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RETIREMENT AND SENIOR
CARE SERVICES

One Trinity Drive East • Suite 201 • Dillsburg, Pennsylvania 17019

September 9, 2008

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

Dear Ms. Weidman:

PHI/Presbyterian Homes Inc. is a provider of senior services, serving thousands of residents in eleven personal care homes throughout Pennsylvania. Our 80-year history of providing services to seniors includes providing **nearly $2 million of charitable care** last year for those personal care residents who cannot afford these services. 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.

Of primary concern are the significant physical plant changes in the proposed regulation which would impose **over $3.5 million in renovations for our corporation just to meet the physical plant requirements**. In addition, these renovations will require us to eliminate dozens of units to make room for these physical plant amenities which will result in over $1 million in lost revenue each year. This focus on the structure, rather than the services, does little to contribute to enhanced care or services for our residents. To pay for just these requirements, we must either increase costs to residents, reduce the amount of charitable care we're able to provide, or consider closing homes that today are highly desired by the market, but tomorrow don't meet these new regulatory standards.

In addition to these physical plant requirements are numerous non-structural requirements whose costs total over $2 million. 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 eleven providers seriously considering whether we, and our residents, can afford this new assisted living product, I believe that access to needed care may actually be reduced through the elimination of high-quality providers who serve low-income seniors and the introduction of new providers who will only be able to afford to serve a private pay market.

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. As you can see from the numbers above, our ability to provide over $2 million in charitable care is jeopardized by over $5 million in new costs. The effect will be reduced access to the care and services moderate and low-income seniors need if these regulations are approved without change.

Thank you for your attention to this matter.

Diane Burfeindt

Diane Burfeindt, MBA, NHA
Vice President of Operations/Residential and Community Services
PHI/Presbyterian Homes, Inc.

Cc: Honorable Patricia Vance
Honorable Scott Perry
Honorable Edwin Erickson
Honorable Vincent Hughes
Honorable Phyllis Mundy
Honorable Tim Hennessey

1. Physical Plant issues
2800.98, 2800.101, 2800.102, 2800.104
These regulations are of the greatest concern to our 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 SEVEN of our eleven facilities not being able to be licensed assisted living without having renovations costing in excess of $3 million. 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. I will note that these homes that are that are negatively affected by this regulation are consistently above 95% occupancy and serve 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 education time. This increased administrative requirement is the equivalent of more than 12 direct caregivers who could not be hired to provide hands-on care to 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 over $500,000. 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.

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 facilities 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 requirements 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. For our facilities, the impact of this regulation alone is over $300,000 which could pay for 12 additional direct caregivers to provide hands-on care rather than administrative oversight.

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 all of our campuses have at least one handicapped accessible vehicle, we would not be able to provide transportation services if required to replace our other non-handicapped vehicles. The price tag for this conversion is well over $300,000 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.

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.

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 regulatorily-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 these kits, 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 vehicle will be cost-prohibitive and will contribute to our reduced ability to provide needed transportation services. 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 for even one of our larger communities to have staff respond.