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From: Gail Inderwies [ginderwies@keystonecare.com]
Sent: Monday, September 15, 2008 9:28 PM
To: IRRC
Cc: vhoak@pahomecare.org; ibucher@state.pa.us; gweidman@state.pa.us
Subject: Response to assited living proposed regulations!
Attachments: September 15.doc

Please advise if you need me to resend. Since I am not in Pa, or even the country at the moment, hope I have the right emails? Sorry for the delay, I believe I am still within my timeframe for comments. Thanks in advance and hope they are helpful!

Could someone either direct this to Mike Hall or give me the correct email?

Gail Inderwies, RN,BSN,MBA
Keystone Hospice

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September 15, 2008

Gail Weidman
Office of Long-Term Care Living
Bureau of Policy and Strategic Planning
P. O. Box 2675
Harrisburg, PA 17105

Arthur Coccodrilli, Chair
Independent Regulatory Review Commission
333 Market St, 14th Floor
Harrisburg, PA 17101

RE: Draft regulations by the Department of Public Welfare, providing for the licensure of Assisted Living Residences - # 14-514.

Dear Ms. Weidman:

Keystone Hospice provides care in many assisted living facilities and personal care homes in the Southeastern Pennsylvania region. In addition, we have for 11 years provided residential care for hospice patients in Keystone House which is a licensed personal care home facility in Wyndmoor, Pennsylvania. On behalf of our staff and those individuals we serve in these facilities we applaud you others in the Department of Public Welfare for taking a leap of faith to develop regulations that will help advance the development of a more flexible model of care along the continuum for long term living. In light of this I would like to raise some concerns that I feel may impede you from accomplishing your goal of choice and "Aging in Place." Thank you for your time and consideration in advance.

§2800.11 – Procedural requirements for licensure or approval of ALR. The proposed bed fee is cost prohibitive to many providers, especially to those residences that are smaller, and in remote rural areas. I would suggest a fee structure that takes in account the size of a residence, whether it is a single or multiple and service area. This would be somewhat more progressive as compared to a regressive fee structure that penalized smaller less wealthy residences who took in a lower income population.

§ 2800.41 - Notification of rights and Complaint Procedures. Should include a provision for visitation when the client is under hospice; or dying, as it relates to a terminal condition, with a DNR status.

§ 2800.53 – Qualifications and responsibilities of administrators. Qualifications are inconsistent with credentialing criteria given the various levels of training. You go from an RN to 2 years of college and finally an LPN with an expectation that all provide direct personal care services or supervise or direct the work to provide personal care services. Under current nurse practice laws for this state the LPN must be supervised by an RN or Physician.

§ 2800.56 – Administrator staffing. Expecting an administrator to be available 40 hours per week regardless of circumstances is rather unrealistic and does not include time off for training, holidays and possible meetings. To further expect that a designee has the same training is equally prohibitive. If your intention is to assure quality on sight supervision, then having a person overworked or underpaid, especially if it is a small facility is not the right answer. Pennsylvania has borders on the East and West with everything else in between. If your purpose as defined in §2800.1. Is to: (a) Protect the health, safety and well-being of assisted living residents; and (b) allow individuals to age in place. Then this restriction will be cost prohibitive in the more rural sectors of Pennsylvania and create excessive financial burdens which could undermine the original intent of aging in place. Reducing the number of smaller more home like residences is counter intuitive to the states mission of aging in place in a least restrictive environment.

§ 2800.60 – Additional Staffing based on needs of the residents. This is too vague and should have some level of FTE's based on acuity. In 2800.53 you allow for the administrator to be an LPN who could in turn be the direct supervisor of an RN, who ultimately will need to supervise the LPN in development of the support plan. This is insane at best.

§2800.65 – Direct care staff person training and orientation. As I commend the state for including dementia as part of its annual core curriculum and initial training. It should be an expectation for all core curriculum as well as hospice and palliative care for an aging population. I further recommend that the annual requirements should be 12 hours consistent with department of health requirements for home health aide. This would allow for consistency throughout the continuum of care.

§2800.101 – Resident living units. The states requirement of 250 square feet for new construction and 175 square feet for pre-existing is at best cost prohibitive, especially in light of reimbursement. Spatial requirements are also twice the norm of other states with similar regulations. Kitchen capacity although a nice plus; is not necessary and can be accommodated through a common kitchen space for residents to use. Again the concern here is the smaller facilities throughout Pennsylvania and the realistic application of these regulations.

§2800.108 – Firearms and weapons. I would like to ask if you guys are just kidding or if this is in actuality an oversight. Given the current loss of lives in Pennsylvania due to firearms, I wonder how this regulation is even acceptable. Since I did not notice the NRA on this committee I feel that this regulation sets a very bad precedent and poses a huge safety risk. That being said, I have nothing more to comment other than it needs to be stricken.

§2800.130 - Smoke detectors. All residences should have smoke detectors on each floor with signaling device for hearing impaired and hard wired to fire department 24 hours per day monitoring regardless of census. If the goal is to age in place individuals with mobility needs should have these assurances, including an active and working sprinkler system. Buildings that have a *fully operational sprinkler system* have never had a death related to fire that spread from its primary source. Standards should be the same regardless the size to protect those with mobility needs.

§ 2800.142 – Assistance with health care and supplemental healthcare services. Assisted Living residents and those who would consider entering an assisted living residence (ALR) want autonomy, and freedom to self direct care. Even in nursing homes clients are to be given the right to choose their provider of choice. This includes physician, providers of hospice services, home health, etc... Currently we have seen how healthcare has not benefitted from large complex health systems and closed healthcare systems that have few checks and balances from outside sources.

§2800.183 – Transfer and discharge. (h)(3) Although I believe the intent is to safeguard the resident at no time can the state or its delegates direct a facility to take on risk that it may have discomfort with. If a client's care is beyond the scope of the facility then it should be within the facilities right to transfer to a more appropriate setting in a timely manner. This regulation does not take in account weekends and holidays, or quite frankly urgency of such situations.

§ 2800.225 – Initial and annual assessment. This is somewhat of a concern because of the 15 day limitation on performing an initial assessment. In this case the resident could be in a facility up to 15 days without knowing whether or not said facility was able to meet their needs, or receive a possible waiver of exclusion if exclusionary factors. Recommend an evaluation on admission, and expedited waiver system for exclusionary criteria. Moving into a facility is traumatic enough for many who may be leaving their homes, going through several transitions for the convenience of the facility or the state is not acceptable. In addition, delay in initial assessment s could place both the client and facility at potential risk if there was a condition or situation unknown.

Areas of additional concern:

Although it is the intent to give freedom of choice with self-determination for all who enroll in an assisted living program, it is important to note that the liability of a residence should never be waived over the rights of a single individual. There needs to be provisions that provide protections for the residence in the case where judgment is at best impaired and poses a potential injury or harm to the residence or its other clients. That includes financial, environmental and regulatory risk.

Currently Department of Welfare staff performs the regulatory review process on assisted living facilities. I would strongly suggest that either the Department of Health performs this survey function, or Department of Welfare adopts a nurse driven review process for assisted living facilities. Having non-nursing personnel perform this review process completely diminishes the survey capacity of the staff in

regards to oversight of the medical and ADL needs of this more dependant population. Nurses have the basic training to make a fair and adequate assessment of the potential exclusionary factors. Support plan should be completed within 72 hours of admission, not 15 or 30 days. Changes in condition should be reflected within 48 hours or less depending on the severity and nature of the condition. These few modifications can help improve conditions and protections for a client.

Finally, I believe that it would be within the best interest of all to develop two levels of care for assisted living, with reimbursement tied to the acuity and performance of each. In conjunction with this, the state needs to develop a quality assurance performance improvement program that ties in reimbursement to quality, taking into consideration diversity and income capacity of its residents and the geographical location and size. Taking into account the number of type I and II incidences within a given year and following up the plan of correction over the course of several years. This is especially important when there is a history of falls. Bedsores, incidents or communicable diseases or infestations as an example. Too often due to decreased census will envelops be pushed. This should be monitored somehow to make sure it is the client pushing the envelope out of choice versus the residence to maintain equitable market share.

I thank you for your openness. Feel free to contact me with any additional questions or concerns. I hope that you will reconsider some of the choices put forward, and understanding the fine balance between freedom of choice and the need for some regulatory protections for the common good.

Respectfully,

Gail A. Inderwies, RN, BSN, MBA
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