14-514 #2712 2-23

THE
EASTON HOME

A not-for-profit Presbyterian Homes Assisted Living Residence

Gail Weidman
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Bureau of Policy and Strategic Planning
PO Box 2675
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Independent Regulatory Review Commission
c/o Arthur Coccodrilli, Chairman
333 Market Street, 4th Floor
Harrisburg, PA 17101

Senator Robert Wonderling
1701 Washington Blvd
Easton, PA 18042

Representative Robert Freeman
215 Northampton Street
Easton, PA 18042

September 9, 2008

RE: Proposed 2800 regulations, IRRC #14-514

Dear Ms. Weidman,

I am the Administrator of the Easton Home at 1022 Northampton Street in Easton, Pennsylvania. We provide assisted living services to over 50 residents, including 20 residents in a secured memory impairment unit. We have been providing services to the elderly at the Easton Home for 116 years. We are part of the PHI/Presbyterian Homes Inc. organization, a non-profit company which has provided services to seniors for over 80 years, including $2,000,000 in charitable care in 2007 to our residents for those residents who cannot afford these services. At the Easton Home alone, we currently subsidize the care for over 25% of our population, providing $240,000 in charitable care in 2007, while allowing them to remain at the Easton Home as long as their care needs can be met here.

I am writing to you today to comment on the proposed Assisted Living Regulations because I feel they jeopardize seniors' ability to access care, as well as our ability to provide care and services at an affordable rate and continue to provide for the charitable needs of our residents.

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Of primary concern are the significant physical plant changes in the proposed regulation which would impose significant new costs on many homes, especially existing older facilities such as the Easton Home. This focus on the structure, rather than the services, does little to contribute to enhanced care or services for our residents. Should the regulations be finalized with the current square footage requirements for "living units" we will not be able to apply for licensure as assisted living due to the size of our rooms. If we would have to renovate our building to meet these requirements, it would mean a cost of at least $850,000. We would also end up losing an estimated 10 of our units which would be an annual revenue loss of over $200,000, not to mention that that would be 10 less seniors that we would be able to serve. Many of the other requirements would result in significant costs, some of which would be passed on to the residents out of necessity. It does not seem fair that we would not be able to provide the same quality health care services to the population that we have served for over 100 years, mainly due to the fact that our rooms are not large enough and don't have a tub or shower in them. We would actually be in good position to transition to assisted living as we currently have many of the staffing requirements such as RNs in place, however the physical plant requirements would make this transition cost prohibitive.

The Easton Home operates at an average of 95% occupancy on an annual basis. If we had to renovate our building to meet the requirements, while having to eliminate 10 units which would be a steady source of revenue, it would seriously jeopardize the Easton Home's ability to operate or provide any type of charitable care to our seniors.

Obviously, the overall impact of these regulations needs to be evaluated to determine if Pennsylvania's seniors will have greater access to the services they need, as was the intent of the Assisted Living Licensure Act. With our facility as well as many others are considering if they can afford this new assisted living product, I believe that access to needed care may actually be reduced.

I have attached specific comments detailing a prioritized list of concerns to our organization, particularly those that have a dramatic cost impact, and ask that you please consider these comments in formulating a decision. The effect on seniors in my community and many others are going to be very negatively impacted if these regulations are approved without change.

Thank you for your attention to this matter.

Respectfully submitted,

Paul Cercone, Administrator
The Easton Home

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1. Physical Plant issues
2800.98, 2800.101, 2800.102, 2800.104
These regulations are of the greatest concern to our organization's communities and their ability to even be able to participate in this new level of care and services. The minimum square footage, as well as the requirement to have a bath or shower in the resident's bathroom will result in the Easton Home (as well as five other facilities in my organization) not being able to be licensed assisted living without having renovations costing in excess of $850,000. The enabling assisted living legislation only required a private bathroom, not a private tub/shower. I am concerned that these regulations have exceed the scope of the legislation and will severely limit seniors' access to assisted living. In my community, we serve seniors with Alzheimer's Disease and other memory disorders in a secured unit. A private tub or shower in their rooms would not be an enhancement to their unit, but a hazard. I will note that our community is consistently above 95% occupancy and serves both a private pay and charitable market, an indication that the market has and should decide what the physical plant requirements should be, not regulation. As written, these regulations will ensure that low-income individuals will not be able to buy their way into an Assisted Living facility in vast expanses of the Commonwealth. It is the care and services we provide that enhances the life of our residents, not arbitrary building requirements.

2. Administrator staffing and Direct care staffing
2800.56 and 2800.57
The intent of this regulation as written appears to require a licensed administrator 24 hours per day/7 days per week which not only dramatically increases our costs, but is also well beyond the requirements of skilled nursing facilities. A more reasonable requirement is to have qualified back-up in the case of an extended absence by the administrator. In addition, the requirement for 40 hours per week of on-site administrator is double the current requirement, higher than skilled nursing, and does not allow for any vacation or required education time. The cost implication for our community is $27,000 which will result in increased costs to our residents to offset the expense, reduction of the number of residents able to receive charitable care or fewer direct care employees staff to care for our residents.

3. Additional staffing
2800.60
The requirement for a nurse on-call essentially requires a facility to have a nurse employed 24 hours per day since these professionals are not likely to allow their license to be jeopardized through a contractual arrangement they have no direct control over. While all of our facilities currently have a nurse during at least one shift each day, this requirement for additional nurse staffing increases our cost to our residents by an average of $19.00 per hour or a cost of $138,000 in 2007. As an isolated cost, we may be able to incorporate this as an acknowledgement of the increased level of care, however, with the other costs of these regulations, it just becomes one more cost that will reduce our ability to provide quality care to lower income seniors.

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4. Pharmacy and Prescription Drug Accountability
The facility should be permitted to dictate the manner in which prescription drugs are delivered and packaged by a pharmacy. The facility must be able to ensure the integrity of its medication administration regimen, and to deviate from that system is to pave the way for medication administration errors. Accordingly, if a pharmacy refuses to package prescription drugs in a manner consistent with the facility's operation, the facility should not be forced to accept drugs from that source. Our facility and other facilities in my organization recently completed a transition to a medication administration process that we feel improves the safety of medication administration, particularly when medications are administered by unlicensed staff. To allow deviation from this standard is contrary to enhanced resident care and enhanced acuity. This is an issue of safety.

5. Initial and annual assessment
2800.225
This requirement requires an RN to complete the assessment and support plan which are not clinically necessary and is a mandate that simply increases the cost profile of delivering care. Our communities currently provide a higher standard of care by ensuring completion and/or input by an LPN, so the additional cost of having an RN complete these versus the benefit is not balanced.

6. Dementia-specific training
2800.65(e) and 2800.69
The intent of this regulation is consistent with our facilities' practice to provide appropriate training on dementia, however, the requirement that dementia care-centered education be in addition to the already mandated educational requirement does not contribute to improved resident care. Dementia care education can easily be incorporated into the already robust educational requirement, not in addition to it. As this regulation stands, direct care workers are being asked to obtain more CEU's than RNs which is unnecessary and costly.

7. Bundling of core services
2800.25c and 2800.220
The portion of this regulation of most concern is the requirement to have all vehicles be handicapped accessible if we provide transportation. While we have one handicapped accessible vehicle (a 14 passenger bus) , we would not be able to provide transportation services if required to replace our other non-handicapped vehicles. With current gas prices, transporting one resident to a physician's appointment in a 14 passenger bus is not environmentally friendly or cost effective. The price tag for replacing these vehicles which would eliminate our ability to spend our dollars on other meaningful resident care and facility upgrades. The current complement of vehicles on our campuses meets the needs of our residents, while this regulation is arbitrary and will reduce services.

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8. Discharge of Residents
The facility must be permitted to maintain control over the transfer and discharge of its residents to ensure that residents are being appropriately care for. The proposed regulation curtails that power, and inserts the Long-Term Care Ombudsman as 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. The Ombudsman should provide a counseling role for the resident, not act as a legal advisor.

9. Licensing Fee
2800.11
The dramatic increase in licensing fee is an administrative cost that does not have a direct effect on improving care provided to residents, and will serve to decrease care due to our having to either cut resources and charitable care or increase costs to residents. The $6905 price tag for our community means that less residents will be able to receive charitable care or the number of caregivers employed to care for our residents will be reduced.

10. First aid kits
2800.96 and 2800.171
These two requirements appear to mandate an AED in each first aid kit and in each vehicle.. Our facilities currently provide more than the regulatory-required number of first aid kits because we believe that will enhance resident care. However, if we are required to provide AEDs in each of the first aid kits in each of our vehicles, we will have no choice but to reduce the number of first aid kits in our buildings. In addition, the requirement to have an AED in each of our three vehicles will be cost-prohibitive and will contribute to our reduced ability to provide needed transportation services. We currently have 6 first aid kits in our community and our vehicles. The price tag for adding an AED to each of these kits would be over $9,000. While AEDs are an important component of care provided, it should be noted that in ALL successful outcomes that have been studied, the use of an AED typically doesn't occur for between 1.7 and 2.5 minutes – more than enough time to have staff respond.

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