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Foxdale Village

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A Quaker-Directed Continuing Care Retirement Community

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We are writing in response to the proposed regulations for Assisted Living Residences. As a Quaker-Directed Continuing Care Retirement Community (CCRC) in State College, we were eagerly awaiting the new guidelines since we anticipated being able to add this care option for our residents. However, after careful review of the proposed rules, we have several concerns that will impact our ability to comply with these regulations, and, as a consequence, to offer this new care option. Since the majority of the proposed Assisted Living regulations follow the Chapter 2600 Code for Personal Care Homes, the following points draw appropriate comparisons between the existing personal care regulations and the proposed assisted living regulations.

2800.11 Licensing Fees. At present, our campus is licensed to provide personal care services to 64 residents. However, our average census is 35 residents in order to provide residents private living space. Based on our current licensed capacity of 64 residents, the proposed assisted living fees will cost us $7,220 annually, compared to $35 we currently pay for our personal care license. This significant increase will have to be passed onto the residents' rates. We believe that these fees are exorbitant and that the fee structure should be reconsidered.

2800.16 Incident Reporting. We recognize the importance of reporting significant incidents to the Department. We are very concerned about the requirement of reporting (a3*) an injury, illness or trauma requiring treatment at a hospital or medical facility.* The language in the 2600 regulations states that a reportable incident must be a serious bodily injury or trauma and there is no requirement to report illnesses. We feel that the proposed language does not adequately define "medical facility." Our health care clinic,

which is adjacent to our personal care residences, is where our residents receive the majority of their health care. This "medical facility" treats all types of injuries and illnesses. Our residents also receive podiatric care in this clinic. Would all of these visits have to be reported to the Department since the health clinic is a medical facility? We doubt that this is the intent, but, as written, 2800.16 will require an inordinate amount of staff time spent writing reports. This time would be much better spent caring for residents. We would have to greatly increase our staffing hours to fulfill this paperwork requirement, which would result in substantial increases to residents' rates. We recommend further clarification of what defines a "medical facility."

We are wondering if the Department has evaluated the outcome of the 2600 regulation regarding the reporting of all medication errors. While we strive for no medication errors, errors do occur. The Department has taken a stricter stance on reporting these errors than any other licensing agency. We recommend that the language be changed such that reportable incidents include "errors or adverse drug reactions that cause serious injury" to residents, rather than requiring us to report minor events such as a missed prescription multivitamin or a stool softener given an hour later than prescribed. We track all medication errors internally and have policies in place to notify the physician, family, etc. when errors occur. We question the necessity of reporting minor medication errors to the Department. These reports take away from time with residents and create unnecessary paperwork that we have to complete and the Department has to process.

2800.22 Application and admission. Under (b), the timing for providing the list of written disclosures can is a concern. We understand the intent of making sure that prospective residents and their responsible parties are well informed about this important information regarding our center. We suggest that you permit this information to be shared *prior to or on the day of admission.* Because we are a CCRC, many residents are admitted directly from our apartments; there is no application process for admission to our health care center. Also, in many emergency situations, it would be difficult for us to provide the entire list of documents *prior to* transfer. We ask that the 2800 regulations consider the array of residential options that exist, and view communities like ours as part of a lifestyle that is already helping residents to age in place.

2800.25 Resident-residence contract. Regarding (e), we recommend adding a clause that acknowledges life-care CCRC contracts and the existing procedures for residents who are moving through a continuum of care. Our residents have three months to reconsider their decision when they move to our campus. These life-care residents then have an additional seven days to opt out. Therefore, our residents are given two opportunities to rescind their agreement. When they enter personal care or assisted living, it is part of the continuum of their care. The contract is different for residents who may enter assisted living from their homes in the community at large (i.e., *per diem* residents). We recommend that a distinction be made between CCRC/life care residents and per-diem residents when requiring a 72-hour rescission. The similar 2600 regulation regarding the 72-hour rescission has created difficulty for us during past inspections depending on the subjective interpretation of the surveying agent. Similarly, we believe the termination notice needs to distinguish between a life-care resident and a per-diem care resident.

(b) For per diem residents, we do not understand why residents can give only 14 days' notice to us while we are required to afford them 30 days' time if we are terminating the agreement. This is not adequate time to plan a discharge and make sure that the departing resident has adequate services in place. It is also not clear why the Department would require so much time and expense for residents and providers in terms of assessments, contracts, medical evaluation, etc., and not correlate these requirements with the timeline established for completion. Since the Department seems to recognize the need for 30 days to complete the assessments, why have residents potentially leave within 14 days after admission? Even though the 14-day notice could apply at any time, the Department is essentially granting residents two opportunities to rescind their agreements (i.e., 72 hours and 14 days), if they so desire. We will not have fully evaluated residents' needs in 14 days to assist in their discharge. We recommend that residents be required to give 30 days' notice to providers to terminate the agreement.

2800.30 Informed Consent. We are concerned about the language in (a)(1) that suggests that we need to discuss "reasonable alternatives" with residents who may be placing others in "imminent risk of substantial harm." While our concern seems to be partially addressed in (2)(g), residents should never be permitted to put others at risk by their behaviors or actions. The liability concerns surrounding this section seem to require further review.

2800.53 Qualifications and responsibilities of administrators. We recommend that all licensed personal care administrators be included in the list of qualified assisted living administrators.

2800.56 Administrator staffing. (a) As written, administrators are never permitted to have any time off-site without penalty. It is unduly harsh to require administrators to work "an average of 40 hours or more per week in a calendar month." This regulation has no provision for professional development off-site. In addition, as currently written, administrators' "vacation time" must be made up to fulfill this requirement. While most administrators work far more than 40 hours per week, it does not seem appropriate for the Department to require more than full-time hours be worked after administrators take vacation time, which is how this regulation is worded. That is, if an administrator takes two weeks of vacation time an additional 80 hours will have to be worked at another time during that month in order to fulfill the average of 40 hours that month. If designees are making sure that residents' needs are appropriately met, is that not the goal? In what other field of work is an employee told that any time she is out of the building for education or meetings for the betterment of the organization, she will need to make up that time in the building? We believe that the intent of the Department is to have steady on-site administration. We recommend that the wording be changed to exclude vacation time and should accommodate off-site professional development.

2800.56 (b) makes the assisted living license prohibitive in terms of cost to our organization. Within our CCRC, designees are licensed nurses who are in charge when the administrator is not present. Our evening and night shift nurses would need to complete 100 hours of training, orientation, plus 24 hours of annual training per year. In addition to the course costs, successful completion would require travel expenses

(mileage, hotel, meals) as well as the scheduling of other "qualified" designees to cover their time away for training. This translates into tens of thousands of dollars unless the administrator works 24 hours per day. It seems that all of our nurses would have to complete this training since the regulation implies that all of the charge persons for each shift need to be administrators.

2800.60 Additional staffing. (d) The requirements for the "on call nurse" need to be clarified. We are fortunate to have LPNs and RNs on our campus round-the-clock. If the requirement is for a registered nurse, will the RN in our skilled nursing area fulfill this requirement?

2800.64 Administrator training and orientation. (a) "Prior to initial employment as an administrator" suggests that all administrators, no matter what credentials or experience they have, will be required to complete the Department-approved 100-hour training course plus orientation. It does not seem reasonable to require experienced administrators to repeat education that they have already obtained. Nursing Home Administrators must complete 48 hours of training every two years. The material covered in these sessions is also appropriate to assisted living administration, and it is hoped that the Department will accept these hours as meeting the annual training requirement of 24 hours (d). If 24 additional educational hours are required by nursing home administrators, this is an unnecessary duplication that results in more expense (cost of credits, travel costs, additional staffing costs), including more time away from the residence. Thousands of dollars would need to be spent annually to meet this requirement.

2600.65 Direct care staff person training and orientation. We recommend that Administrators as well as those persons with medical licenses and certifications (Physicians, Registered Nurses, Graduate Practical Nurses, Licensed Practical Nurses, Certified Nursing Assistants, etc.) be exempt from these requirements.

2800.69 Additional dementia-specific training. We acknowledge the importance of dementia education. However, we recommend that the 4 hours of training be included as part of the list of inservice topics required annually.

The training requirements for volunteers are a concern. Many family members assist their loved ones with direct care. At-home caregivers who move their loved ones to assisted living should be given the opportunity to continue being involved in the provision of this care as long as it can be done safely. While there is no expectation that family will assist with direct care, they oftentimes want and feel a need to help. To be told that, even though they were providing care for their loved one at home for years, they, as volunteers, cannot help in the assisted living center until they complete training on 16 topics (a 1-7 and b1-6) as well as receive 4 hours of dementia-specific training within 30 days of admitting their loved one (2800.69) is excessive and unreasonable. In addition, this will not lead to positive relations with administration. The transfer of care from family to facility is difficult enough without insulting family caregivers by suggesting that they are not competent to give care and therefore need extensive training before they can continue to assist their loved one.

2800.85 Sanitation. The 2600 regulations for (d) were modified to allow residences that remove trash daily to have uncovered trash receptacles in resident bathrooms. The majority of our residents had great difficulty with covered trash cans due to vision, mobility, and dexterity limitations. Residents were at increased risk for falling due to items not making it into the receptacles or because of residents' repeated attempts to get items into the receptacles. These trash cans were a costly expense for us since they had to be fire retardant. We recommend that facilities that empty trash daily be exempt from having lids on the receptacles.

2800.96 First aid kit. Since CCRCs maintain medical supply rooms, a first aid kit is not necessary. We suggest that you include wording that will permit centers to forego a first aid kit as long as the same supplies are readily available from a designated location. The likelihood of using an Automatic Electronic Defibrillator (AED) on a resident in our community is extremely low. One hundred percent of our personal care residents have Do-Not Resuscitate (DNR) orders. At a cost of $2300 per AED and the low probability of use, one AED per campus seems satisfactory.

2800.97 Indoor activity space. Our personal care residence is adjoined to our Community Building, which provides exceptional and accessible recreational space for our residents, including an Auditorium, Needleworks Room, Library, Computer Room, Art Room, Exercise Room, Woodshop, a large Meeting Room, Puzzle Room, Café, and spacious lobbies. Within the residence, we have one large living room (2480 sq. ft.) for various activities. Our personal care residents enjoy using the Community Building space daily. We cannot add another common room "within the residence" and our residents would not want us to divide the one common room we have into two rooms simply to fulfill a regulation that does not address residents' needs. Two common rooms within the residence are not necessary for quality care. Once again, we ask that you consider CCRCs when defining activity space

2800.101 Resident living units. It is surprising to us that the opening remarks under *Fiscal Impact* state the assumption that those facilities that choose to apply for an AL license *will already comply with the facility structural requirements of the proposed regulations, so no costs are assumed for structural modifications.* The square footage that is required for resident rooms is likely to disqualify large numbers of applicants, particularly those who serve residents with limited financial resources. In our own case, we are fortunate that 33 of our 35 rooms currently meet the requirement of 175 square feet for single occupancy. However, we do not have an additional 80 feet per room required for double occupancy, which our current personal care license permits. We have chosen to provide private rooms for our personal care residents but appreciate the flexibility of space to accommodate more of our life-care residents when needed. According to the regulation, two of our 35 residents would not be able to receive supplemental services even though they reside in the same area as the other 33, simply due to square footage. This is not reasonable.

Our residents are given the option to have a refrigerator in their rooms. Only 5 of 35 residents have opted to do so. Our residents also do not use our kitchenette, which has

a refrigerator, stove, microwave, sink, ice machine, cupboards for storage, and counters for food preparation. None of our 35 residents use the kitchenette, despite its central location and availability at all times. Our residents can choose from two dining areas (a café and a more formal dining room setting) for their meals. It seems that a refrigerator and microwave should be an option, not a requirement, for living units. It is not a good use of finances to provide a refrigerator and microwave in every room when they are not going to be used. The residents should be able to use their living space as they would like, and not be required to take up living space with kitchen appliances that they do not want. In addition, microwaves can be a serious safety concern for residents with dementia. We estimate that this requirement would cost upwards of $10,000.

2800.102. Bathrooms. (c) Thirty-three of our 35 rooms have a shower in the living unit. Two of our bathrooms do not. Thirty-one of our residents prefer to use our specialized tub for supervised bathing, which is located in a separate room within the residence. We also have a shower area for the two rooms without an in-room shower, in case someone residing there would want this option. In-room showers create additional safety challenges since residents who often need assistance initiate bathing on their own without notifying staff. We cannot offer supplemental services through an assisted living license to 33 of our residents and exclude two residents due to room size. This seems to defeat the goals of the assisted living model.

2800.103 Food service. (d) Food shall be stored *off the floor* needs to be re-worded and/or clarified.

2800.131 Fire extinguishers. We have serious concerns about placing a fire extinguisher in each living unit. We have an automated fire alarm response system and full sprinkler system in the residence. We have fire extinguishers located throughout the residence, and staff are responsible for knowing the location of the extinguishers. We have staff members who are assigned to carry a fire extinguisher to the fire location when the alarm sounds. The placement of extinguishers in each living unit is not necessary and creates greater risk of misuse and injury to the residents who may attempt to fight a fire themselves. This would not add to the safety of residents, but rather, might actually increase safety risks. In addition, the total cost for us to add an extinguisher to each room is estimated to be $2800.

2800.141 Resident medical evaluation and health care (a). Our residents are frequently admitted to health care due to emergency situations. Therefore, completion of a medical evaluation *prior to* admission is not possible. Communities with a care continuum already in place should be considered to enable them to meet their residents' urgent health care needs. We recommend extending the completion of the medical evaluation to within 30 days after admission, as written in the 2600 regulations.

2800.162 Meals. (g) We recommend that "appropriate cueing shall be used to encourage and remind residents to eat and drink" *if indicated in their support plans.*

2800.171 Transportation. (b)(5) We have four vehicles used for resident transportation. If each first aid kit must have an AED, this is an added cost of $9200 for equipment that is not going to be used (See 2800.96 concerns). Our community still questions the time we were cited for not having a pair of tweezers in a first aid kit in our van, even though we had tweezers in all other kits as well as ample medical supplies in various designated locations. Our medical director does not want drivers or escorts to be using tweezers on our residents in vehicles. (d) Two of our vehicles are wheelchair accessible; two are not. For residents who are able to travel by automobile, it is not reasonable to require all vehicles to be wheelchair accessible.

2800.185 Accountability of medication and controlled substances. (b)(5) We recommend that clarification be provided to describe what is meant by the requirement to *keep an adequate supply of resident medication on hand at all times.* We are concerned that this could be interpreted to mean that an on-site pharmacy is needed, which is not something we need or can afford.

2800.220 Assisted living residence services. We recommend that escort service to and from medical appointments not be required unless indicated by the resident's Support Plan or is requested by the resident. We also suggest that language be added to reflect that fees may be charged for supplemental services.

2800.224 Preadmission screening. (b) Clarification is needed regarding the expectations when providing a basis for denial for admission. Providers must be very careful when writing reasons for denial so as not to result in litigation related to fair housing laws. If we state that we cannot meet the needs of any resident, we could be accused of discrimination.

2800.225 Initial and annual assessment. We do not see the need for an LPN to be under the supervision of an RN to complete the written assessment. Administrators and designees are not necessarily nurses, so why would an LPN's assessment skills need to be checked by an RN? This requirement adds unnecessary cost to our organization since it is generally the LPN Charge Nurse who completes the assessment. Thousands of dollars in RN time would be incurred.

2800.226 Mobility criteria. As long as agents are made aware of residents with mobility needs when they inspect the residence, it does not seem necessary to notify the Department when a resident has mobility needs.

2800.227 Development of the support plan. Here again we question the need for RN supervision (Please see 2800.224). We also recommend that support plans be reviewed semi-annually rather than quarterly. Support plans are already reviewed when there is a change in condition. Quarterly reviews take time from resident care and add costs. This point also applies to 2800.234(d). Please also add the qualifying phrase that a copy of the support plan will be given to the designated person *upon the resident's request.*

We are concerned that these regulations are promoting an either-or determination: Either we offer personal care on our campus OR we offer assisted living. We see this as defeating the goal of "aging in place" and having a continuum of care. These regulations also do not consider care options that already exist, such as CCRCs, but rather, are intended for newly constructed stand-alone facilities. The costs of compliance far exceed reasonable standards. As written, staff and administration requirements are cost prohibitive for the new assisted living designation. We do not expect to be able to provide this care option.

Thank you for your careful consideration.

Sincerely,

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