This document is a comment on the preliminary DRAFT final regulation. On June 24, 2009, the Department of Public Welfare provided a DRAFT final regulation for public review and comment. The DRAFT final can be found at : http://www.irrc.state.pa.us/Documents/SRCDocuments/Regulations/2712/AGENCY/Document-12700.pdf.

This is an informal process. The Department will consider these comments in preparation of a formal final regulation to be submitted at a later date.

WESTMINSTER VILLAGE
a part of PRESBYTERIAN SENIOR LIVING

2712

24 July 2009

Independent Regulatory Review Commission
333 Market Street, 14th Floor
Harrisburg, PA 17101

To Whom It May Concern::

I am the Administrator of Westminster Village Allentown, a Presbyterian Senior Living Community in which we are currently licensed for 90 beds. I am writing to you to submit my comments on the proposed Assisted Living regulations prior to the department's final submission for approval.

Many changes would need to be made in order to meet these new requirements which are cost prohibitive. The costs associated with compliance regulations passed along to our residents would cause hardship and need for them to convert to charitable care, which would severely impact operating costs at our facility.

A list of concerns regarding the new proposed regulations is listed below.

Licensure Fees: While the Department has adjusted the initially proposed licensure fees, the newly proposed $300 initial application fee coupled with the per bed fee of $75 would still results in a significant burden on facilities. My facility would have to divert $4,875.00 allocated to Resident care services to even apply for licensure. This cost would need to be passed on to our private paying residents. It is still a significant barrier to entrance and will result in large areas of the Commonwealth left without Assisted Living Services.

Discharge of Residents: The residence must be permitted to maintain control over the transfer and discharge of its residents as is called for in Act 56 of 2007. Certain provisions that were advanced in previous proposed regulations have been appropriately disposed, however newly inserted language forces this issue to remain as a preeminent concern for us.

Administrator Requirements: The requirement for the Administrator to be on site for 40 hours a week is higher than the requirement for higher levels of care such as skilled nursing. This is also impractical as conferences, CEU education, marketing and community events are all a normal part of the Administrator's job and take place off site. Also, an exception for licensure as an Assisted Living Administrator should be granted to Personal Care Home Administrators by passing a competency test, rather than attend a 100 hour training course.

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Proposed Regulations Ignore Key Provisions of Act 56 of 2007: The Department's proposed regulations at several points either exceed the authority granted by Act 56 of 2007 or are contrary to the statute. Those areas include:

a. TRANSFER AND DISCHARGE. The proposed regulations exceed the statutory framework with regards to transfer and discharge. Act 56 clearly notes that the residence, through its medical staff and administration, will determine what services it is comfortable having provided on its campus, and when it feels the needs of the resident can no longer be served at that level may initiate a transfer in Section 1057.3(f) and Section 1057.3(h). The regulations at 228(b)(2) counter the statutory framework when it mandates that the —residence may not transfer or discharge a resident if the resident or his designated person arranges for the needed services.

b. USE OF OUTSIDE PROVIDERS. Supplemental health care service provision is another area in which the regulations deviate from what the legislature intended. The legislation states that the provider —may require residents to use providers of supplemental health care services designated by the assisted living residence, so long as it is stated in the contract. Section 1057.3(a)(12). The regulations in Section 142(a) scale back the clearly articulated right of providers to designate preferred providers in contradiction to the statute.

Survey Process - 2800.3(b): The proposed regulations give the Department very broad authority to survey Assisted Living Residences. The language permits the Department to survey a residence at any time, without and standard for justification, and as frequently as it wishes. No other long-term care provider is subject to such a standard. The regulations should require annual surveys, with additional inspections when evidence of reliable complaint.

Access 2800.5(a): There is a concern with mandating access to organizations or individuals to information on residents that could be sensitive in nature. In particular, any record involving medical information could lead to HIPPA violations. Language should be included that resident records and information would be provided appropriate levels of confidentiality consistent with federal and state law.

Resident handbooks 2800.22(b)(3): We strongly believe that it is inappropriate for the Department to have the authority to approve or disapprove of an Assisted Living Residence's resident handbook. This provision exists nowhere else in the continuum of care, and should not exist here either. The presumption is that not only will the Department have to approve the initial release of the handbook, but also approve any alterations and amendments to the handbook. We fail to see how the Department will have the resources to allocate to the review and approval of all resident handbooks and all amendments to existing handbooks. Delays and backlogs are inevitable, and providers will be left to wait and watch as the Department tries to keep pace. This provision should be stricken.

Contract Termination - 2800.25(b): We are concerned with the lack of equity in the allowance to terminate a residency contract. Automatic renewal of the residency contract on a month-to-month basis is an appropriate method of treating the relationship. However, there is no basis for allowing the resident to terminate the contract with 14 days notice to the provider, while binding the provider to 30 days notice of termination to the resident. The administrative responsibilities placed upon the residence in order to discharge a resident, whether at the provider's request or the resident, demands a 30 day timeframe. Moreover, the general principle in contract law is to all both parties 30 days notice to terminate a month-to-month contract. It seems reasonable to uphold that principle. **Both parties should be held to the same notification requirements, and the appropriate time frame is 30 days.**

Room Furnishing 2800.42(l): We currently enjoy having residents decorate and furnish their living spaces with personal items from their own home, but this is not without real concerns. Should a resident choose to include a gas burning fireplace as part of their furnishings, dire consequences could result. We ask the Department to include language that would allow unsafe items that are inconsistent with Fire safety/Life safety regulations to be prohibited without fear of regulatory violations under this section.

Training - 2800.65([e](g)): The combined educational requirements set forth in this proposed regulatory package exceed those required for Nursing Home Administrators and Registered Nurses. This poses an insurmountable burden for assisted living residences. We urge the Department to abandon this new attempt to increase the training hours and return this requirement to the previously agreed upon 12 hours annually.

Medical Evaluations - 2800.141(a): We strongly recommend that allowances be made for a medical evaluation post-admission. It is not always feasible and practicable, for instance during an emergency placement, for the residence to have an evaluation performed prior to the resident's admission to the residence. The current 2600 Personal Care Home regulations currently allow for a medical evaluation for up to 30 days after admission, and this provision has been working well.

Special Care Units - 2800: We have significant concerns with the inclusion of the intense neurobehavioral rehabilitation and brain injury component to the Special Care Unit subpart. Services provided for INRBI are highly specialized and do not necessarily align with best practices for treatment of Alzheimer's Disease and dementia. In some cases, approaches to the two conditions may be diametrically opposed to each other. For instance, 2800.232(d) prescribes that a residence having a secured dementia unit will —minimize environmental stimulation. While this is sound practice when caring for an individual with an INRBI, it absolutely runs counter to best practice for caring for an individual with Alzheimer's Disease, and makes this provision inappropriate for a Special Care Unit. The two populations are very distinct and should not be governed under the same umbrella of regulations. We strenuously urge the Department to consider the creation of a separate INRBI designation under 2800.11(f). Also, the requirement that an individual diagnosed with Alzheimer's Disease or dementia and residing in a Secured Dementia Unit be assessed quarterly to determine whether the placement is appropriate is excessive. Once an individual has progressed to the point where it has become necessary to place them in a Secured Dementia Unit, their condition is not going to reverse. Alzheimer's Disease is a degenerative disease from which there is no escape and no cure. Assessments that coincide with an annual Support Plan revision are sufficient.

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 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 does not occur for between 1.7 and 2.5 minutes - more than enough time for even one of our larger communities to have staff respond.

Respectfully submitted,

Cathy Berkheiser

Cathy Berkheiser, Administrator
Westminster Village Allentown