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From: Nick Luciano [Nick@panpha.org]
Sent: Monday, September 15, 2008 2:50 PM
To: IRRC; Weidman-Jones, Gail; johhall@state.pa.us
Cc: Russ McDaid
Subject: PANPHA Comments on Regulation ID # 14-514 (#2712)
Attachments: PANPHA AL Comments (August 9 Publication)FINAL.doc

Attached to this email are PANPHA's Comments on the Proposed Assisted Living Regulations published on August 9, 2008 ID # 14-514 (#2712)

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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

RE: Regulation ID #14-514 (#2712)

Dear Ms. Weidman:

PANPHA, an association of more than 360 non-profit senior services providers, is submitting these comments on the Regulation # 14-514 as published in the Saturday, August 9, 2008 edition of the Pennsylvania Bulletin. As a designated member of the Department's working group on these regulations, it was our pleasure to participate in all meetings of the working group, which was convened by the Department of Public Welfare to provide input on the content of the proposed Assisted Living Regulations. As a member of the Workgroup, and as a stakeholder in the regulated community, PANPHA has significant reservations about this regulatory package as proposed, and does not believe that the proposed regulations for Assisted Living Residences advance the public interest. The **public policy directions, financial costs, and the reasonableness of implementation of certain provisions of the proposed regulations give us serious cause for concern. If these regulations are promulgated as proposed, they will have a significant impact on access to assisted living services across the Commonwealth. In certain geographic regions that are not economically robust, there is a strong likelihood that these regulations will result in little or no access to newly licensed assisted living facilities.**

The proposed regulations would impose significant new costs on homes and residents which in most cases would not improve the health or safety of the residents. They would instead focus on the construction of physical plant amenities that have little to no bearing on the care delivered to the resident, and which are likely to make the assisted living level of care too costly for many Pennsylvanians to afford. To pay for these requirements, homes must either increase costs to the resident, reduce care and services, or allow the costs to impact the viability of the provider. PANPHA members already provide significant subsidies so that they can continue to provide the care and services residents need. Further burdening providers with deeper revenue shortfalls jeopardizes the availability of a level of care that is already a predominantly private pay phenomenon.

While Medicaid waiver funding is referenced in the Act, the Department has yet to publicly state the level of reimbursement they intend to provide under a Medicaid waiver or the number of consumers they intend to cover. Given the significant cost increases that these regulations would initiate, they would not only fail to address the severe insufficiency of the public payment source for low-income Pennsylvanians who need the care provided by an Assisted Living Residence, they could potentially magnify it. It is PANPHA's belief that the legislature's intent in passing the Assisted Living Licensure Act was not only to define the term "Assisted Living" and gain a sense of "truth in advertising," but also to ensure access to assisted living services to Pennsylvania's seniors. The economic ramifications of the proposed regulations are counter to that effort, and must be thoughtfully examined.

Below is the list of PANPHA's most significant concerns with the proposed regulations:

1. **Licensure Fees**: The proposed licensure fee structure is a severe change in policy from the system that has been used by personal care homes, and would cause significant burden on the provider. A $500.00 licensure fee, with a $105.00 assessment per bed would result in a 100 bed residence paying a licensure fee of $11,000.00. This would make Pennsylvania possibly the most expensive in the nation. Pennsylvania would be more than twice as expensive as Florida (with a licensure fee of $5,935.00 for a 100 bed residence), and would be five times the cost of licensure in Illinois, Ohio, Texas, and Virginia combined (Illinois being the most expensive of that group at $800.00 for a 100 bed residence). Quality assurance through licensure is a core function of government. These fees, which essentially aim to recoup the costs of regulating Assisted Living Facilities in the Commonwealth are unacceptable as drafted, and will take vital dollars away from resident care.

2. **Bundling of Core Services**: Language in Section 25(c) and Section 220, regarding the fee schedule of services that will be available to an individual, is vague and open to interpretation. It is open to interpretation as to whether a fee schedule for services, and the accompanying charges for these services to the resident, is permissible. The issue is whether the residence has the option to bundle or unbundled charges for core services. Further explanation of these sections must be forthcoming We strongly urge that the regulations require a package of core services, but that the residence have the flexibility of the option of bundling or charging separately for services as long as the pricing structure is clear to consumers. This gives the consumer the right to then make their own choices.

   What does appear to be clear is that Transportation does not have to be provided by the residence. Rather, the residence is permitted to play the role of a coordinator for the individual, and may charge for that service. However, should the residence opt to provide transportation, the draft regulations require that each vehicle must be handicapped accessible. This is untenable. The residence should be required to have handicapped accessible vehicles available, but certainly not all vehicles need to meet that requirement. That would simply ensure that the vast majority of facilities will not provide their own transportation.

3. **Administrator Requirements**: A number of concerns arise regarding the treatment of Administrators by the draft regulations. First, the requirement that a designee be present at all times the named administrator is not present, and that the designee must also possess the qualifications of a fully credentialed administrator themselves. The drafting of this provision would imply that an individual, who possesses the qualifications of an administrator, be present on the property at all times, 24 hours per day and 7 days per week. This cannot be the intended position of the Department. It is reasonable to expect a residence to have a temporary qualified administrator serve in lieu of the permanent administrator during extended leave or planned vacation. However, if an administrator is on the premises to fulfill the weekly hourly requirement, that should suffice; no additional administrator is required.

   The number of on-site hours also gives us reason for concern. Requiring that an administrator be present at least 40 hours per week is doubling the current mandate of 20 hours currently in the personal care home regulations. An increase of this magnitude seems excessive and burdensome, especially in light of the number of continuing education credits an administrator is being asked to accumulate throughout the year, requiring additional time away from the residence. It also ensures that an individual cannot serve as an administrator at both a Personal Care Home and an Assisted Living Residence. Given that the two care settings are permitted to be under the same roof, and one building is permitted to be licensed as both, and given that the regulations so closely mirror each other, it would seem that the same individual could serve as administrator for both.

4. **Physical Plant Requirements**: The proposed square footage requirements of 175 per living unit for existing facilities and 250 per living unit for newly constructed facilities are excessive and will place Pennsylvania providers at a competitive disadvantage if implemented at these levels. The higher the square footage of the living unit, the higher the cost profile to the provider, and by extension the higher the cost to the consumer. Having a square footage minimum that is within the top 10% nationally does not enhance the level of care or intrinsically heighten the dignity of the resident occupying the room. That is accomplished through the delivery of quality care. **What it does ensure is that low-income individuals will not be able to buy their way into an Assisted Living residence in vast expanses of the Commonwealth.**

   The square footage minimum of 125 for existing facilities and 150 for newly constructed facilities, which providers have suggested, provides an appropriate regulatory floor that ensures a dignified quality of life for residents, is within the mainstream nationally, and does not close the market on significant portions of Pennsylvania's geography. Market forces will result in many providers offering rooms well beyond the 125 or 150 square foot minimum. We believe it is critical to the viability of Assisted Living here in Pennsylvania that consumers drive the market, with both their feet and their dollars, rather than the Department doing so via

square footage requirements that will leave large segments of the Commonwealth without Assisted Living as a viable option.

Along with the minimum square footage requirement, is the necessity for all newly constructed facilities to equip living units with a kitchen that possesses a sink with hot and cold running water. The costs associated with equipping each living unit with plumbing for the kitchen will not be insignificant. This is an amenity many will not request or use, as three full meals will be provided by the residence. However, the provision of a "country kitchen," or a small congregate style kitchen area will adequately meet the needs of residents. Again, many providers will opt to equip all living units with a kitchen sink of some type, but the market should decide whether that is a necessity for **Assisted Living.**

5. **Supervision by RN in Assessment and Support Plan Development: An RN is not a clinical necessity in the completion of an Assessment or in t**he development of a Support Plan. This is a mandate that simply increases the cost profile of delivering care. A provision that mandates that an RN review Assessments and Support Plans for accuracy may be reasonable, but to require direct supervision during the completion is not warranted.

6. **Discharge of Residents**: The residence must be permitted to maintain control over the transfer and discharge of its residents as is called for in Act 56 of 2007. The draft regulatory package curtails the provider's autonomy as called for in the Act, , and inserts the Long-Term Care Ombudsman into an active participant. While we recognize the need for the resident to be able to access the Ombudsman, we feel it is inappropriate for the Ombudsman to take an active role in negotiations or in the disposition of informed consent agreements or in discharge proceedings. Those activities should be negotiated between the resident and/or their designee and the residence as allowed for in the Act. The Ombudsman should provide a counseling role for the resident, not act as a legal advisor.

7. **Dual Licensure**: Act 56 of 2007 clearly and definitively addressed the issue of dual licensure. The legislature delineated in Section 1021(C) that dual licensure was permissible, even going so far as to outline how facilities with dual licensure were to be surveyed by the Department. The regulatory package as proposed is silent on the matter. There is no explanation of how a residence is to pursue a dual license. Will facilities be permitted to license a wing as Assisted Living under the same roof as a Skilled Nursing Facility or a Personal Care Home? Will facilities have the flexibility to designate individual rooms or suites of rooms as Personal Care within an Assisted Living Residence. These are questions that are left unanswered, and must be addressed.

   PANPHA strongly suggests that facilities and providers be afforded the greatest flexibility possible in order to meet the needs of their residents. Accordingly PANPHA recommends that the regulations permit providers to licensure their facilities by door. This flexibility will allow facilities that have suites or pockets of

rooms that will not meet all of the physical plant requirements for assisted living units to license those as Personal Care rooms. There will be no additional strain on the state beyond coordination of the survey dates. The statute notes that when a dually licensed residence is to be surveyed that the Personal Care portion of the residence will be surveyed by Personal Care Home Surveyors, and that the Assisted Living units will be surveyed by Assisted Living Residence Surveyors. The bulk of the responsibility will be with the provider, to coordinate scheduling, to track services and staff, and to comply with the differentiation of the regulations. Allow the provider to assume that responsibility, if they so choose.

8. **Proposed Regulations Ignore Key Provisions of Act 56 of 2007**: The Department's proposed regulations at several points either exceed the authority granted by Act 56 of 2007 or are contrary to the statute. Those areas include:
    a. **TRANSFER AND DISCHARGE.** The proposed regulations exceed the statutory framework with regards to transfer and discharge. Act 56 clearly notes that the residence, through its medical staff and administration, will determine what services it is comfortable having provided on its campus, and when it feels the needs of the resident can no longer be served at that level may initiate a transfer in Section 1057.3(f) and Section 1057.3(h). The regulations at 228(b)(2) counter the statutory framework when it mandates that the "residence may not transfer or discharge a resident if the resident or his designated person arranges for the needed services."

    b. **USE OF OUTSIDE PROVIDERS.** Supplemental health care service provision is another area in which the regulations deviate from what the legislature intended. The legislation states that the provider "may require residents to use providers of supplemental health care services designated by the assisted living residence," so long as it is stated in the contract. Section 1057.3(a)(12). The regulations in Section 142(a) scale back the clearly articulated right of providers to designate preferred providers in contradiction to the statute.

    c. **DUAL LICENSURE.** As noted above, the legislation was clear in articulating that a residence may pursue and hold licenses as both a Personal Care Home and an Assisted Living Residence, yet the Department did not address it at all in the proposed regulations.

    d. **KITCHEN CAPACITY**. Another item on which the regulations over-reach, and are contrary to the statute, relates to Kitchen capacity. The legislation states that the living units shall have "kitchen capacity," which "may mean electrical outlets to have small appliances such as a microwave and refrigerator." There is no mandate in the statute that the residence provide anything more than space and electrical outlets to support kitchen appliances. The regulations go well beyond this definition. The Department proposes not electrical outlets to support microwaves and refrigerators, but the actual provision of microwaves and

refrigerators. In addition, the proposed regulations mandate that newly constructed facilities include a sink with hot and cold water. The appliances and sinks are amenities that should be market driven, not called for in a regulation. Consumers will vote with their feet and dollars. If a provider required to provide these amenities, they will naturally have to charge their residents to recover the cost. This means the resident will bear the burden of the cost whether it is an item they want or not. Regulations should establish minimum requirements and allow the greatest flexibility for consumers and providers.

9. **Informed Consent:** The regulatory language proposed by the Department distorts the legislative language outlined in the statute, which was developed after lengthy and thoughtful discussions. The proposed regulation, as pertaining to liability, imposes the extreme pre-condition on a residence of having to determine that residents or staff are at "imminent risk of substantial harm" before it may initiate actions to address a "dangerous" situation caused by a resident. This standard, which is similar to that necessary for involuntary committal for mental health treatment, is simply unreasonable from a personal security safety perspective and liability perspective. Such a standard is assuredly inappropriate in the context of a residence's having to react promptly and effectively to a "dangerous" situation caused by a resident. Our proposed revision provides the residence, which is ultimately responsible and potentially liable for actions occurring in the residence, the operational flexibility to address the presenting problem.

   The proposed revision also reflects the statutory intent of the legislation as it relates to releasing the residence, "from liability for adverse outcomes resulting from actions consistent with the terms of the informed consent agreement". The language in Act 56 on this matter could not be more clear, and we fear that the proposed regulation is an attempt to dilute the clear intent of the legislature. The changes in the proposed revision not pertaining to liability serve to balance the rights of the residents, the residence and the residence's obligations to its other residents. The proposed revisions support the belief that resident input is necessary and appropriate in this process, but any final clinical judgment, pertaining to the informed consent agreement, must be in the hands of the professional.

THE FOLLOWING ARE PANPHA'S DETAILED COMMENTS ON THE PROPOSED ASSISTED LIVING REGULATIONS.

2800.3(b): The proposed regulations give the Department very broad authority to survey Assisted Living Residences. The language permits the Department to survey a residence at any time, without and standard for justification, and as frequently as it wishes. No other long-term care provider is subject to such a standard. PANPHA proposes that the regulations require annual surveys, with additional inspections when evidence of reliable complaint.

Suggested Language
3(b) Additional announced or unannounced inspections may be conducted by the Department upon receipt of reliable information suggesting the existence of harmful conditions at the residence.

2800.4 Definitions
Exemplary Compliance: This provision is designed to allow the Department to focus its resources on consistently poorly performing providers. However, it is important to note that not all deficiencies relate to poor quality of care. Accordingly, when defining "Exemplary Compliance" perfect compliance for an arbitrary number of years should not be the standard. Rather, the regulations should allow abbreviated inspections for facilities that are free of deficiencies that substantively and directly impact upon the health and welfare of the resident.

Suggested Language
Exemplary Compliance- **Two** ~~three~~ consecutive years of ~~deficiency-free~~ inspections **which are free of deficiencies that substantively and directly impact upon the health and welfare of the resident**.

2800.11(c): The licensure fees proposed in this section represent an extraordinary increase over current fees, and are out of step with licensure fees nationwide. Currently, Assisted Living Residences are licensed as Personal Care Homes. Personal Care Homes have a tiered licensure whereby a residence with 20 beds or less pay $15.00, a 21-50 bed residence pays $20.00, a 51-100 bed residence pays $30.00, and a residence with over 100 beds pays $50.00. Under the proposed regulations, a 100 bed residence will pay a flat licensure fee of $500.00, with an additional bed assessment of $10,500, for a total licensure fee of $11,000.00.

While the previous licensure fee may have been inadequate, the proposed licensure fee is excessive. The excessive nature of the fees is demonstrated when comparing the proposed licensure fee to those of other states. (See Attachment A) Pennsylvania would be, possibly, the most expensive state in the nation to gain a license. Pennsylvania would be more than twice as expensive as Florida (with a licensure fee of $5,935.00 for a 100 bed residence); and would be five times the cost of licensure in Illinois, Ohio, Texas, and Virginia **COMBINED**. Quality assurance through licensure is a core function of government. The proposed fees would unquestionably put Pennsylvania at a competitive disadvantage. These fees, which essentially aim to recoup the costs of regulating Assisted Living Facilities in the Commonwealth, will siphon needed dollars away from resident care. This section is unacceptable as drafted.

Suggested Language:
(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 $500.00 license application or renewal fee.

(2) A ~~$105.00~~ **$10.00** per bed fee that may be adjusted by the Department ~~annually at a rate not to exceed the consumer price index~~ **proportionately to increases in Medical Assistance reimbursement for Assisted Living services**. The Department shall publish a notice in the Pennsylvania Bulletin when the per bed fee is increased.

(3) No Assisted Living Residence shall be required to pay more than $1000.00 when aggregating the $500.00 license application or renewal fee in paragraph (1) and the per bed fee in paragraph (2).

2800.14: Fire safety approval should be periodically reviewed. However, PANPHA deems that the 3 year period established in the proposed language is sufficient, on its own, to prompt providers to examine their fire safety provisions. Permitting the Department to request more frequent review at its discretion is not only unnecessary, but also susceptible to inconsistent and arbitrary application.

Suggested Language

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

2800.16(a)(3): The provision as proposed is taken from the 2600 Personal Care Home regulations, but adds the requirement that illnesses requiring treatment at a hospital or medical facility also be reportable. PANPHA does not believe that the addition of illness to reportable incidents is necessary. Residents in Assisted Living Residences will be old, frail individuals who will be susceptible to illness. Often times, these individuals will be receiving care intermittently in Assisted Living and Nursing Homes. Mandating a report for each time a resident changes level of care for what will commonly be routine illness, is not necessary. PANPHA endorses the reporting requirements currently found in the 2600 Personal Care Home Regulations

Suggested Language

16(a)(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.

2800.16(a)(20): The language as proposed is vague and undefined. Providers have very little guidance as to how to determine when staffing levels are inadequate and subject to reporting. PANPHA suggests that language be added indicating that the standard is failure to adequately provide care to the residents as indicated in support plans.

Suggested Language

16(a)(20) An absence of staff ~~or inadequate~~ staff **such that residents receive inadequate care as defined by the respective resident support plans** ~~to supervise residents~~.

2800.19(a): PANPHA endorses the criteria and guidelines listed under subsection (a). However, PANPHA advocates that if a waiver application demonstrates compliance with

those guidelines that the Department should be obligated to issue a waiver to the residence, rather than being able to exercise its discretion.

> ***Suggested Language***
> 19(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~~ **shall** grant a waiver of a specific requirement of this chapter if the following conditions are met:

2800.19(e): The Department should be required to provide notice to a residence applying for a waiver under this subsection within 30 days of receipt of application. Having an unspecified timeframe for response places the provider in an unnecessarily precarious situation. The Assisted Living Residence should also be provided with grounds to appeal denials of applications consistent with the appeal guidelines provided for in this regulatory framework.

> ***Suggested Language***
> 19(e) **The Secretary, or the Secretary's appointee, shall approve or deny the waiver request within 30 days of receipt of the request. A residence may appeal the denial of a waiver request consistent with Section 2800.12. (Appeals).** The residence shall notify the affected resident and designated persona 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.

2800.19(f): The Department must have the ability to annually review waivers to ensure that providers are meeting their obligations with respect to any and all conditions set concerning a granted waiver. However, should the Department revoke a standing waiver, a provider should be granted the ability to appeal such a revocation in accordance with the appeals procedures outlined in this regulatory framework.

> ***Suggested Language***
> 19(f) 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 an Assisted Living Residence, that Residence may appeal the revocation consistent with Section 2800.12. (Appeals).**

2800.22(b): PANPHA is concerned that the required provision of written materials listed in 22(b) will become costly and burdensome. No one objects to sharing this information during the application process. However, it is not necessary to provide this material as "walk-away" material at this time in the process, as many potential residents will apply at multiple facilities. Providers should only be mandated to provide these materials to individuals who have demonstrated that they will be moving into the residence.

Suggested Language

22(b) ~~Upon application for residency and~~ Prior to admission to the residence, the licensee must provide each ~~potential~~ resident or ~~potential~~ resident's designated person with written disclosures that include:

2800.22(b)(3): PANPHA strongly believes that it is inappropriate for the Department to have the authority to approve or disapprove of an Assisted Living Residence's resident handbook. This provision exists nowhere else in the continuum of care, and should not exist here either. The presumption is that not only will the Department have to approve the initial release of the handbook, but also approve any alterations and amendments to the handbook. I fail to see how the Department will have the resources to allocate to the review and approval of all resident handbooks and all amendments to existing handbooks. Delays and backlogs are inevitable, and providers will be left to wait and watch as the Department tries to keep pace. This provision should be stricken.

Suggested Language

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

2800.25(b): PANPHA is concerned with the lack of equity in the allowance to terminate a residency contract. Automatic renewal of the residency contract on a month-to-month basis is an appropriate method of treating the relationship. However, there is no basis for allowing the resident to terminate the contract with 14 days notice to the provider, while binding the provider to 30 days notice of termination to the resident. The administrative responsibilities placed upon the residence in order to discharge a resident, whether at the provider's request or the resident, demands a 30 day timeframe. Moreover, the general principle in contract law is to all both parties 30 days notice to terminate a month-to-month contract. It seems reasonable to uphold that principle. Both parties should be held to the same notification requirements, and the appropriate time frame is 30 days.

Suggested Language

25(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 shall run month-to-month with automatic renewal unless terminated by the resident with ~~14~~ **30** days notice or by the residence with 30 days' notice in accordance with 2800.226 (relating to transfer and discharge).

2800.25(c)(v): Transportation should not be included in the core services in the residence-resident contract. This service should be charged separately, as some residents will require extensive use of transportation services, and others will rarely utilize it. This service should be broken out and charged separately.

Suggested Language

Delete this provision, and allow paragraph 171 to stand alone.

2800.25(e): The proposed regulation allows for the resident to rescind the contract for up to 72 hours after signing the contract. This is reasonable and appropriate. However, it also allows the resident to rescind the contract after having received the initial support plan. The submission of the initial support plan is not required by the proposed regulation for 30 days after admission. Allowing an individual to void a contract after this amount of time has elapsed both unprecedented and burdensome on the provider. Such a right does not exist in either Personal Care Homes or in Nursing Homes. A right of rescission after the receipt of the support plan is unnecessary given that the resident is provided with the unique opportunity to have input into their own care planning through informed consent.

> ***Suggested Language***
> 2800.25(e) 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.

2800.28(b): The language of this provision matches the language of .25(b), providing for only 14 days of notice of termination by the resident. As mentioned in the comment to .25(b), 14 days is an insufficient time allotment to process a discharge. PANPHA suggests 30 days notice of termination for both the Assisted Living Residence and the resident.

> ***Suggested Language***
> 28(b) After a resident gives notice of 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~~ **30** days, the resident owes the residence the charges for rent, personal care services and supplemental health care services, or both for the entire length of the ~~14-day~~ **30-day** time period for which payment has not been made.

2800. 30(a)(1): The standard of "imminent risk of substantial harm" is an inappropriately high threshold before a residence may initiate an informed consent process. No resident should be permitted to be placed in any risk of harm, regardless of imminence or whether the harm is substantial, due to the actions or behavior of another resident. The same is also true for the employees of a residence. No individual has the right to submit another to a risk of harm, and the threshold set by this language is untenable.

Moreover, the phrase "by the resident's wish to exercise independence in directing the manner in which they receive care" is overly limiting to situations that may necessitate an informed consent agreement. There maybe far more situations than instances where the resident is exercising independence in directing care.

> ***Suggested Language***

30(a)(1) When a licensee determines that 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 ~~by the resident's wish to exercise independence in directing the manner in which they receive care~~, the licensee may initiate an informed consent process…

2800.30(d)(1): For an informed consent to be meaningful, the resident must fully comprehend the choices and consequences. For this reason, the need for the residence to discuss those options "in a manner that the resident to understand" is vital. PANPHA would like to see this refined, however, to accommodate those with cognitive impairment. To discuss options in a manner that a resident with cognitive impairments can understand may be problematic. It is likely to lead to a frustrating experience for the residence. Since the legal representative of a resident with cognitive impairment is required to be involved in the process, in these instances it is more appropriate for the residence to discuss the informed consent in a manner that the legal representative can understand.

PANPHA also wants the remainder of the paragraph to match the suggested language for section 30(a)(1).

Suggested Language

30(d)(1) In a manner that the resident can understand**, or, in the case of an individual with cognitive impairment, in a manner the legal representative can understand**, the licensee must discuss the resident's wish to exercise independence in directing the manner in which he receives care. The discussion shall relate to the decision, behavior or action that places the resident or persons other than the resident in ~~imminent~~ risk of ~~substantial~~ harm and hazards inherent in the resident's action. The discussion shall 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 resident with a cognitive impairment, the resident's legal representative shall participate in the discussion.

2800.30(d)(2): PANPHA would like to add language 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. It is also necessary to provide for the contingency that the residence deems the resident unable to grasp the discussions of the negotiation. If the resident is unable to comprehend the discussions, the negotiation should be treated as unsuccessful.

Suggested Language

30(d)(2) 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 an policies of the provider.** The licensee 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 must further ascertain whether the resident is consenting to accept or mitigate the risk with full knowledge and forethought. **If the licensee determines that the resident does not understand and appreciate the nature of the discussion, the negotiation shall be treated as unsuccessful according to subsection (f).**

2800.30(f): PANPHA is concerned that the proposed language does not provide sufficient protection to providers who do not accept an informed consent agreement due to an unacceptable level of risk associated with the resident's desired alternative.

Suggested Language

30(f) If the parties do not agree, the licensee shall notify the resident, the resident's legal representative and all individuals engaged in the informed consent negotiation at the request of the resident. **The provider retains the right not to sign an informed consent agreement if it is determined by the provider that an unacceptable level of risk will be attendant to the resident's requested behavior or course of action. When the negotiation concludes unsuccessfully,** the residence shall include 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.

2800.30(g): PANPHA wants the language regarding the acceptable level of risk to be consistent with the suggested language for section 30(a)(1).

Suggested Language

30(g) 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 at ~~imminent~~ risk of ~~substantial~~ harm and, after a discussion of the risk, the resident declines alternatives to mitigate the risk.

2800.30(h): PANPHA wants the language regarding the acceptable level of risk to be consistent with the suggested language for section 30(a)(1).

Suggested Language

30(h) An informed consent agreement shall 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 at ~~imminent~~ risk of ~~substantial~~ harm. A licensee shall not require execution of an informed consent agreement as a standard condition of admission.

2800.30(i): PANPHA is concerned with the consistency of the proposed language of this subsection, and maintaining the ability of the resident to direct their own care. 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 Assisted Living Residence agrees. PANPHA also feels that the proposed language should mirror the language provided in the statute.

Suggested Language

30(i) Execution of an informed consent agreement shall **release the provider from liability 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 ~~beyond the scope of the agreement or~~ with respect to acts of negligence or tort. ~~An informed consent agreement shall not relieve a licensee of liability for violation of statutory or regulatory requirements promulgated under this chapter nor affect enforceability of regulatory provisions including those provisions governing admission or discharge or the permissible level of care in an assisted living residence.~~

2800.42(r): PANPHA believes that this paragraph contains a typographical error. PANPHA believes that the last word of the paragraph should be "resident" and not "residence."

Suggested Language

42(r) A resident has the right to receive visitors at any time provided that such visits do not adversely affect other residents. A residence may adopt reasonable policies and procedures related to visits and access. If the residence adopts such policies and procedures they shall be binding on the ~~residence~~ **resident**.

2800.42(y): The statute clearly delineated that the provider has the authority to ensure the quality of care and safety of the residents by prescribing a list of preferred providers of supplemental health care services. The language of the proposed regulation acknowledges that, and permits a resident to choose their own provider when a list of preferred providers is not indicated. PANPHA does not object to this, however, it is imperative that any outside supplemental health care provider be compelled to act in accordance with the residence's procedures and standard practices.

Suggested Language

42(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 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 Deral laws governing residents.

2800.53 and 2800.54: PANPHA is highly concerned about maintaining access to long-term care and with the current staffing shortages currently being experienced in long-term care generally. There is a difficult balance to be met between increasing the professionalism and qualifications of a certain field, and artificially limiting the pool of potential employees from which a provider can find staff. PANPHA is consistently pushing for greater educational opportunities and increasing the profile of workers in the long-term care sector; however, PANPHA does not want to preclude individuals who have served the field for years, and in some cases decades. PANPHA strenuously urges for a grandfather provision for sections 53 and 54. Regarding administrator provision, a grandfather clause that exempts individuals currently serving as Personal Care Home Administrators is appropriate considering the duties and obligations of Personal Care Home Administrators are nearly identical to those proposed for Assisted Living Administrators.

Suggested Language
53(i) The qualification requirements for administrator do not apply to individuals hired or promoted to the position of Personal Care Home Administrator prior to _____ (effective date of the regulations).

54 (e) The qualification requirements for direct care staff persons do not apply to individuals hired or promoted to the specified position prior to _____ (effective date of the regulations).

2800.56: The Department's proposed standard of 40 hours per week in paragraph (a) will make it virtually impossible for administrators to meet the proposed continuing education requirements and other off-site obligations as may be necessary to ensure the residents receive quality care and programming. The current standard for Personal Care Homes is 20 hours or more per week in each calendar month, and PANPHA contends this is an appropriate standard.

The Department's proposed paragraph (b), in which it mandates that an individual with the "same training required for an administrator" be designated to substitute for the administrator when the administrator is absent is cost prohibitive and unnecessary. The language as proposed would mandate that a residence have 2 qualified administrators on the payroll. Administrators are currently in short supply, and finding a second administrator for each residence, with the second being relegated to a "substitute" position, is neither feasible nor practicable. The individual serving as the stand-in administrator will also demand equal pay as the primary administrator since that individual will hold equal qualifications and background, and this will be crippling.

Suggested Language

56(a) The administrator shall be present in the residence an average of ~~40~~ **20** hours per week in each calendar month. ~~At least 30 hours per month shall be during normal business hours.~~

56(b) The administrator shall designate a staff person to supervise the residence in the administrator's absence. ~~The designee shall have the same training required for an administrator.~~

2800.60(d) and 2800.60(e): The Department's proposed language for paragraphs (d) and (e) represent an unnecessary administrative cost and burden on the provider. These positions are already provided for in 2800.60(a) where it states "staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan." If the needs of the residents of a residence necessitate having an RN on staff or on contract at all times, or if it is necessary for the residence to have a dietician on staff, the residence is obligated to accommodate those needs. However, there is no need to mandate the residence to assume that cost if it is not necessary. The Department should acknowledge that the needs of the residents should be set the standard for staffing, and the regulations should provide for that.

Suggested Language

60(d) and 60(e) should be deleted in their entirety.

2800.64(a)(2) and 2800.64(b)(10): The 100 hour administrator training course that all Assisted Living Administrators will be expected to have passed, should encompass all material that an Assisted Living Administrator should be expected to study during the first year on the job. Additional education requirements in excess of the 100 hour training course should not be expected or mandated. PANPHA requests that the education requirement of 4 additional hours of dementia-specific training within 30 days of hire be enveloped into the 100 hour training course. PANPHA suggests that dementia-care education content be combined with paragraph 64(b)(10), as it is with the Personal Care Home Administrator training program.

PANPHA also suggests that the informed consent provisions be explicitly included in the listing of items to be covered in the 100 hour course. Informed consent is a brand new concept in Pennsylvania. It is one of the most impactful steps toward culture change in healthcare in that it allows the resident to have a greater say in how they receive care. PANPHA therefore calls for its inclusion in the 100 hour course.

Suggested Language

64(a)(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.~~

64(b)(10) Care for residents with **dementia, cognitive impairments and,** special needs.

64(b)(18) The requirements of this chapter**, including the informed consent process**.

2800.64(d): The Department must accept credits from courses that are produced by National Association of Boards of Examiners of Long Term Care Administrators (NAB) and National Continuing Education Review Services (NCERS). Many administrators and staff attend conferences and symposia that are produced for larger groups. These educational opportunities will be sanctioned and accredited by the NAB or the NCERS. These courses must be accepted as valid CEU opportunities by the Department. The Department should also recognize classes that are sanctioned by the Bureau of Professional and Occupational Affairs and Department of State.

Suggested Language

64(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**, or courses approved for credit by NCERS/NAB or the Bureau of Professional and Occupational affairs in the Department of State**.

2800.64: The proposed language does not provide an exception for a Nursing Home Administrator with a valid license from substituting credits to keep their Nursing Home Administrator license current. Nursing Homes are the most skilled level of long-term care, and individuals who have attained this level of license should have their license and credits be applied to an Assisted Living Residence. PANPHA recommends that a paragraph be added to allow for such an exception.

PANPHA also has concerns that access to Assisted Living will not be possible at the outset because the regulations require that facilities have administrators who have completed the 100 hour training course, and passed the competency test prior to commencing operations. Since no individual in the Commonwealth is qualified until the course and the test have been completed and passed, it will be a period of months before Assisted Living can exist as a care setting. Of course that is assuming that the Department is prepared Day 1 with a curriculum and test. PANPHA recommends 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. In addition, we would recommend that any individual working as a Personal Care Home Administrator prior to the effective date of the regulations be exempted from the 100 hour course, and simply be required to pass the competency test. This will ensure that there is no significant void between the effective date of the regulations and the existence of Assisted Living.

Suggested Language

64(g) A licensed nursing home administrator who is employed as an administrator of a personal care home or nursing home prior to _____ (effective date of the regulations), is exempt from training and education requirements of this chapter if the administrator continues to

meet the requirements of the Department of State. A licensed nursing home administrator hired as an administrator of an Assisted Living Residence after (effective date of regulations) shall complete and pass the Department-approved assisted living residence administrator competency-based training test.

64(h) A certified personal care home administrator who is employed as an administrator of Personal Care Home prior to (effective date of the regulations), is exempt from the 100 hour training course, but shall pass a competency test to be developed by the Department. A certified Personal Care Home administrator hired as an administrator of an Assisted Living Residence after (effective date of regulations) shall complete and pass the Department

2800.65(e): The requirement that dementia care-centered education be in addition to the already mandated educational requirement removes staff from direct care duties, and can easily be included in the within the 12 hour yearly allotment. Dementia care education should be required, but not in addition to an already robust requirement. Direct care workers are being asked to obtain more CEU's than RN's if the dementia care education is in addition to the 12 yearly credits; that is unnecessary.

Suggested Language

Direct care staff persons shall have at least 12 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 hour annual training.~~

2800.69: Training on dementia and cognitive impairment issues is important when working with the elderly. It is for this reason that PANPHA strongly supports mandating that all administrators and direct care staff have 2 hours of annual dementia care-specific training per year included in their respective yearly CEU requirements. PANPHA also supports 4 hours of the direct care workers first yearly continuing education requirements be in dementia care areas.

Suggested Language

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~~ the first year of hire, and at least 2 hours of dementia-specific training annually thereafter ~~in addition to th training requirements of this chapter~~. **For direct care workers, these hours shall be incorporated into the 12 hour annual requirement of paragraph 65(e). For Assisted Living Administrators, these hours shall be incorporated into the 24 hour annual requirement of paragraph 64(c). Time spent on dementia care during the 100 hour administrator training course shall count toward the first year's 4 hour requirement.**

2800.83(b) and 2800.83(c): It is important for an Assisted Living Residence to regulate the temperature within the residence. However, it is not necessary for a residence to have central air conditioning to moderate the temperature. Window air conditioning units are sufficient to provide the comfort residents of a residence require. Window units have not be proven unsafe and unfit for congregate living facilities, and accordingly are an acceptable method to cool a residence.

Suggested Language

83(b) A residence ~~in existence prior to _____ (Ed. Note: effective dhibitive window aira conditioning is not feasible or is cost prte)~~ shall provide ~~central air conditioning~~ **window air conditioning units**. 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.

~~83(c) For new construction after _____ (Ed. Note: effective date), the residence shall provide central air conditioning.~~

2800.96: The inclusion of Automatic External Defibrillators (AED's) as a mandated device in every first aid kit will be a very costly provision. The average cost for an AED is approximately $2,300.00 (American Red Cross website). Many facilities opt to have a first aid kit for each floor, or each wing. This goes above and beyond the requirements. However, if the residence opts to have more than one first aid kit, this language would seem to require them to have an AED in all first aid kits. In addition, paragraph 171(b)(5) mandates that all vehicles owned by the residence possess a first aid kit with the same contents as stated in paragraph 96. Therefore, a residence with 3 floors and 2 vans would be asked to purchase 5 AED's. This will be very cost prohibitive. A residence should not be required to have more than one AED on its campus.

2800.98: PANPHA is concerned that the requirement to have two rooms available for indoor activities, as opposed to the one room that is currently required of Personal Care Homes, will be cost prohibitive and may prevent a number of facilities from pursuing an Assisted Living license without incurring construction/remodeling costs. This is especially true if one of those congregate rooms must be at least 15 square feet per living unit up to 750 square feet. These costs may be quite significant and may have a great impact on the accessibility of Assisted Living in Pennsylvania. An appropriate compromise would be to allow the dining room to function as the lounge area and count as one of the two wheelchair accessible rooms. Without this allowance accessibility will suffer.

Suggested Language

98(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 such use does not affect or disturb others. <u>One of these rooms may be the same space living space or lounge area as required in 98(b).</u>

98(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 shall accommodate all residents at one time. There must be at least 15 square feet per living unit for up to fifty living units. There must be a total of 750 square feet if there are more than 50 living units. These rooms or areas shall contain tables, chairs and lighting to accommodate the residents, their families and visitors. **The dining room may be counted as living space under this subsection.**

2800.101(b): The proposed square footage requirements of 175 per living unit for existing facilities and 250 per living unit for newly constructed facilities are simply unacceptable. The higher the square footage of the living unit, the higher the cost profile to the provider, and by extension the higher the cost to the consumer. Having a square footage minimum that is within the top 10% nationally does not enhance the level of care or intrinsically heighten the dignity of the resident occupying the room. (See Attachment B) That is accomplished through the delivery of quality care. **What it does ensure is that low-income individuals will not be able to buy their way into an Assisted Living residence in vast expanses of the Commonwealth.** A square footage minimum of 125 for existing facilities and 150 for newly constructed facilities provides an appropriate floor that ensures a dignified quality of life for residents, is within the mainstream nationally, and does not close the market on significant portions of Pennsylvania's geography. Many providers will offer rooms well beyond the 125 or 150 square foot minimum due to market realities where they are operating. Allowing the consumers to set the minimum, with both their feet and their dollars, is the most appropriate course to pursue.

Suggested Language

101(b)(1) For new construction of residences after _____ (Ed. Note: effective date), each living unit for a single resident must have at least ~~250~~ **150** 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~~ **60** square feet in the living unit.

101(b)(2) For residences in existence prior to _____ (Ed. Note: effective date), each living unit must have at least ~~175~~ **125** square feet measured wall to wall, excluding bathrooms and closet space. If two residents share a living unit, there must be an additional ~~80~~ **60** square feet in the living unit.

2800.101(d): Along with the minimum square footage requirement, the proposed regulations make it necessary for all newly constructed facilities to equip living units with a kitchen that possesses a sink with hot and cold running water. The costs associated with equipping each living unit with plumbing for the kitchen capable of delivering hot and cold running water will not be insignificant. These costs will probably not prevent facilities from building new Assisted Living Residences, but probably will prevent potential residents with less means from being able to afford the care package at

such a residence. The enabling legislation makes no mention of required or intended equipment relating to individual kitchens in unit and is in fact overreaching by requiring such. Act 56 specifically directs the Department to establish "minimum guidelines" (pg 6, line 21) and further clarifies in Section 1021(a)(2)(iv) "Kitchen capacity, which may mean electrical outlets to have small appliances". The market should be the ultimate arbiter as to which amenities a living unit should possess.

Suggested Language

~~101(d)(1) New Construction. For new construction of residences after _____ (Ed. Note: effective date), the kitchen capacity, at a minimum shall 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. 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.~~

101(d)~~(2) Existing facilities. Facilities that convert to residences after _____ (Ed. Note: effective date)~~ Assisted Living residences must meet the following requirements related to kitchen capacity:

(1) The residence shall ensure an area located within the individual living unit is equipped with electrical outlets that meet all code requirements sufficient for supporting the use of small appliances if the resident so chooses to obtain and use them.

~~(i) (1) The residence shall provide a small refrigerator in each living unit.~~
~~(ii) (2) The residence shall provide a microwave oven in each living unit.~~
~~(iii)~~ ~~(3)~~ (2)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 shall not include the kitchen used by the residence staff for the preparation of resident or employee meals, or the storage of goods.

2800.101(j)(1): PANPHA recommends that an exception to the fire retardant mattress requirement be allowed for individuals who wish to provide their own. Many elderly applicants wish to move their own personal mattress to the residence, as they have slept on the same mattress for a number of years. These mattresses are often of an older make and model, and would not be compliant with this section as proposed.

Suggested Language

101(j)(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**.

2800.102: The statute and the regulations mandate that each living unit in an Assisted Living Residence shall be equipped with its own private bathroom. This provision, along

with the minimum square foot requirement, represents the most crucial determinant as to whether a residence will pursue an Assisted Living license. Many current Personal Care Homes are not equipped with private bathrooms in each living unit, and to retrofit current structures to accommodate this requirement will be costly and time consuming. PANPHA recommends a five year delayed implementation of this requirement sufficient to allow facilities who wish to undergo the necessary renovations time to complete the construction.

2800.104(a): As mentioned in PANPHA's comment on 2800.98, with respect to recreation and lounge areas, the dining room must be permitted to serve the dual purpose of dining room and living and lounge space. Additionally, to keep the language consistent, PANPHA recommends changing the wording of this section from "15 square feet per person for residents scheduled for meals at any one time" to "15 square feet per living unit for up to fifty living units."

> ***Suggested Language***
> 104(a) An assisted living residence shall have an accessible common dining space outside of the resident living units. A dining room area shall be equipped with tables and chairs and able to accommodate the maximum number of residents scheduled for meals at any one time. There must be at least 15 square feet per ~~person for residents scheduled for meals at any one time~~ **living unit for up to fifty living units. There must be a total of 750 square feet if there are more than 50 living units. The dining room may be counted as living space under subsection 2800.98(b).**

2800.124: The requirement of notification to the local fire department of "the assistance needed to evacuate in an emergency" is a directly from the 2600 Personal Care Home regulations. This provision, while clearly written in regulation, as been interpreted in the Department's interpretive guidelines to demand an update to the fire department "when the evacuation assistance needs of the residents change." This essentially mandates that first responders must learn of each significant change in a resident's health condition. This is going beyond what is necessary. An annual update to the local fire department of the evacuation needs will suffice.

> ***Suggested Language***
> 124 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 residence shall provide annual notification to the local fire department of** the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

2800.131(a): PANPHA has strong concerns with the placement of a fire extinguisher in every living unit. Fire extinguishers are capable of causing harm when misused, and placing these devices in living units with elderly individuals who may have the onset of dementia, not to mention rooms within the special care units, will place these individuals at risk of harm. Additionally, even if the residents are aware of how to use a fire

extinguisher, placing a fire extinguisher in the room may embolden some residents to engage in heroic acts should an emergency arise. This could lead to tragic consequences.

This is especially true given that fire extinguishers have ratings noting specific purposes. An extinguisher that is rated 2-A is for ordinary solid combustibles that give off ash when burning. Any attempt to use this extinguisher on a fire of a different source, such as a grease fire, would serve only to spread the flame and exacerbate the danger. Firefighters and trained staff should be the only individuals attempting to extinguish a fire; that is not a role residents should attempt to undertake. For this reason PANPHA recommends that at least one fire extinguisher with a minimum 2-A rating be placed in public walkways every 3,000 square feet, excluding living units. This is consistent with National Fire Protection Act specifications.

> ***Suggested Language***
> 131(a) There shall be at least one operable fire extinguisher with a minimum 2-A rating ~~for each floor and living unit, including the basement and attic~~ **in public walkways and common areas every3,000 square feet,** including the basement and attic**, which is accessible to residence staff. There shall be no fire extinguishers placed in living units.**

2800.131(c): PANPHA reiterates its comments from 131(a), and stresses that fire extinguishers should not be placed inside a living unit.

> ***Suggested Language***
> 131(c) A fire extinguisher with a minimum 2A-10BC rating shall be located in each kitchen, ~~and~~ **excluding the kitchen areas inside** the living units. The kitchen extinguisher must meet the requirements for one floor as required in subsection (a).

2800.141(a): PANPHA strongly recommends that allowances be made for a medical evaluation post-admission. It is not always feasible and practicable, for instance during an emergency placement, for the residence to have an evaluation performed prior to the resident's admission to the residence. The current 2600 Personal Care Home regulations currently allow for a medical evaluation for up to 30 days after admission, and this provision has been working well. For this reason, PANPHA advises that the residence be allowed to perform the medical evaluation for up 30 after admission to the residence.

> ***Suggested Language***
> 141(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 **or within 30 days after admission**. The evaluation must include the following:

2800.142(a): PANPHA is concerned that the proposed language is inconsistent with the statute in that it limits the residence's ability to control what outside health providers are permitted to care for its resident's. The statute explicitly states that "to the extent

prominently disclosed in a written admission agreement, an assisted living residence may require residents to use providers of supplemental health care services designated by the Assisted Living Residence." (Section 1057.3(a)(12)) The language as proposed is counter to the statutory right of the residence to have a preferred list of supplemental health care providers. The intent of this legislative provision was to protect the residence from having to permit health care providers, with whom the residence was not comfortable with that particular provider's practices or reputation, from operating on the residence's premises. This right should not be diluted.

Suggested Language

142(a) 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 such approval shall 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.

2800.162(g): It is important that the resident's independence and choices regarding the amount and variety of food and drink is not overly infringed. It is recommended that the phrase this provision be limited to individuals whose support plan calls for prompting. This addition will provide some protection from residents feeling "harassed" by staff at meal times, and permit some exercise of independence.

Suggested Language

162(g) All appropriate cueing shall be used to encourage and remind residents to eat and drink**, if provided for in the resident's support plan**.

2800.171(a): PANPHA is concerned with the inclusion of social appointments in this provision. To mandate that the residence procure transportation to every social appointment that each resident makes will represent a serious administrative burden and divert allocation of resource away from care. There is also no limitation to the requirement. For example, a resident of a residence may want to attend the graduation of a grandchild from college in a distant location, perhaps out of state. The language as drafted would still demand that the residence bear the burden of providing or coordinating that trip. PANPHA recommends that the language be amended to include only social activities scheduled by the residence.

Suggested Language

171(a) A residence shall be required to provide or coordinate transportation to and from medical **appointments,** and social ~~appointment~~ **activities scheduled by the residence**.

2800.171(b)(5): PANPHA's comments to paragraph 96 noted our objection to the inclusion of an AED in the first aid kits for residence vehicles. Please reference those comments.

2800.171(d): It is important that residents who are confined to wheelchairs or other mobility devices have the same access to transportation as other residents of the Assisted Living Residence. However, mandating that every vehicle operated by the residence to be handicapped accessible is excessive and will be costly. As PANPHA believes the intent of this paragraph is to ensure access to transportation to handicapped individuals, we suggest the language be changed to reflect that requirement. Moreover, given that the residence is not mandated to provide transportation, only coordinate transportation, the suggested change will be consistent across all providers.

> ***Suggested Language***
> 171(d) ~~If a residence supplies its own vehicle for transporting residents to and from medical and social appointments, any vehicle used for this purpose shall be accessible to resident wheelchair users and any other assistive equipment the resident may need.~~ **The residence shall ensure adequate access to transportation, through either direct provision or coordination of transportation services, for residents utilizing wheelchairs and any other assistive equipment the resident may need.**

2800.202(4): PANPHA strongly endorses the intent of this section and believes that all residents should be free from restraints, but recommends clarification so as to avoid similar issues faced by the application of the 2600 regulations in Personal Care Homes. Often medications are prescribed on a *pro re nata* with the intent of alleviating anxiety for the resident. Documentation then is often construed by surveyors as application of a chemical restraint resulting in a violation where none exists. Clarification at this point is paramount.

> ***Suggested Language***
> 202(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. **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.**

2800.203(b): The Personal Care Home regulations in Chapter 2600 have proven to be adequate regarding the use of bed rails. The language as drafted could be construed as a restraint. PANPHA has wholly endorsed all measures to eradicate the use of restraints, and we believe that the language in the 2600 regulations is appropriate. We suggest that Paragraph 203(b) be deleted in its entirety.

2800.220(c)(7): As written the language suggests that the residence is responsible for providing escort services to and from *every* medical appointment that the residence coordinates. As the aging population remains more active and the decrease in the average age of the population living in congregant living continues to lower, many residents would like to exercise their right to medical privacy and attend medical appoints unaccompanied. The regulation should be amended to take into account resident rights in this instance.

Suggested Language

220(c)(7) Escort service **if professionally determined to be required and/or requested by the resident will be provided** to and from medical appointments. ~~if transportation is coordinated by the residence.~~

2800.224(b): In consideration of Federal statutes such as; Fair Housing **(Sec. 804.c [42 U.S.C. 3604])** and the Americans with Disabilities Act, the language as written potentiates liability and gives rise to federal code violation(s) for providers. A written basis of denial is in direct conflict with the stated statues, does not meet the standards for permissible discrimination and therefore cannot be required. PANPHA urges the Department to amend the language as follows.

Suggested Language

224(b) A potential resident whose needs cannot be met by the residence shall be ~~provided a written decision denying their admission and provide a basis for their denial. The potential resident~~ **informed of the decision and** shall then be referred to a local appropriate assessment agency.

2800.225(a): The proposed language for 225(a) is limiting in that an LPN is more than capable of completing an initial or annual assessment. Supervision by an RN is not required and is simply an unnecessary additional cost.

Suggested Language

225(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 a Licensed Practical nurse~~, under the supervision of a registered nurse,~~ may complete the initial assessment.

2800.226(c): In order to maintain a focus on resident care versus becoming purely administrative, and to clarify the Department's expectation of notification, the language should be amended as recommended below. This will save the Department from multiple daily notifications of mobility changes and allow residences to comply with the intent of the regulation in a more meaningful manner.

Suggested Language

226(c) The administrator **or 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**s who** develops mobility needs.

2800.227(b): A licensed practical nurse has the requisite knowledge and expertise to review and approve a support plan. Supervision by a Registered Nurse is not necessary, and simply represents an additional cost.

Suggested Language

227(b) The 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,~~ must review and approve the support plan.

2800.227(c): With the requirement of support plans to change as the resident's condition changes, it is excessive to require quarterly updates as well. The focus of implement meaningful resident services and care will be lost if resident care staff are required to complete more than semi-annual documentation updates. From a programmatic standpoint, the focus would become purely administrative resulting in a compromise of service.

Suggested Language

227(c) The 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 support plan on a ~~quarterly~~ **annual** basis and modify as necessary to meet the resident's needs.

2800.227(k): As a practical matter, PANPHA supports the addition of language that allows the resident and his designated person to choose whether they would like to receive a copy of the support plan.

Suggested Language

227(k) The residence shall **inform and** give a copy of the support plan to the resident and the resident's designated person **upon request**.

2800.228(a): PANPHA raises serious potential consequences with the existing language based upon direct provider experience dealing with transfer and discharge. As written, the requirement that the "facility *ensure* the transfer and discharge is appropriate to meet the resident's needs" runs afoul of resident rights. For example, a cognitively impaired resident wishing to be discharged home alone and without support services due to refusal, would clearly not permit the residence to meet the intent of this section. No alternative for compliance exists since the resident ultimately has the right to make poor decisions. Adult Protective Services may monitor the resident post-discharge, but will not take any action until harm occurs, and similarly, the residence cannot be expected to assume any type of guardianship to ensure safe choices on behalf of the resident with cognitive

impairment. The existing section must be stricken *in toto*. PANPHA supports the adoption of the following suggested language.

> ***Suggested Language***
> 228(a) **At the resident's request, in accordance with the notice requirements indicated in the resident's agreement, the residence shall provide assistance in relocating to the resident's own residence or to another residence that meets the needs of the resident to ensure a safe and orderly relocation. In the event that such assurances cannot be determined, the residence must show documentation that the resident was apprised of possible consequences, the designated person (if applicable) was made aware, and the local Office on Aging, Adult Protective Services was notified for follow-up post discharge.**

2800.228(b)(2): Reiterating PANPHA's objection to the previously noted section, the language as written severely limits the residence's ability to ensure protection of resident rights as related to their choice of where they call home. Additionally, few if any, providers will choose to become licensed as an Assisted Living Residence if made to assume the liability of having non-trained, non-professional family members attempting to provide care that the residence has already determined is beyond their trained, professional abilities. This section, as written raises many difficult questions which are not addressed in the language, such as; will resident and/or resident families be required to meet the training requirements outlined in previous sections, how will residences assure appropriate documentation, should a family member caregiver injury result – who would be liable? PANPHA's members readily make available to resident's under the 2600 regulations, additional supports and services as needed, in order to facilitate aging in place. The state should not force additional liability and potentially cause greater harm to resident's by requiring providers to allow residents to remain in their communities after a professional determination that the care requirements exceed their ability is made. PANPHA strongly insists that the entire paragraph simply be removed.

> ***Suggested Language***
> 228(b)(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 must 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 residence. This shall be stipulated in the resident-residence contract.~~

2800.229(c)(2): The Department should provide for minimum experience qualifications for medical personnel providing consultation on exception requests. This would ensure the outcome is based on sound medical practices and would serve the best interests of the resident.

Suggested Language
229(c)(2) The Department will review the exception request in consultation with a certified registered nurse practitioner or a physician with **at least five (5) years** experience caring for the elderly and disabled in long-term living settings.

2800.229(c)(3): In an effort to be responsive to the resident's need for an exception, the Department must realize that often family members who are unfamiliar with the long term care system, would be making decisions about placement in the event of an adverse determination for the exception. Five days as written would cause an undue burden upon the resident who is waiting to find out if they would be forced from their home.

Suggested Language
229(c)(3) The Department will respond to the exception request in writing within ~~5 business days~~ **48 hours** of receipt.

2800.229(c)(4): The providers must have confidence that the Department will act in the best interest of providing services for residents, and thus the resident directly if an exception is requested and the provider has met all of the statutory requirements as set forth by the subsequent 5 sections. PANPHA encourages the Department to adopt the following suggested language in order to strengthen support among residents and providers.

Suggested Language
229(c)(4) The Department ~~may~~ **shall** approve the exception request if the following conditions are met.

2800.231: The Department must take into account the population and the cognitive abilities of residents residing in special care units that this section addresses. PANPHA believes in the inalienable rights of these residents but also understands the significant challenges this section would impose on providers.

2800.231(a): While largely applicable, the final statement of this section causes PANPHA pause. The lack of meaning and intent of "other service options that may be available to a resident shall be considered" would directly inhibit the ability of a loved one who is attempting to provide care on their own to make the move directly to a secured, specialized unit without first considering a less restrictive environment such as a typical assisted living resident. Should a potential resident to a unit defined in this section suffer from wandering, a typical symptom of Alzheimer's disease, be made under this section to be placed in a non-specialized care residence first, the likelihood of a catastrophic outcome is high. While the section does seem to imply the ability to write into the support plan the need for secured placement, the final sentence allows the decision for placement into a secured, specialized unit to be called into question, or worse yet denied, due to a second contradictory opinion. Currently, under 2600 rules, a physician and the designated person can make the decision for secured placement when

the resident, suffering from cognitive impairment cannot. This option should be available under this rule.

Suggested Language

.231(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 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.~~

2800.231(e): Reiterating the issue of cognitive impairment, the requirement of a person with dementia to document their agreement to admission or transfer to a specialized unit is counter intuitive. Symptoms of cognitive impairment include inability to formulate ideas and have sound decision-making skills. A person with cognitive impairment is not able legally to enter into a binding contract and surely cannot be expected to fully understand an agreement to be cared for in a special care until. PANPHA urges the department to follow case precedent in legal matters and alter the wording of this section to better reflect the likely scenario of admission or transfer into a special care unit.

Suggested Language

231(e) Each resident record must have documentation that the resident **did not object** and the resident's designated person agreed to the resident's admission or transfer to the special care unit. **In the event that a resident is unable to indicate their acceptance, their physician must document such inability of sound judgment and order placement.**

2800.231(f): With the requirement of support plans to change as the resident's condition changes, coupled with the degenerative nature of dementia, it is excessive to require quarterly updates as well. The focus of implement meaningful resident services and care will be lost if resident care staff are required to complete more than semi-annual documentation updates. From a programmatic standpoint, the focus would become purely administrative resulting in a compromise of service.

Suggested Language

231(f) In addition to the requirements in §2800.225 (relating to initial and annual assessment), the resident shall also be assessed ~~quarterly~~ **semi-annually** for the continuing need for the special care unit.

2800.234(d): With the requirement of support plans to change as the resident's condition changes, it is excessive to require quarterly updates as well. The focus of implementing meaningful resident services and care will be lost if resident care staff are required to

complete documentation updates more frequently than necessary. From a programmatic standpoint, the focus would become purely administrative resulting in a compromise of service.

> ***Suggested Language***
> 234(d) The support plan shall be reviewed, and if necessary, revised at least ~~quarterly~~ **annually** and as the resident's condition changes.

2800.251(e): PANPHA supports the overall intent of this section but strongly recommends additional language to be inserted in order to clarify timelines for facilities to comply as well as clarify expectations for consumers.

> ***Suggested Language:***
> 251(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 **for inspection and review within a specified time frame** upon **written** request from the resident and/or designated person.

Conclusion

PANPHA would like to reiterate that we endorsed Act 56, which created the framework for a system of licensure and regulation that has the potential to provide consumers an important housing and services alternative along the continuum of long term living.

Unfortunately for potential consumers of assisted living, and despite the optimism created by Act 56, the proposed regulations that were published on August 9, 2008, will most likely prevent assisted living from becoming a robust industry in Pennsylvania and prevent access to care except for those individuals with substantial financial resources.

Respectfully submitted,

W. Russell McDaid

W. Russell McDaid
Vice President of Public Policy
PANPHA, *An Association of Non-Profit Senior Services*

Attachment A

A 100 Bed facility would pay the following in each state:

Arizona-- $1,350/yr

California-- $1,314/yr

Delaware-- $550/yr

Florida-- $5,935/yr

Illinois-- $800/yr

Indiana-- $700/yr

Massachusetts--$6,350/yr

Michigan-- $627/yr

Minnesota-- $625/yr

New Jersey-- $3,000/yr

New York-- $500+$50 a resident over 400% of poverty, with a maximum cap of $5,000

North Carolina--$1,600/yr

Ohio-- $170/yr

Oregon-- $160/yr w/ Alz Unit

Texas-- $600 for a 2 year license

Virginia-- $140/yr

Washington-- $7,900/yr.

Attachment B