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Philadelphia, PA 19147
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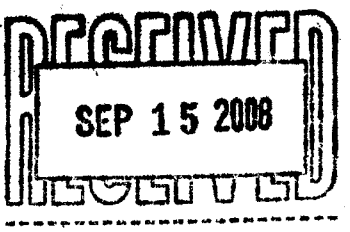

Gail Weidman
Department of Public Welfare, Office of Long-Term Care Living,
P.O. Box 2675,
Harrisburg, PA 17105

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INDEPENDENT REGULATORY
REVIEW COMMISSION

RE: Draft regulations 15-514 Assisted Living

Dear Ms. Weidman:

I am pleased to be able to offer my comments on the proposed regulations governing the licensure and operations of assisted living facilities in Pennsylvania. These regulations are an excellent start to improving the current misleading system, in which "assisted living" is a marketing term and it is unclear to consumers which services may be provided, as well as the potential inadequacy of those services.

As a Gerontological Nurse Practitioner of 11 years, who has worked in geriatrics and long term care for these past 11 years, I feel that I am a qualified person to respond to the proposed regulations regarding Assisted Living Residences. I am also an advocate for our seniors. When I have encountered poor patient management in the long term care setting, I have been vocal to Administrators, Directors of Nursing and Medical Directors to have corrections made. My objective in writing to you is to see that our seniors, and generations to come are given the dignity and care that they deserve when opting for care in an Assisted Living Residence in Pennsylvania.

I would also like to express my concern and disappointment that there were no nurses or nurse organizations, physician or physician organizations included in this process, as mentioned in the Regulatory Analysis Form. This is of particular concern as nurses and physicians, (particularly geriatric nurses, Gerontological Nurse Practitioners and Geriatricians) are experts in caring for geriatric patients. Consumers certainly expect as do clinicians, that regulations in areas such as this, which affect health and welfare, would seek the opinions of these experts. This should be addressed.

I would like to direct my comments on the following areas of the regulations in particular:

2800.4 Definitions
Activities of daily Living- Activities of Daily Living typically do not include "securing health care, managing health care, self administration of medications". It is understood in

the long term care industry that activities of daily living encompass basic care needs: eating, drinking, transferring, grooming, toileting and ambulation.

Age in Place-This definition is inadequate- I have reviewed the comments of the Pennsylvania Assisted Living consumer alliance and agree with their suggestion for a definition. Aging in Place refers to an individual's desire to remain "in their home" environment and have adaptations made to that environment to facilitate any declines in function that they experience due to aging and disease. Persons who age in place, and, depending this degree of decline, potentially require assistance with ADLs and IADLs to maintain their health and well being.

Assisted Living Services- This needs further definition. I have read, online, the suggestion of the Pennsylvania Assisted Living Consumer alliance and these appear to be good definitions.

Cognitive Support Services- Who is determining the appropriate activities for a person with a diagnosis of dementia.

Dementia- Note that the current definition does not comment on progressive decline and how it impacts the ability to express oneself, perform activities of daily living or ability to follow simple commands.

IADL- medication management is typically categorized here, as well as laundry, money management, bill paying, light household cleaning.

Informed consent- Persons must be evaluated at time of admission for ability to make decisions.

Mobile resident- This is not a meaningful clinical term. This term should be substituted for clinical terms which used in the long term industry. It is of particular concern as this is misleading, and may affect the number of hours of care that a resident receives and may not address a persons needs for personal care.

Immobile resident- Again this term is not a meaningful term and does not highlight the assistance that an individual requires.

Special care designation- As presumably many of these patients are a safety risk and at risk for wandering, there must be safeguards for elopement. There needs to be screening for dementia. Strongly recommend MMSE be conducted on admission and semiannually. There must be elopement assessment and plans in place to keep these residents safe, via use of wander guard bracelets, secure door pads, etc. There needs to be a plan for rescue if a person does in fact have a successful elopement.

Support Plan-This should be based on a comprehensive preadmission screening, such that the consumer is informed of how the Assisted Living Residence will meet their needs with regard to cognition, function/ mobility, continence, medication administration,

nutrition and medical care. This currently does not have to be in place until 30 days after admission. It would be understandable that a consumer would want to discuss with family or physician whether this plan would be adequate. I would strongly recommend that the support plan be developed before a contract is signed.

2800.5
Access- there is no mention of providing access to community based physician or nurse practitioner to make 'home visit', if this is the plan for providing primary care.

2800.14
Fire safety approval
There is not mention of building code. What is this requirement?

2800.16
Reportable incidents- This needs to be expanded to include falls which result in injury and potential alteration in mobility, as well any acquired pressure ulcers. Also, 'absence from special care unit' needs to be clarified- all elopements from a secure unit need to be reported.

2800.188
Prescription medication error- Who is reviewing records of medication administration records.

2800.17
Confidentiality- There is no mention of a visiting physician / visiting nurse's ability to review facility record.

2800.22
A 1. Please clarify the reference to the preadmission screening which is completed prior to admission on a form "specified by the department". What form is used? Who completes this form? A physician or an Advanced Practice Nurse (Nurse Practitioner)? I have concerns about the proficiency of an administrator's ability to evaluate in these areas. What are the elements of this assessment? Essential elements for this assessment should include assessment of cognition, including MMSE, emotional /psychiatric problems, functional status, continence issues, medication issues/ management, nutrition, medical assessment. (The MA 51 is an inadequate assessment tool; this form merely comments that a person is 'appropriate for 'services.) How is it determined that a person is not appropriate for Assisted Living? There should be review of any legal documents, including living will, advanced directives, durable power of attorney, etc. prior to admission.
2. Medical evaluation completed at 60 days prior or up to 15 days after admission. Who is completing this? Is this completed by the resident's primary physician in the community or a physician working for the facility? There is no mention of a Medical Director. How is medical management overseen? It is typical for consumers seeking residence in an Assisted Living to not have local family available to follow up on physician recommendations, consults, studies, preventative health, etc.

3. Assisted Living Resident assessment form provided by department. Other clinicians who I would strongly recommend be part of the admission screen and annual reassessment include Social Work, Physical Therapy, Occupational Therapy, Registered Nurse, Dietitian and Physician.
4. Support plan- This should be based on a comprehensive preadmission screening, such that the consumer is informed of how the Assisted Living Residence will meet their needs with regard to cognition, function/ mobility, continence, medication administration, nutrition and medical care. This currently does not have to be in place until 30 days after admission. It would be understandable that a consumer would want to discuss with family or physician whether this plan would be adequate. I would strongly recommend that the support plan be developed before a contract is signed.

2800.22
Support plan
B 2. I strongly recommend that the consumer should be able to review their support plan prior to signing their contract, and would make most sense if assessments and support plan be designed prior to "move in".

2800.24
Personal hygiene- should include all of the care aspects mentioned. There is not mention of incontinence care for persons with bowel and bladder incontinence. With regard to foot care- does the facility have / contract for podiatry services?

2800.25
Resident-Residence Contract
2. Fee schedule- if resident is charged by # of hours in need of personal care-the resident will need assessment of these needs to determine fee schedule.

2800.25
i) Will supplemental health services be billed to Medicare, or will consumers be billed. How will this be managed if patient's primary care physician orders skilled nursing care, physical therapy?

2800.29
Hospice care-I am glad to see that as "Assisted Living" becomes a senior's home, that the senior can have the option of remaining in the Assisted Living for end of life care.

2800.30
Informed Consent Process- A 1. Concerns regarding unsafe actions or behaviors on behalf of the resident should be explored to the greatest extent possible prior to admission. Some other areas to consider include the following problem situations: (alcohol abuse, drug use both legal and illicit, diabetics who are non compliant with diet/ meds).
The informed consent process needs to address how to discharge if behavior remains unacceptable. Also, cognitive assessment should be assessed prior to enrollment and

annually to assess if person can participate (has insight) for informed consent for future bad behavior.

2800.53
Qualifications of administrators
No geriatric experience required. I strongly recommend a minimum of one year experience in geriatrics and long term care.

2800.54
Qualifications for direct care staff persons
No geriatric experience required. I strongly recommend a minimum of one year of experience in geriatrics or long term care. I strongly recommend that there be demonstration of competency in ADLs and care of persons with prior to employment.

2800.58
Administrative Staff
a. Strongly recommend that language state that administrator is awake during "presence in the residence".
b. Strongly recommend using standards with regard to labeling residents as "mobile" vs. "immobile" – these are not meaningful clinical terms, and need to define further whether a person needs assistance with ambulation, transfers, toileting, etc.

2800.59
Multiple buildings
It is unclear from the language but it would seem that all direct care staff might be absent when they are needed. Would strongly recommend that there is minimum staffing present in each building at all times when residents are present.

2800.60
Staffing
d. Not required for nurse to staff facility but only to be "on call". This is insufficient. This language never then requires a nurse to ever be in the facility to do rounds, deliver or provide oversight to care. From the language it seems that the only requirement is for nursing to approve care plans. There is no stated requirement for Physician input or oversight or the mention of medical director oversight of care provision of residents who are nursing facility clinically eligible. This has been a past concern of the American Medical Directors Association. Certainly this is particularly alarming as consumers may "age in place" in an assisted living. There is no requirement for social work services, which is concern. It is unclear how the state proposes that high quality care will be delivered to residents in Assisted Living if the professional staff is absent to oversee and deliver care. Social work, nursing and physicians are advocates for their patients, and it is concerning to see the absence of these professionals in the proposed Assisted Living Regulations.
e. I would strongly recommend that there be at a minimum a preadmission as well as an annual assessment by the dietitian for all residents, as seniors will be aging in place. Seniors nutritional health becomes even more critical for them as they age.

2800.63
First Aid, CPR
It is unclear what constitutes "sufficient staff" to deliver first aid and CPR. Strongly recommend that all direct care staff receive training in CPR and first aid.

2800.64
Administrator training
Administrator training is not different form personal care boarding home administrators. It is unclear what is meant by the required training "gerontology". The content for the training courses are unclear. I would also strongly recommend that there be specific training in core areas of geriatric care such as cognitive impairment, caring for incontinent residents, advanced directives and skin assessment.

2800.65
Direct care staff persons training and orientation
It is unclear who is overseeing training of staff, as well as what is involved in the Department approved direct care training cause. It is unclear who determines competency of staff. It is unclear how many hours of training are required before direct care staff are allowed to begin work and that they are competent in these areas at that time.
Would strongly recommend that direct care staff also pass safe serve certification, and consideration that direct care staff pass either home health aid or nursing assistant certification.
It is unclear what is meant by "gerontology". Training of this staff needs to be specific to the needs of older adults with regard to safe ambulation and transfers, bed mobility, skin care and personal hygiene, nutrition and hydration, behavior management to name a few.

2800.66
Staff training
It is unclear who is conducting training.

2800.69
Dementia Specific
Direct care staff need training specific to safe behavior management, dealing with uncooperative patients, continence care, training regarding changes in cognition.

2800.89
Water
There is no mention that there needs to be safety checks of water temperature, with regard to minimum temperature for care. Persons with dementia need to be protected against being washed with cold water as well as hot water, for safety as well as dignity and comfort.

2800.104
Dining room

d.) mentions 'adaptive eating equipment' shall be available. This does not address that there is an absence of Occupational Therapy to do evaluation. How will this item be purchased?

2800.141 Resident health
Presently, the assessment of cognitive function is only required for possible admission to a special care unit. I would strongly recommend that there be a cognitive assessment of all residents at time of admission over the age of 65, as well as anyone under 65 with a diagnosis of a cognitive dysfunction. There is also need for ongoing assessment of cognitive decline, perhaps conducted every 6 months, as the model is that seniors are "aging in place". I would strongly recommend a minimum of MMSE annually. Strongly recommend reevaluation by medical staff at least every 6 months if not quarterly, the current regulations simply say "if the medical condition of the resident changes prior to the annual evaluation" without commenting who makes that assessment.

2800.143
Emergency Medical Plan
This does not address advanced directives, living will, etc.

2800.161
How is nutritional decline managed? Who / how is poor oral intake documented? How and with what frequency are weights checked to ensure nutritional adequacy?

2800.182
Medication administration
What provisions are there when a person is sick and needs nursing judgment with regard to holding medications (diuretics, insulin, oral hypoglycemic agents) if medications are passed by direct care staff?

2800.185
Controlled substances
Certainly there will be a proportion of seniors who are on narcotics for pain management due to chronic disease. I am concerned that there is not a nurse overseeing medication management as I do not feel that the direct care staff would not be able to identify problems related to use of narcotics, including constipation and over-sedation, changes in gait, etc.

2800.188
Medication errors
Who oversees this? How are med errors reported to the state?

2800.190
Medication Administration training
There is no mention of administration of other injectables, such as epogen, which in home situation would be administered by family. This is beyond the scope of care of the direct care workers.

2800.210
Safe management techniques
This statement does not go far enough to address the need for and training of staff about behavior management of persons with agitated dementia or longstanding mental health disorders

2800.203
Bedside rails
I am glad to see that bedside rails have been recognized as a restraint if not used for mobility purposes.

2800.220
Services provided in Assisted Living
Please define core packages, including hours of care, services and costs. Consumers need to know what they will be getting and what will cost extra. It is important to consider that the elderly are often the victims of financial abuse, and there needs to be clear delineation of the services that they require and do not require, and for which they should not be responsible for payment.
Again, if it is not clear what services the facility is expected to provide because of licensure, what extra services are available, what is in a basic service package and what can be purchased in addition, it will be very hard for consumers to compare facilities.
Under summary core package, PALCA has suggested services that should be available in every Assisted Living facility, and has suggested two core packages. Consider that the needs of the cognitively impaired differ from younger residents with mobility problems.

2800.221
Activities program
There is no mention that persons are encouraged to walk to the dining room, to the toilet, or to activities during the day. This needs to be addressed. Seniors can become disabled because they are encouraged to "use a diaper" and use a wheel chair. These seniors need to be assisted to walk to the toilet to maintain optimal function, to maintain dignity and quality of life.

2800.224
Preadmission screening
a. Again, I am concerned that an administrator to be able to evaluate in these areas. What are the elements of this assessment? Essential elements for this assessment include assessment of cognition, including MMSE, functional status, continence issues, medication issues/ management, nutrition, medical assessment. (The MA 51 is an inadequate assessment tool; this form merely comments that a person is 'appropriate for' services.). There must be a threshold – where- over a certain number of personal care hours, a person might be seen as inappropriate for assisted living. There should be review of any legal documents, including living will, advanced directives, durable power of attorney, etc.
b. How is it determined that a person is not appropriate for Assisted Living?

E Concern that supplemental services (presumably referral to OT, PT, SW, etc) that if the consumer was not receiving these services prior then it does not appear from the regulations that these services will begin.

2800.225
Initial and annual assessment
It is concerning again that the administrator or LPN is felt adequate to perform this task. Would expect at a minimum that there be a required initial and annual assessment by a RN who writes the care plan and that there is an annual evaluation/ or semi annual evaluation and review of support plan by a physician Medical Director There is no mention of a Medical Director. How is medical management overseen? Physicians, particularly geriatricians, have extensive experience in team work. National standards support a nurse complete the assessment. Aspects highlighted above (including assessment of cognition, including MMSE, psychiatric and emotional assessment, functional status, continence issues, medication issues/ management, nutrition, medical assessment) should be occurring annually.
The frequency of repeat medical evaluations is not addressed. Re assessments should occur at minimum every 6 months, and after hospitalizations.

2800.227
Support plan
This should be based on a comprehensive preadmission screening, such that the consumer is informed of how the Assisted Living Residence will meet their needs with regard to cognition, function/ mobility, continence, medication administration, nutrition and medical care. This currently does not have to be in place until 30 days after admission. It would be understandable that a consumer would want to discuss with family or physician whether this plan would be adequate. I would recommend that the support plan be developed before a contract is signed, and prior to move in. PALCA has extensive recommendations regarding support plan which should be referred to.
How will recommendations by dental, ophthalmology, etc be incorporated and acted on?

2800.231
Admission to special care units
a. Are persons with all stages of dementia admitted to these units? This would include persons with mild cognitive impairment, moderate impairment and severe impairment. If so- what protections are instituted to keep these consumers safe? Language such as using the "least restrictive manner" is of concern, as some persons with dementia are at greater risk for wandering and elopement and this of course would want to be avoided. These consumers should be evaluated for history of elopement. Facilities should institute tools to help protect these consumers such as wander guard bracelets, and these seniors should not be operating key pads allowing them to leave the unit unattended.
c. strongly recommend use of MMSE for cognitive evaluation.
d. Further explanation is required with reference to geriatric assessment team. This is the only mention of this type of evaluation in the regulations. Very few people have access to a geriatric assessment team. Who is part of this team? When is this required? Again, I recommend that this assessment should occur prior to admission.

2800.234
Resident care
b.The support plan does not address functional status/ needs evaluation and treatment.
d. Regulation does not mention who participates in review of support plan.

2800.235
Discharge
This does not address how facility handles involuntary discharge

2800.238
Staffing
Again, I am concerned that this use of mobility to determine staffing is inadequate. Strongly recommend using standards with regard to labeling residents as "mobile" vs. "immobile" – these are not meaningful clinical terms, and need to define further whether a person needs assistance with ambulation, transfers, toileting, etc.
This term should be substituted for standard clinical language and mobility assessments, as there are different shades of independence across the continuum. It is of particular concern as this is misleading, and may affect the number of hours of care that a resident receives and may not address a persons needs for personal care.
Hours of personal care, and staffing should be determined according to consumer need. Perhaps minimal staffing ratios need to be considered.

2800.250
Content of medical records. There is no mention of discussion of advanced directives, living will, or durable power of attorney for medical decision or financial decisions.

Thank you for reviewing my comments and opinions regarding these proposed regulations. I hope that clinician input such as mine will be considered as regulation for this industry in Pennsylvania is developed. I think it is critical to have nurses and physicians who actually care for this population are part of this conversation. Our seniors and their families expect it and deserve it.

Respectfully,
Patricia Johnston, CRNP