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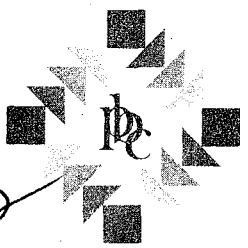

Peter Becker Community

#2712

September 12, 2008

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

Re: Proposed 2800 regulations, IRRC #14-514

Dear Ms. Weidman:

Peter Becker Community is a continuing care retirement community (CCRC) located in Harleysville Pennsylvania. We have 292 residential living unit, are licensed for 47 personal care beds (37 currently used because we have made some units private rooms), and are licensed and have in use 72 nursing beds. We have never marketed ourselves as assisted living, choosing to use personal care under which we are licensed.

We are in the process of designing a new health care center for our nursing and personal care beds and we are trying to be flexible enough to be able to be licensed as either personal care or assisted living because we do not know which license will be most appropriate for us in the future. Some of the reasons we are not "jumping at" the assisted living licensure are because of the requirements and cost of licensure as assisted living.

As we try to explain the difference between personal care and assisted living to our residents, many of them are just confused. I can only think that many consumers are also going to be confused. In my opinion, it would have been better to have modified the 2600 legislation and regulation to allow what you want to allow in assisted living and give providers a chance to migrate from one end of the spectrum to the other along a timeframe that would work for them financially and programmatically. As it is, you are making it very difficult for older facilities to even have the choice. Care and services that they have been providing to residents for years in personal care, they may no longer be able to provide and who is hurt by that – the residents. How can that be what the Department is really looking for?

I am sure that it will be costly to survey and enforce a new set of regulations and so that is probably why the licensure fees are going to be so much higher than for personal care. So by charging more you are actually making it harder for providers to provide the level of care and services that you deem appropriate for residents. How can that make sense?

I am not an attorney. My background is finance and I am licensed as a nursing home administrator in both Pennsylvania and Delaware. I can look at the regulations from a legal perspective. However, I think we should be looking at them in terms of what do residents of existing facilities need and want and how can we best support providers who want to give their best to the residents they serve.

800 Maple Avenue, Harleysville, PA 19438 215.256.9501 Fax: 215.256.9768
Web: www.peterbeckercommunity.com
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In some cases it seems like the regulations were developed for providers who serve a different population than many of us in retirement communities provide. Perhaps there should have been some thought to a differentiation between stand alone assisted living providers and those who are part of a continuum of care.

I'd like to go through some specific concerns that I have, but please always keep in mind that my focus is on what is best for the residents and how you can help us be able to provide what is best for them.

The licensure fees are of real concern, as I mentioned earlier. For us it would mean $5,435. That may not sound like a lot of money to you but for our residents it will add to the daily rate (our only source of revenue is from our residents) and could be $10/month. For our residents that adds up.

I am concerned about the bundling of services. If resident choice is what our services should be all about, then this doesn't make sense to me. We should be able to provide a very basic level of services and then add on to the services (and the fees) for those who need it. Of course if we determined that there were services that everyone needed and wanted, it would make sense to include them in the basic or core services. For the regulators to decide what those core services are seems to take some of the choice away from those we serve.

The issue of transportation and requiring that all vehicles be handicap accessible could be a real burden to some providers. For us in a CCRC we have vehicles that are both handicap accessible and those that are not. There are times when some of our personal care residents go out for rides in the van or to a doctor's appointment and they do not need an accessible van. They are able to ride in one of our other vehicles – a car or a minivan. Sometimes if they have to ride in the larger vehicle they feel stigmatized – "I don't need this big bus". They feel more like home if they can ride in a regular vehicle. Again you are taking away some of their choice.

It seems unreasonable to me that the requirements for an assisted living administrator are greater than that of a personal care administrator. For a facility of our size whether we are licensed as personal care or assisted living, it seems like the 20 hour/week requirement for the administrator is fine. Perhaps the hours requirement should be more determined by the number of beds. And on top of that you are essentially requiring another fully trained administrator to be there when the designated administrator is away from the building. This is an expensive proposition for many facilities. At Peter Becker Community we have one certified Personal Care Administrator and two licensed nursing home administrators on our staff. And now you would require that we have someone else who meets the training requirements for the assisted living administrator be on staff plus enough others equally trained to cover just in case the designated administrator for assisted living is out of the building. Sounds like a little overkill to me. This is perhaps another area where it might be different for a stand alone facility than it would have to be for a CCRC.

For us the physical plant requirements will keep us from being licensed as assisted living until we get our new building constructed. The cost of building new is enormous and of course the debt service related to that building will have to be built into our fees. Will this mean that many of our residents can't afford to stay with us? Maybe, but more than

likely it will mean that they will have to be subsidized. The Commonwealth may think it is going to save money by keeping people out of nursing beds and in assisted living beds, but in the end there will be more people in assisted living needing care and subsidy. We want to provide adequate space for our residents and we are working to build a new unit for both nursing and personal care with private rooms and baths, but in the meantime, what happens to the residents who need our care now and have been satisfied with the care they receive now? Because on some date certain, you change the rules, they can't get what they are getting now. How can that be in the best interests of those residents?

And what does a kitchen really do for residents of assisted living? When I talk to our residents about this, they usually laugh. They say that they came to personal care because they don't want to cook any more. The country kitchen, which is supplied with beverages and snacks that they have access to, suits them just fine.

Requiring an RN to complete the assessments and support plans will create another hardship. Do you know how hard it is to get RNs where we need them in nursing now? Do you understand that the pool of RNs is not necessarily growing in all areas? And now you want to add another RN duty to the mix. In our CCRC can we make it happen? Probably, but we believe that our RNs should be focused on our nursing care center. Others can provide the assessment and develop the support plan. If you want an RN to review it, that might make sense.

I am not sure what benefit is provided to the resident and certainly there is none to the facility by having the Ombudsman be an active participant in the discharge process. If agreements are between the facility and the resident, then that is where the negotiations should be. If the resident is deemed to be incompetent, then the resident should have a power of attorney. Only if a POA does not exist might the Ombudsman have a role.

Since we currently have licensed nursing and licensed personal care, will there be a way to also license as assisted living under the same roof. Can there be assisted living in the nursing wing? Can there be assisted living in the personal care wing? You see, for us it might make sense to be able to be flexible with the licensure of the beds/units based on the needs of the residents at the time. There is nothing in the regulations that speaks to any dual licensure of units and yet I thought that had been a part of the legislation.

If we cannot control the pharmaceuticals that come into our facility, I do not know how you expect us to be held accountable for the integrity of the prescriptions. I think you need to be a little more considerate of the facilities needs in this area.

The fact that DPW wants to approve the resident handbook of every assisted living facility sounds like you want to create cookie cutter facilities. Again, we are concerned about resident choice. Your proposal sounds to me like you don't believe that we really want what is best for our residents.

You are also suggesting that a resident should be able to voluntarily cancel their contract with a 14 day notice. It does take time to fill a unit and if we can not regularly fill units because residents give only a 14 day notice, it will affect the overall daily cost of running the facility. Where does this cost come from? The residents, of course, would pay and so it may in fact drive up rates for all residents. Most residential living rental arrangements, etc. have thirty day cancellation requirements. On one hand you want

this to be more like a residential facility and on the other hand you want special considerations. I'd hope that you would be concerned about the overall well-being of the residents. I would think if there is some just cause for the termination, then that might lend itself to a shorter notice, but not just because the resident decides to leave.

Other provisions for staffing that specifically identify an RN or a dietician for instance again might be different for a stand alone facility as opposed to a CCRC. Why should we have to have a separate dietician when we already have one on the campus for our other levels of care. If an RN is needed because of the acuity of the residents being served then that makes sense, but why require one if in fact it is not needed. Again, more expense to be borne by the residents who might not really need this – taking away resident choice.

I noticed that there is an extra 4 hour training requirement for those serving in a dementia unit. In fact, a large majority of residents that we serve now in personal care have some level of dementia and I think the dementia training should just be part of the training that is required for all administrators not in addition to the 100 hour course. In addition you should also consider courses approved by NAB, NCERS or the Bureau of Professional and Occupational Affairs in the Department of State as acceptable training. Nursing Home Administrators in good standing should be able to serve as administrators of assisted living facilities without any additional training requirements if they can pass the competency test. For direct care workers in dementia units, you should allow a little more time for the specified training to be delivered to and attended by them.

Requiring central air conditioning will most certainly eliminate the ability of a number of older facilities to be licensed as assisted living. Certainly window air conditioning, if used properly can meet the requirement.

Having an AED is a good idea, but not in the first aid kit. This section should also be clarified that you only require one AED but that an ALR may have more than one first aid kit.

The requirements for common area space are too stringent and don't allow that the dining areas could be considered to be one of those areas. Think about your home. The dining room generally has more than one use. Shouldn't it be the same for the residents in an assisted living home? If not, the costs will be too much for many providers and you'll have fewer assisted living residences than you want.

If we are trying to provide "home" then why require the fire retardant mattresses? If the facility provides it, then that is fine, but what if the resident wants to bring their own mattress? Again, this seems to limit resident choice.

I worry about the requirement of having a fire extinguisher in each unit. Some residents would not know what to do with it and it could end up causing more damage or injury to the resident. If you follow the NFPA specifications it should be sufficient.

Please look at section 2800.142(a). I think this is another area in which you are limiting resident choice. Providers should be able to provide a listing of preferred providers but not mandate that residents use a specific provider.

The facility should not have to provide an escort for every medical appointment. This is not even a requirement in nursing homes.

I know that you will receive comments that are more technical in nature and that our state association, PANPHA, has submitted comments to you as well. All of these are important and I trust that you will take them into consideration as well.

Thank you for your attention to these comments.

Sincerely,

Carol A. Berster
President/CEO