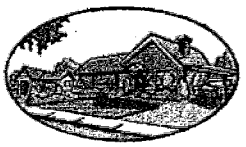
Pamela Walz

Pamela Walz
Director, Elderly Law Project

Sharon Dietrich
Managing Attorney

cc: Senator Edwin Erickson
Senator Vincent J. Hughes
Rep. Frank Oliver
Rep. George Kenney

January 2007 Volume 2 PCH Connection Newsletter



Personal Care Home Connection

Pennsylvania Department of Public Welfare Edward G. Rendell, Governor Estelle B. Richman, Secretary	January 2007 Volume 2
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	Web site: www.dpw.state.pa.us Keyword: Personal Care

§ 2600.122 (relating to 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.

This applies to every floor used by the residents, including basements and attics, even if used only occasionally.

§ 2600.130(e) (relating to smoke detectors and fire alarms)

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.

If one or more residents or staff persons are not able to hear the smoke detector or fire alarm system, a signaling advice 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.

This applies if one or more residents or staff persons cannot hear the detector or alarm, and NOT to all individuals with a hearing impairment. Many individuals who have a hearing impairment can hear the alarm.

This applies to all detectors and alarms in any area that may be accessed by the resident or staff person. The detectors and alarms must be equipped with a strobe light, OR, each individual who cannot hear the alarm must have a personal body device to alert them to the fire signal at the same time others who can hear the alarm are alerted. This is necessary to provide equal fire protection for all residents. This applies to all staff persons who cannot hear the detector or alarm since they must be notified immediately so that they can assist residents to

Attachment 1

evacuate.

During sleeping hours, for each resident who cannot hear the alarm, there must be a strobe light in the resident's bedroom, a personal body device or a bed/pillow vibrating device (type depends on what is effective for each individual resident).

Strobe lights must be UL approved, have a single intensity of 75cd or higher and have a flash rate of 1-3 flashes per second. Use of hearing dogs is acceptable instead of strobe lights and other devices both during the day and while sleeping.

If a resident can hear the alarm during the day through the use of a hearing aid, but he/she removes the hearing aid while sleeping and can no longer hear the alarm, a bed vibrator device is necessary while the individual is sleeping.

It is recommended, but not required, that strobe lights be interconnected.

For assistance in purchasing a hearing device, see the yellow pages of your telephone book under fire protection equipment. You may also contact the local Association for the Deaf.

§ 2600.182(b) (relating to medication administration)

Prescription medication that is not self-administered by a resident shall be administered by one of the following:

Medications Administrator Training

The new Medications Administration Train the Trainer Course for personal care homes in Pennsylvania is now available! The training course is available to staff of personal care homes who are selected by personal care home administrators or owners to become trainers for medication administration in a licensed personal care home. The brochure describing the registration process and course dates/locations is available on the Department's Web site at: www.dpw.state.pa.us Keyword: Personal Care.

FREQUENTLY ASKED MEDICATION ADMINISTRATION TRAINING QUESTIONS

1.Must all homes pay the required fee of $280 to send a staff person to the training?

Individuals working for a personal care home that serves at least one Supplemental Security Income (SSI) recipient may attend the course (one time) at no cost until July 2007. All other registrants must pay a non-refundable fee of $280.

2.If a staff person attended another medications training course in the past, must they attend the new course?

Yes. The Department's Medication Administration Training is the only course that meets the requirements of § 2600.190(a) (relating to medication administration training)

3.Are individuals who have completed the Office of Mental Retardation (OMR) Medication Administration Training for OMR facilities in the past permitted to be the trainer for PCH facilities as well?

Individuals who completed the medication administration training for OMR are permitted to train PCH staff if they have completed the new course that has been available since the fall of 2004. Anyone who completed the medication administration training prior to the fall of 2004 must take the new course before providing any training.

4.May someone who is not an employee of the home attend the Medication Administration Training (such as a community pharmacist or a state provider association, etc)?

No, only an employee of a licensed personal care home may attend the Medication Administration Training.

5.May more than one employee per home attend the Medication Administration Training?

In order to provide an opportunity for all personal care homes to participate in the training, only one person per licensed home may attend the course until July 2006; however, the home may register (paying full fee even for SSI homes) additional staff persons and they will be put on a waiting list; about a week before each course is held, persons will be contacted on a first serve basis to fill any vacant slots.

6. If a person attends the Medication Administration Training while working for one personal care home, but later is employed by another personal care home, is the person eligible to train staff at the new personal care home?

Yes, as long as the home provides a brief refresher course on the home's medication policies.

7. How many hours may be counted towards the 12 and 24 hour annual training requirements in § 2600.64(c) and § 2600.65(e)?

Six (6) hours may be counted towards the 12 and 24 hour annual training requirement.

8. After completing the medication administration training, will I be permitted to administer injections?

No. A staff person is permitted to administer insulin injections following successful completion of a Department-approved medication administration course that includes the passing of a written performance-based competency-based test within the past 2 years, AS WELL AS successful completion of a Department-approved diabetes patient education program within the past 12 months.

A Department-approved diabetes patient education program is one provided by an individual who is a certified diabetes educator who has been trained by the National Certification Board for Diabetic Educators.

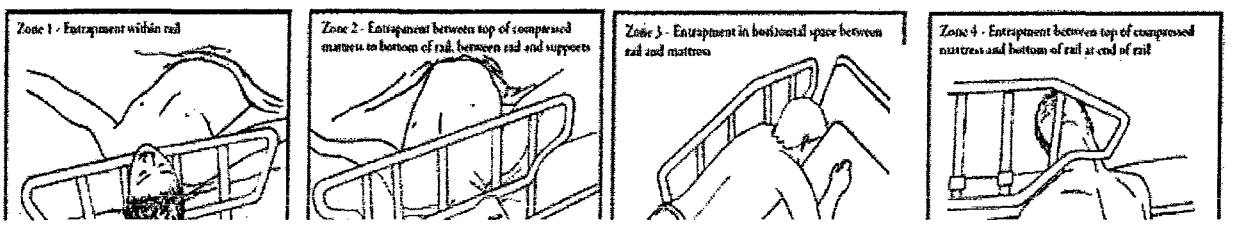
Personal care homes can locate a certified diabetes educator by contacting one of the following:

- Local hospitals
- The American Association of Diabetes Educators. The Association has a list of individuals who are certified on their website. (www.diabeteseducator.org)
- The American Diabetes Association. Their website provides contact information for local ADAs that may be able to provide information. (www.diabetes.org).
- The Pennsylvania Department of Health. Local diabetes consultants may be able to offer a few names in local areas. (www.health.state.pa.us)

Bed Rail Safety

The U.S. Food and Drug Administration (FDA) recently issued guidelines to try to end a little known, but not uncommon, cause of death to people in long term care facilities: entrapment in the bed rails on hospital beds.

Bed rails are simple, metal devices that are supposed to be helpful. Individuals use the rails to pull themselves up and they can prevent individuals from rolling out of bed. But sometimes, individuals – particularly frail, older persons with dementia or Alzheimer's Disease – can get trapped between the rails of a bed rail or between a bed rail and the mattress, which can lead to serious injury or even death.



Between 1995 and 2005, 691 incidents of individuals caught, trapped, entangled and strangled in beds with rails were reported to the FDA. Of these reports, 413 people died, 120 had a nonfatal injury and 158 were not injured because staff intervened. Most individuals were frail, restless, elderly, confused or had uncontrolled body movement.

Potential benefits of bed rails include:

- Aiding in turning and repositioning within the bed.
- Providing a hand-hold for getting into or out of bed.
- Providing a feeling of comfort and security.
- Reducing the risk of individuals falling out of bed.
- Providing easy access to bed controls and personal care items.

Potential risks of bed rails may include:

- Strangling, suffocating, bodily injury or death when an individual or part of his/her body is caught between the rails or between the bed rails and mattress.
- More serious injuries from falls when individuals climb over rails.
- Skin bruising, cuts and scrapes.
- Inducing agitated behavior when bed rails are used as a restraint.
- Feeling isolated or unnecessarily restricted.
- Preventing individuals, who are able to get out of bed, from performing routine activities such as going to the bathroom or obtaining a personal item.

The FDA recommends that most residents of personal care homes can be in bed safely without bed rails. Consider the following:

- Use beds that can be raised and lowered close to the floor to accommodate both the needs of the resident and the staff person.
- Use position-wedges.
- Keep the bed in the lowest position with wheels locked.
- When the individual is at risk of falling out of bed, place mats next to the bed, as long as this does not create a greater risk of accident.
- Use transfer or mobility aids.
- Monitor each resident frequently.
- Anticipate the reasons individuals get out of bed such as hunger, thirst, going to the bathroom, restlessness and pain; meet these needs by offering food and fluids, scheduling ample toileting, and providing calming interventions and pain relief.
- Complete frequent assessments and update support plans to address each resident's needs and the required health and safety protections.

The FDA recommends when bed rails are used, staff perform an on-going assessment of the individual's physical and mental status and that staff closely monitor high-risk individuals. Consider the following:

- Lower one or more sections of the bed rail, such as the foot rail.
- Use a proper size mattress or mattress with raised foam edges to prevent individuals from being trapped between the mattress and rail.
- Reduce the gaps between the mattress and side rails.
- Use only rails that meet FDA safety guidelines.

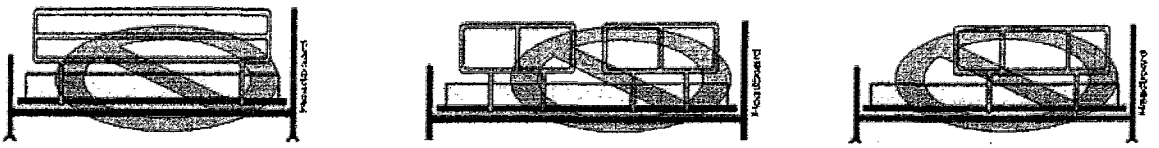
ATTENTION* New Regulation Interpretation – Effective March 1, 2007

§ 2600.81(b) (relating to physical accommodations and equipment)

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

Explanation: In accordance with § 2600.202 (relating to prohibitions) a bed rail may not be used unless the

resident can raise and lower the rails on his/her own. Bed rails may not be used to keep a resident in bed. Use of any length rail longer than ½ 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.



Half-length bed rails are usually not appropriate for residents of personal care homes. See the above FDA recommendations to avoid the use of bed rails.

Half-length bed rails are permitted only if ALL of the following conditions are met:

- 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.
- The rails meet the guidelines of the FDA (see FDA Web site at: http://www.fda.gov/cdrh/beds/guidance/1537.html) or contact your Regional Director for a copy of the FDA guidelines.
- The space between the bed rails and the mattress meet the guidelines of the FDA. Staff persons must complete a physical check of each resident who uses a half-length rail at least every 15 minutes during the time the bed rail is in use.
- The resident's assessment and support plan completed within the past 6 months, addresses the resident's needs and the health and safety protections necessary for the use of half-length rails.

Fire Safety

FACTS ON FIRES:

- A fire can happen in any home at any time. **YES, A FIRE CAN HAPPEN IN YOUR HOME.**
- Smoking materials (i.e. cigarettes, cigars, pipes, etc.) are the leading cause of fire deaths in the United States. One out of every four fire deaths in 2001 was attributed to the misuse of smoking materials.
- Your ability to get out of the home in a fire depends on advance warning from smoke alarms and advance planning.
- The most common material first ignited in home fires is trash, followed by mattresses and bedding and upholstered furniture
- It is necessary to practice home fire drills to be certain everyone is familiar with the smoke alarm signal and to determine if there are any obstacles to a quick and safe evacuation (including the inability for some to awaken to the smoke alarm signal).
- It is critical that each fire drill simulate the evacuation procedures to be followed in the event of a real fire. Fire drills save lives. **PRACTICE, PRACTICE, PRACTICE.**
- Evacuation procedures should be: close off area, sound alarm and get out of the building. Do not fight fire

A news quote from an administrator of a recent Pennsylvania personal care home fire:

"It worked remarkably well, exactly the way it should," he said of the evacuation. "Everyone was out in less than three minutes. They were actually joking with me saying 'Now we see why you run all those fire drills!'"

FIRE SAFETY TIPS:

- All smoking must be in the smoking area – never smoke in bedrooms or a living room.
- Avoid overloading electrical outlets.
- Don't install smoke alarms near windows, doors or ducts where drafts might interfere with their operation.
- Test each smoke alarm once a month.

- Regularly vacuum or dust your smoke alarms and follow the manufacturer's instructions to keep them working properly.
- Install smoke alarms with "long-life" (ten year) batteries.
- Fire extinguishers should be located at exit doors or by paths of egress from building.
- Request fire safety training from your local fire department.

National Fire Protection Association
Rate of Fire's Growth and Speed
How fast does a fire grow?

:30 minutes
Fire ignites and grows rapidly
1:04 minutes
From first flame, fire spreads and smoke begins to fill the room
1:35 minutes
Smoke layer descends rapidly, temperature exceeds 190o F
1:50 minutes
Smoke detector alarms
2:30 minutes
Temperature above burning object is more than 400o F
2:48 minutes
Smoke pours into other rooms
3:03 minutes
Temperature 3 feet above floor in room of origin is over 500o F (no one could survive)
3:41 minutes
Flashover. Energy in room of origin ignites everything. Temperature is 1400o F
3:50 minutes
Two minutes after smoke detector sounds, second exit only way out
4:20 minutes
Two and a half minutes after smoke detector sounds, § 2600.130(d) (relating to fire drills) requires residents must be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated by a fire safety exit.
4:33 minutes
Flames just now visible from exterior of home – first evidence of fire from outside. At this point, rescue may not be possible. A video demonstrating the above fire growth and speed is available by contacting your regional licensing administrator. Please call to reserve your copy.

Direct Care Staff Person Training

The direct care staff person training required in § 2600.65(d)(2) is currently under development under contract with Pennsylvania State University. This course is **FREE of charge** to personal care homes. It is expected that the course and test will take from 4-8 hours to complete. The length of time will depend on the persons' knowledge, experience and reading level. This course will be available through use of a computer with internet access and may be completed at the home, the library or in the staff person's own home. Until the course and test are available, they are not required.

Administrator Competency-Based Training Test

The Department-approved competency-based training test required in § 2600.64(a)(3) is not yet available. It is currently being developed under contract with Pennsylvania State University with the assistance of an advisory team that includes medical and program professionals, advocacy groups and statewide provider organizations.

The Department-approved competency-based training test required in § 2600.64(a)(3) is not yet available. It is currently being developed under contract with Pennsylvania State University with the assistance of an advisory team that includes medical and program professionals, advocacy groups and statewide provider organizations.

The test will be administered to all individuals who complete the 100-hour standardized Department-approved administrator training course required in § 2600.64(a)(2) by the Department-approved training institution. It is an on-line test. Individuals who complete the 100-hour standardized Department-approved administrator training course before the test is available will not be required to take or pass the test.

We expect that the test will be available within the next several months. Until the test is available, it is not required.

Administrator Scholarships – NEW PROGRAM

The Department of Public Welfare's Adult Residential Licensing Program is offering Personal Care Home Administrator scholarships. The scholarship allows eligible homes to send an individual to the administrator training required in § 2600.64(a)(2) (related to administrator training and orientation) **free of charge.** In order to be eligible to receive a scholarship, a licensed personal care home must meet specific criteria and complete an application. A letter regarding the availability of the administrator scholarships and an application form was sent to each personal care home on December 9, 2006. If you did not get the information and would like to apply for a scholarship, the application can be found on the personal care home Web site.

Free Training

"Useful Tools: Pre-Admission Screening, Assessment and Support Plan"

3 annual training hours

The Department of Public Welfare is offering training on the use of the Pre-Admission Screening, Assessment and Support Plan required in § 2600.221-228 (relating to services). The trainings will be offered in March 2007 and are free of charge. You can find trainings dates and times on the Department's list of approved training sources in the Department's Personal Care Home Administrator Training Resource Directory. This directory can be found on the personal care home Web site at www.dpw.state.pa.us/Disable/PersonalCareAssistedLiving. As always, if you do not have access to the internet, please contact your regional licensing administrator to get a copy of the Resource Directory.

"On-line Training for Mandatory Abuse Reporting and Criminal History Background Checks"

1.5 annual training hours

See enclosed brochure

You must complete, print and sign the bottom of the quiz at the end of each part of the training. This documentation must be kept.

Norovirus Outbreaks

Please review the attached document titled "Norovirus in Health Care Facilities Fact Sheet". The fact sheet provides information regarding symptoms of norovirus, the use of standard precautions and limiting transmission of the virus. Personal care homes are required to notify their local health department or State Health Center of all possible outbreaks by calling 877-PA-HEALTH.

Next Issue

If you have suggested topics to cover in future editions of this newsletter, please contact Kimberly Black, Director of Training, 423 Health and Welfare Building, Harrisburg, Pa 17120 or at telephone number 717-783-3670.

Remember to sign-up for the Governor's Newsletter at:
http://www.governor.state.pa.us

www.dpw.state.pa.us

Last modified on: October 16, 2007

PROHIBITIVE OFFENSES CONTAINED IN ACT 14 OF 1997

OFFENSE CODE	PROHIBITIVE OFFENSE	TYPE OF CONVICTION
CC2500	Criminal Homicide	Any
CC2502A	Murder I	Any
CC2502B	Murder II	Any
CC2502C	Murder III	Any
CC2503	Voluntary Manslaughter	Any
CC2504	Involuntary Manslaughter	Any
CC2505	Causing or Aiding Suicide	Any
CC2506	Drug Delivery Resulting in Death	Any
CC2702	Aggravated Assault	Any
CC2901	Kidnaping	Any
CC2902	Unlawful Restraint	Any
CC3121	Rape	Any
CC3122.1	Statutory Sexual Assault	Any
CC3123	Involuntary Deviate Sexual Intercourse	Any
CC3124.1	Sexual Assault	Any
CC3125	Aggravated Indecent Assault	Any
CC3126	Indecent Assault	Any
CC3127	Indecent Exposure	Any
CC3301	Arson and Related Offenses	Any
CC3502	Burglary	Any
CC3701	Robbery	Any
CC3901	Theft	1 Felony or 2 Misdemeanors
CC3921	Theft by Unlawful Taking	1 Felony or 2 Misdemeanors
CC3922	Theft by Deception	1 Felony or 2 Misdemeanors
CC3923	Theft by Extortion	1 Felony or 2 Misdemeanors
CC3924	Theft by Property Lost	1 Felony or 2 Misdemeanors
CC3925	Receiving Stolen Property	1 Felony or 2 Misdemeanors
CC3926	Theft of Services	1 Felony or 2 Misdemeanors
CC3927	Theft by Failure to Deposit	1 Felony or 2 Misdemeanors
CC3928	Unauthorized Use of a Motor Vehicle	1 Felony or 2 Misdemeanors
CC3929	Retail Theft	1 Felony or 2 Misdemeanors
CC3929.1	Library Theft	1 Felony or 2 Misdemeanors
CC3930	Theft of Trade Secrets	1 Felony or 2 Misdemeanors
CC3931	Theft of Unpublished Dramas or Musicals	1 Felony or 2 Misdemeanors
CC3932	Theft of Leased Properties	1 Felony or 2 Misdemeanors
CC3933	Unlawful Use of a Computer	1 Felony or 2 Misdemeanors
CC4101	Forgery	Any
CC4114	Securing Execution of Document by Deception	Any
CC4302	Incest	Any
CC4303	Concealing Death of a Child	Any
CC4304	Endangering Welfare of a Child	Any
CC4305	Dealing in Infant Children	Any
CC4952	Intimidation of Witnesses or Victims	Any
CC4953	Retaliation Against Witness or Victim	Any
CC5902B	Promoting Prostitution	Felony
CC5903C	Obscene and Other Sexual Materials to Minors	Any
CC5903D	Obscene and Other Sexual Materials	Any
CC6301	Corruption of Minors	Any
CC6312	Sexual Abuse of Children	Any
CS13A12	Acquisition of Controlled Substance by Fraud	Felony
CS13A14	Delivery by Practitioner	Felony
CS13A30	Possession with Intent to Deliver	Felony
CS13A36	Illegal Sale of Non-Controlled Substance	Felony
CS13A37	Designer Drugs	Felony

Attachment 2

Department of Aging
Special Announcements 2004

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

Subject: Older Adults Protective Services Act – Criminal Background Check Provisions

***Nixon v. Commonwealth of PA, et al*, 2003 LEXIS 2604 (12/30/2003)**

The Supreme Court of Pennsylvania issued the above-referenced decision on December 30, 2003, which, in effect, held the criminal history background check prohibitive hire provisions of the Older Adults Protective Services Act (OAPSA) to be unconstitutional "as applied to the individual plaintiffs." The Court only granted specific relief to the individual plaintiffs and not to all persons affected by the criminal history background check provisions in OAPSA.

The Pennsylvania Department of Aging (PDA) anticipates legislative action in the near future. In the interim, the protective services program in PDA will operate as follows for all facilities required to comply with OAPSA:

1. Criminal history reports are still required for all applicants.
2. The PA State Police will continue to process applications for state criminal history reports and provide such information to the entity requesting the criminal history report.
3. PDA will continue to process FBI criminal history reports.
4. Letters from PDA will continue to indicate "clear" or "prohibited", based on FBI criminal history background check information.
5. Effective February 4, 2004, facilities will not be sanctioned for hiring or continuing to employ individuals who demonstrate rehabilitation by evidence of a minimum five-year aggregate work history in care-dependent services, without incident, from either the date of conviction or release from incarceration, whichever is later. Applicants are responsible for providing official verification of such dates. Care-dependent services include healthcare, eldercare, childcare, mental health, mental retardation, or care of the disabled. Facilities must reasonably investigate the character of an individual with a previously disqualifying criminal offense by means of

Attachment 3

interviews, references and evidence of work history. Facilities that hire such an individual are required to obtain specific employer-provided documentation of that individual's employment in care-dependent services and retain it in the individual's personnel file.

6. The Court's ruling in no way prohibits a facility from refusing to employ an individual, even one who has a clean aggregate five-year work history, based on information obtained in a criminal history report. Pennsylvania law, 18 Pa.C.S. § 9125, provides that an employer may consider criminal history felonies and misdemeanors, to the extent they relate to the applicant's suitability for employment in the position sought. The employer is required to notify the applicant, in writing, if the decision not to hire the applicant is based, in whole or in part, on the applicant's criminal history.

If you have any questions, please contact Debra Carroll at the Pennsylvania Department of Aging at (717) 783-6207.

For more information contact:

Name: **Pennsylvania Department of Aging**
Email: aging@state.pa.us
Address: 555 Walnut Street
5th Floor
Harrisburg, PA 17101
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