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July 24, 2009

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INDEPENDENT REGULATORY REVIEW COMMISSION

Mr. Bill White
Office of Long Term Living
Bureau of Policy and Strategic Planning
P.O. Box 2675
Harrisburg, PA 17105

Dear Mr. White:

Please accept the following comments to the Assisted Living Residence Draft Final Regulations for Pennsylvania Health Care Association (PHCA) and the Center for Assisted Living Management (CALM). Jointly, PHCA/CALM represents approximately 325 long term care and senior service providers throughout Pennsylvania. Our members offer care and services along the full continuum – from retirement housing with services, nursing centers to assisted living residences to personal care home – and include both proprietary and non-profit organizations.

PHCA/CALM continues to strongly endorse the concept of assisted living as a safe and appropriate setting for many older and disabled Pennsylvanians. While we thank the Department for including some of the changes that were recommended both during the stakeholder process and in our comments on the proposed regulatory package, PHCA/CALM continues to have serious concerns if assisted living will really be a viable option for all Pennsylvanians needing this level of care whether additional significant changes are not made to these regulations before they are published in final form.

PHCA/CALM believes that the final draft regulations are likely to be too costly for the average consumer to afford. We also believe that for many quality facilities currently operating under personal care home licensures, these regulations are as arduous, impractical and unattainable as the proposed regulations which will result in limiting the potential for a vibrant assisted living sector to develop in Pennsylvania.

In our comments, we make suggestions that we believe will create a vibrant and robust assisted living community which will be accessible to all, and protect the interests of both consumers and providers.

Our comments are in four sections. The first section outlines our thoughts on what has commonly become known as "fatal flaws". This section includes areas where we believe the regulations seek to reinterpret the law or are cost prohibitive. The second section describes the two areas that we previously asked to have clarified but have not received any further information to date. The third section is our detailed comments on changes that were made between the proposed regulations and the final draft regulations. The fourth section is a list of sections and sub-sections that were included in our September 2008 comments to the proposed

regulations but were not included in the final draft regulations. We would ask for reconsideration of these comments.

"Fatal Flaws"

Core Services

PHCA/CALM feels that the regulations should define a basic Core Service package which is designed so that consumers are not forced to accept services or pay for services that they neither need nor want. We feel the final draft regulations goes too far in requiring such a broad range of services in the various core services packages. These packages as drafted will be costly, and middle class consumers will be required to pay for services they may neither want nor need thus forcing them to deplete assets more quickly. Individuals with lower income and asset levels may not be able to afford to choose assisted living as an option for their long term care needs. This may create a long term living option only affordable for those that are well off.

We believe that a basic core service package should be offered which can be augmented by the offering of ancillary services as well as supplemental services if the residence chooses. The price of the basic core service package as well as any ancillary services and supplemental health care services provided by the ALR should be fully disclosed to the resident/potential resident. Having the prices of the basic core service package and ancillary services fully disclosed allows individuals seeking AL admission to comparison shop.

ALR's should also not be required to charge the basic core service package charge to resident's that don't require services, i.e. independent living residents. Often these individuals have a spouse in the ALR that does require services.

PHCA/CALM recommends the following regulatory amendments:

2800.4 Definitions

Requested Revisions

Core Services – The assisted living services that are provided by a residence as part of a core service package and charged as a single price.

Ancillary Services – The assisted living services that are provided by a residence and may be charged on a fee for service basis.

2800.22 Application and Admission

Requested Revisions

2800.22(e)(4)(i) The services and the basic core service package[s that are] offered by the residence.

(ii) the cost of those services and of the basic core service package[s] to the potential resident.

(iii) When a potential resident may require the services not provided in the basic core service [offered in a different core] package.

2800.25 Resident-residence contract

Requested Revisions

2800.25(c)(2) [A fee schedule that lists the actual amount of charges] The charge for [each of the services that are included in]the [residence's] resident's basic core service package

[assisted living services that the individual is purchasing] in accordance with § 2800.220 (relating to service provision).

2800.220. [Assisted living residence services] Service provision.

Requested Revision

2800.220 (a) *Services*. The residence shall provide [core] assisted living services [as specified in subsection (b)]. The residence shall offer the basic core service packages specified in subsection (c) AT A PACKAGE PRICE. THE RESIDENCE SHALL OFFER THE ANCILLARY SERVICES SPECIFIED IN SUBSECTION (D) AND MAY CHARGE A FEE FOR SERVICE PRICE FOR SUCH SERVICES. The residence shall provide or arrange for the provision of supplemental health care services as specified in subsection (d). Other individuals or agencies may furnish services directly or under arrangements with the residence in accordance with a mutually agreed upon charge or fee between the residence, resident and other individual or agency. These other services shall be supplemental to the [core] assisted living services provided by the residence and shall not supplant them.

(b) [*Core services*] *Assisted living services.* The residence shall, at a minimum, provide the following services:

(1) Nutritious meals and snacks in accordance with §§ 2800.161 and 2800.162 (relating to nutritional adequacy; and meals).

(2) Laundry services in accordance with § 2800.105 (relating to laundry).

(3) A daily program of social and recreational activities in accordance with § 2800.221 (relating to activities program).

(4) Assistance with performing ADLs and IADLs [as indicated in the resident's assessment and support plan] in accordance with §§ 2800.23 and 2800.24 (relating to activities; and personal hygiene).

(5) Assistance with self-administration of medication or medication administration as indicated in the resident's assessment and support plan in accordance with §§ 2800.181 and 2800.182 (relating to self-administration; and medication administration).

(6) [Household] Housekeeping and other household services essential for the health, safety and comfort of the resident based upon the resident's needs and preferences.

(7) Transportation in accordance with § 2800.171 (relating to transportation).

(8) Financial Management in accordance with § 2800.20 (RELATING TO FINANCIAL MANAGEMENT).

(9) 24-hour supervision, monitoring and emergency response.

(10) Activities and socialization.

(11) Basic cognitive support services as defined in § 2800.4 (relating to definitions).

[(b)] (c) ~~*Core service packages.* The residence shall, at a minimum, provide the following core service packages:~~

~~(1)~~ *Basic Core SERVICE Package.* ~~This core package shall be provided to residents who do not require assistance with ADLs.~~ THE RESIDENCE SHALL, AT A MINIMUM OFFER A BASIC CORE SERVICE PACKAGE THAT INCLUDES ~~The services shall include~~ the following ASSISTED LIVING SERVICES:

~~(i)~~ (1) 24 hour supervision, monitoring and emergency response.

~~(ii)~~(2) Nutritious meals and snacks in accordance with §§ 2800.161 and 2800.162 (relating to nutritional adequacy; and meals).

~~(iii)~~ (3) Housekeeping and other household services essential for the health, safety and comfort of the resident based upon the resident's needs and preferences.

~~(iv)~~ (4) Laundry services EXCLUDING PERSONAL LAUNDRY in accordance with § 2800.105 (relating to laundry).

~~(v)~~ (5) ~~Assistance with unanticipated ADLs for a defined recovery period~~ UP TO ONE HOUR PER DAY OF INDIVIDUAL SERVICES TO INCLUDE THE FOLLOWING:

(i) ASSISTANCE WITH PERFORMING ADLS AND IADLS.

(ii) BASIC COGNITIVE SUPPORT SERVICES AS DEFINED IN § 2800.4 (RELATING TO DEFINITIONS).

(iii) ASSISTANCE WITH SELF-ADMINISTRATION OF MEDICATION AS INDICATED IN THE RESIDENT'S ASSESSMENT AND SUPPORT PLAN IN ACCORDANCE WITH § 2800.181 (RELATING TO SELF-ADMINISTRATION).

~~(vi)~~ (6) A daily program of social and recreational activities in accordance with § 2800.221 (relating to activities program), INCLUDING TRANSPORTATION TO AND FROM THE SOCIAL AND RECREATIONAL ACTIVITIES SCHEDULED BY THE RESIDENCE.

(7) THE ARRANGEMENT OF TRANSPORTATION TO AND FROM MEDICAL APPOINTMENTS.

~~(vii) Basic cognitive support services as defined in § 2800.4 (relating to definitions).~~

~~(2) *Enhanced Core Package*. This core package shall be available to residents who require assistance with ADLs. The services shall include the following:~~

~~(i) The services provided in the basic core package under subsection (c)(1)(i) through (vii).~~

~~(ii) Assistance with ADLs and unanticipated ADLs for an undefined period of time.~~

~~(iii) Transportation in accordance with § 2800.171 (relating to transportation).~~

~~(iv) Assistance with self-administration of medication or medication administration as indicated in the resident's assessment and support plan in accordance with §§ 2800.181 and 2800.182 (relating to self-administration; and medication administration).~~

(D) *ANCILLARY SERVICES.* THE FOLLOWING ASSISTED LIVING SERVICES MAY BE OFFERED BY THE RESIDENCE AS AN ANCILLLARY SERVICE:

(1) PERSONAL LAUNDRY SERVICES.

(2) FINANCIAL MANAGEMENT SERVICES IN ACCORDANCE WITH § 2800.20 (RELATING TO FINANCIAL MANAGEMENT).

(3) INDIVIDUAL SERVICES IN EXCESS OF ONE HOUR OF CARE INCLUDING THE FOLLOWING SERIVCES:

(I) ASSISTANCE WITH PERFORMING ADLS AND IADLS.

(II) MEDICATION ADMINISTRATION AS INDICATED IN THE RESIDENT'S ASSESSMENT AND SUPPORT PLAN IN ACCORDANCE WITH § 2800.182 (RELATING TO MEDICATION ADMINISTRATION).

(II) BASIC COGNITIVE SUPPORT SERVICES AS DEFINED IN § 2800.4 (RELATING TO DEFINITIONS).

(4) TRANSPORTATION TO AND FROM MEDICAL APPOINTMENTS AND INDIVIDUAL SOCIAL APPOINTMENTS, IF PROVIDED BY THE RESIDENCE.

[(c)] ~~(d)~~ (E) *Supplemental health care services*. The residence shall provide or arrange for the provision of supplemental health care services, including, but not limited to, the following:

(1) Hospice services.
(2) Occupational therapy.
(3) Skilled nursing services.
(4) Physical therapy.
(5) Behavioral health services.
(6) Home health services.
(7) Escort service if indicated in the resident's support plan ~~or requested by the resident~~ to and from medical appointments [if transportation is coordinated by the residence].
(8) Specialized cognitive support services as defined in § 2800.4 (relating to definitions).

[(d) *Cognitive support services*. The residence shall provide cognitive support services to residents who require such services, whether in a special care unit or elsewhere in the residence.]

Informed Consent

PHCA/CALM believes that the language regarding informed consent found in the final draft regulations seems to broaden and otherwise reinterpret the plain language of Act 56 of 2007 rather significantly. SB 704 is clear under the definition of "informed consent agreement" when it specifies that such agreements will be used when a resident's choices "place the resident or other residents at risk of harm". The final draft regulations make this standard much higher when it changes the language to allowing an individual resident to place others at "IMMINENT risk of SUBSTANTIAL harm". This isn't an acceptable standard to the general public and so it is curious why this language would be include in an ALR regulatory package when AL residents are likely to be among Pennsylvania's most vulnerable citizens.

Again, per Act 56 of 2007, informed consent agreements shall only be entered into upon the mutual agreement of the resident and residence. The final draft regulations state that the purpose of the agreement is to document the RESIDENT's choice to accept or refuse services hence negating the aspect of being a "mutual agreement". The final draft regulation also limits the use of this process to choices regarding services and doesn't take into account that the process may be used to modify the inappropriate behavior of a resident. Additionally, while a resident's input is necessary and appropriate in the informed consent process, any final clinical judgment pertaining to such an agreement must be in the hands of the professionals who are providing assisted living and supplemental health care services.

Act 56 is clear in that the informed consent agreement releases the facility from liability for adverse outcomes resulting from actions consistent with the terms of the informed consent agreement. The final draft regulation seems to remove this important protection also.

If the informed consent language is not redrafted to meet the full intent of the law many personal care homes are unlikely to seek assisted living licensure. PHCA/CALM previously submitted language to the proposed regulations that we would ask the Department to reconsider.

2800.30 Informed Consent Process

Requested Revision

2800.30 (a) Initiation of process.

(1) When a residence determines that a resident's decisions, behavior or action creates a situation that places the resident, other residents, or staff members at risk of harm, the residence may either initiate a transfer or discharge as indicated in section 2800.228, or initiate an informed consent process to address the identified risk and attempt to reach a mutually agreed-upon plan of action with the resident or the resident's representative. The initiation of an informed consent process does not guarantee that an informed consent agreement, which is agreeable to all parties, will be reached and executed.

(2) When a resident wishes to exercise independence in directing the manner in which he/she receives care, the resident may initiate an informed consent process to address the identified deviation from the residence's care plan and attempt to reach a revised and mutually agreed-upon plan of action with the residence.

(b) Notification.

(1) When the residence chooses to initiate an informed consent negotiation, the residence shall do so by notifying the resident and, if applicable, the resident's representative in writing and orally. Notification shall be documented in the resident's file by the residence.

(2) When a resident chooses to initiate an informed consent negotiation, the resident shall do so by notifying the residence in writing and orally. Notification shall be documented in the resident's file by the residence.

(3) Residents who are diagnosed with cognitive impairment shall be eligible for an informed consent agreement only if the individual's guardian or legal representative is included in the negotiation of the informed consent agreement and signs the agreement when executed.

(c) Resident's involvement. The resident shall be entitled, but is not required, to involve his representative and physician, to assist in developing a satisfactory informed consent agreement.

(d) Informed consent meeting.

(1) In a manner the resident can understand, or in the case of an individual with cognitive impairments that individual's guardian or legal representative, the residence may discuss the decision, behavior or action that places the resident or persons other than the resident in potential harm, the substantial risks and hazards inherent in the resident's action, reasonable alternatives for mitigating the risk, if any, the significant benefits and disadvantages of each alternative reasonably identified and the most likely outcome of each alternative. If no acceptable alternatives exist, the negotiation shall be treated as unsuccessful.

(2) A resident shall not have the right to place persons other than themselves at risk, but, consistent with statutory and regulatory requirements, may elect to proceed in the possible development of an informed consent agreement which affects only his or her own safety or health status At this point, the resident and residence may initiate negotiation on an informed consent agreement acceptable to all parties. During the negotiation of the informed consent agreement, the resident shall cease the actions and/or behavior that prompted the initiation of

the negotiation and comport himself/herself according to the original care plan and according to all rules and policies of the residence.

(e) Successful negotiation. If the parties agree, the informed consent agreement shall be reduced to writing and signed by all parties, including individuals engaged in the negotiation, and shall be retained in the resident's file as part of the service plan.

(f) Unsuccessful negotiation. The residence retains the right not to sign an informed consent agreement if it determines that the agreement creates an unacceptable level of risk for the residence. The residence shall notify the resident and the resident's representative that agreement has not been reached, and whether the residence will issue a notice of transfer or discharge.

(g) Freedom from duress. An informed consent agreement must be voluntary and free of force, fraud, deceit, duress, coercion or undue influence. A residence may issue a notice of discharge in the event a resident's decision, behavior or action fails to mitigate the risk under discussion, and places the resident or persons other than the resident at risk of harm and, after a discussion of the risk, the resident declines alternatives to mitigate the risk, including entering into an acceptable informed consent agreement. The issuance of a notice of discharge shall not be considered as duress, coercion, force or undue influence.

(h) Individualized nature. An informed consent agreement shall be unique to the resident's situation and utilized only when a resident's decision, behavior or action creates a situation that places the resident or persons other than the residents at risk of harm. A residence shall not require execution of an informed consent agreement as a standard condition of admission.

(i) Liability. Execution of an informed consent agreement shall release the provider from liability for adverse outcomes resulting from actions consistent with the terms of the informed consent agreement.

(j) Change in resident's condition. An informed consent agreement must be updated following a significant change in the resident's condition that affects the risk potential to the resident or persons other than the resident, according to the process outlined above.

Transfer/Discharge

PHCA/CALM feels that the transfer and discharge provisions contained in the final draft regulation have the potential to require that a resident stay in a setting where they cannot safely receive care. We believe that the law provided for safeguards so that the final clinical judgment regarding whether an individual can be safely cared for in an ALR setting should rest in the hands of health care professionals who ultimately are responsible for the care of the resident. The regulations seem to indicate that the ALR must keep the resident if they or their designated person arranges for services – no matter what. Hence the law and the final draft regulations seem to be in direct conflict. Furthermore, if facilities cannot transfer or discharge individuals who they believe they cannot safely care for – they may not be willing to become ALR's

PHCA/CALM respectfully requests that the language we previously submitted to the proposed regulations be reconsidered.

2800.228 Transfer and Discharge

Requested Revision

(a) When a residence determines that it can no longer provide services, including services as defined in 2800.220, residence shall provide a safe and orderly transfer or discharge for the resident. The resident shall be transferred or discharged with all his medications, durable

medical equipment and personal property. The residence may permit the resident to participate in the decision relating to the relocation.

(b) If the residence initiates a transfer or discharge of a resident, or if the legal entity chooses to close the residence, the residence shall provide a 30-day advance written notice to the resident (except as noted in section (3) below), the resident's family or designated person or legal representative as stipulated in the resident-residence contract.

(1) The 30-day advance written notice must be written in a language and manner the resident understands, or performed in American Sign Language or presented orally in a language the resident understands if the resident does not speak standard English. The notice must include the following:

(i) The [specific] reason for the transfer or discharge.

(ii) The effective date of the transfer or discharge.

(iii) The location to which the resident will be transferred or discharged, if it is known.

(2) Prior to initiating a transfer or discharge of a resident, the residence shall make reasonable accommodation for aging in place that may include services from outside providers as defined in 2800.220 as stipulated in the resident residence contract.

(3)Notice must be provided at least 30 days prior to the transfer. Exceptions to the 30-day requirement apply when the transfer is effected because of:

(i)Endangerment to the health, safety or well-being of others in the residence;

(ii) When a resident's medical or psychiatric needs require more immediate transfer

(iii)When a resident is abused in a residence;

(iv) When the Department initiates closure of the residence and

(v)When a resident has not resided in the facility for 30 days.

(c) A residence shall provide the Department written notice of its intent to close the residence at least 60 days prior to the anticipated date of closing.

(d) A residence may not require a resident to leave the residence prior to 30 days following the resident's receipt of a written notice from the residence regarding the intended closure of the residence, except when the Department determines that removal of the resident at an earlier time is necessary for the protection of the health, safety and well-being of the resident.

(e) The date and reason for the transfer or discharge, and the destination of the resident, if known, shall be recorded in the resident record and made available to the Department upon request.

(f) If the legal entity chooses to voluntarily close the residence or if the Department has initiated legal action to close the residence, the Department working in conjunction with appropriate local authorities, will offer relocation assistance to the residents. Except in the case of an emergency, each resident may participate in planning the transfer. These procedures apply
even if the resident is placed in a temporary living situation.

(g) Within 30 days of the residence's closure, the legal entity shall return the license to the Department.

(h) The grounds for transfer or discharge of a resident from a residence include the following circumstances:

(1) If a resident is a danger to himself or others and the behavior cannot be managed through [interventions,] services per 2800.220 [planning] or informed consent agreements.

(2) If the legal entity chooses to voluntarily close the residence, or a portion of the residence.

(3) If a residence determines that a resident's functional level has advanced or declined so that the resident's needs cannot be met in the residence. The residence will provide all supporting documentation regarding the discharge to the Department, upon request. If assistance with

relocation is needed, the administrator may contact appropriate local agencies, such as the area agency on aging, county mental health/mental retardation program or drug and alcohol program, for assistance. The administrator may also contact the Department.
(4) If meeting the resident's needs would require a fundamental alteration in the residence's program or building site, or would create an undue financial or programmatic burden on the residence.
(5) If the resident has failed to pay the residence after reasonable documented efforts by the residence to obtain payment.
(6) If closure of the residence is initiated by the Department.
(7) Documented, repeated violation of the residence rules.
(8) A court has ordered the transfer or discharge.

Supplemental Health Care Services

We believe the law is somewhat ambiguous regarding whether or not a resident can select or retain their primary care physician. Hence we believe that as long as the physician follows the policies/procedures of the ALR, the resident should be permitted to continue to utilize that physician

Additionally, while the law is clear that an ALR may require a resident to use approved or designated providers of supplemental health care services, we also believe that it is prudent that an ALR attempt to allow residents to utilize supplemental health care providers that are covered by the resident's health care coverage. That being said the supplemental health care provider must agree to abide by the policies/procedures of the ALR.

In both of these provisions, if the physician or supplemental health care provider refuses to follow the policies/procedures of the ALR, the ALR should aid the resident in finding service providers who will.

2800.142. Assistance with [health] medical care and supplemental health care services.

Requested Revision

2800.142[(a)] (b) The residence shall assist the resident to secure medical care and supplemental health care services.

(i)The residence shall permit a resident to select or retain his primary care physician PROVIDED THAT THE PHYSICIAN COMPLIES WITH THE POLICIES AND PROCEDURES OF THE RESIDENCE. IF THE RESIDENT'S PRIMARY CARE PHYSICIAN FAILS TO COMPLY WITH THE POLICIES AND PROCEDURES OF THE RESIDENCE, THE RESIDENCE SHALL ASSIST THE RESIDENT IN THE SELECTION OF A PRIMARY CARE PHYSICIAN APPROVED BY THE RESIDENCE.

(ii) To the extent prominently displayed in the written admission agreement, a residence may require residents to use providers of supplemental health care services approved or designated by the residence.

(iii) If the resident has health care coverage for the supplemental health care services, ~~the approval may not be unreasonably withheld~~ THE RESIDENCE SHALL MAKE EVERY EFFORT TO APPROVE A SUPPLEMENTAL HEALTH CARE PROVIDER THAT ACCEPTS THE RESIDENT'S HEALTH CARE COVERAGE PROVIDED THAT THE SUPPLEMENTAL HEALTH CARE PROVIDER COMPLIES WITH THE POLICIES AND PROCEDURES

OF THE RESIDENCE. IF THE SUPPLEMENTAL HEALTH CARE PROVIDER FAILS TO COMPLY WITH THE POLICIES AND PROCEDURES OF THE RESIDENCE, THE RECIDENCE SHALL ASSIST THE RESIDENT IN THE SELECTION OF A SUPPLEMENTAL HEALTH CARE PROVIDER APPROVED BY THE RESIDENCE .

(iv) The residence shall document the resident's need for the medical care, including updating the resident's assessment and support plan IF THERE IS A CHANGE IN THE RESIDENT'S CONDITION.

Number of staff with CPR training/certification

The cost to train, certify and recertify staff for a 1 – 20 ratio would be very high and would not increase quality care. We suggest an appropriate ratio might be 1 – 20 individuals trained in CPR for residents requiring supplemental health care services. For those not requiring supplemental health care services, a ratio of 1 – 50, the same as personal care homes would be appropriate.

2800.63. First aid, CPR and obstructed airway training.

Requested Revision

2800.63(a) [There shall be sufficient staff] For every 20 residents REQUIRING SUPPLEMENTAL HEALTH CARE SERVICES there shall be at least one staff person trained in first aid and certified in obstructed airway techniques and CPR present in the residence at all times to meet the needs of the residents. FOR EVERY 50 RESIDENTS NOT REQUIRING SUPPLEMENTAL HEALTH CARE SERVICES THERE SHALL BE AT LEAST ONE STAFF PERSON TRAINED IN FIRST AID AND CERTIFIED IN OBSTRUCTED AIRWAY TECHNIQUES AND CPR PRESENT IN THE RESIDENCE AT AL TIMES TO MEET THE NEEDS OF THE RESIDENTS.

Licensing Fees

While we appreciate the fact that the department lowered the fee structure, for a 100 bed facility in the final draft regulation, the licensure fee would still amount to $7800 per year, which is greater than other states with AL with the exception of Washington State which is $7900. This $7800 when compared to the current licensure fee for a 100 bed personal care home of $30 or a 100 bed nursing home of $300 seems seriously out of line. Frankly, the language in Act 56 of 2007 is clear in that the licensure fees for ALR's is meant to augment the funds otherwise provided by state government to pay for quality assurance. With fees of the magnitude proposed in this final draft regulation it would seem that they will do more than augment state funds. Finally but foremost, high licensure fees may hinder the ability of facilities to become licensed as ALR's thus reducing consumer choice.

To this end, PHCA/CALM recommends that the per facility fee stay at the $300 in the final draft regulation but the per bed fee be dropped to $10 with an aggregate cap of $1000.

2800.11. Procedural requirements for licensure or approval of assisted living residences; special care designation and dual licensure.

Requested Revision

2800.11(c) (2) A [$105] ~~$75~~ $10 per bed fee that may be adjusted by the Department ~~annually at a rate not to exceed the Consumer Price Index~~ PROPORTIONATELY TO INCREASES IN MEDICAL ASSISTANCE REIMBURSEMENT FOR ASSISTED LIVING SERVICES. The Department will publish a notice in the *Pennsylvania Bulletin* when the per bed fee is increased. NO ASSISTED LIVING RESIDENCE SHALL BE

REQUIRED TO PAY MORE THAN $1,000 WHEN AGGREGATING THE LICENSE APPLICATION OR RENEWAL FEE AND THE PER BED FEE.

2800.101 Resident Living Units – Size of Living Units

PHCA/CALM feels strongly that in order for assisted living to be a vibrant sector of the long term care continuum, consumers should have choice regarding the size of the living unit they want and can afford. While we appreciate the survey information that the Department requested of personal care homes and the sharing of those results, we believe this information to be inconclusive. According to the results shared, only 50% of the homes completed the survey. Some counties didn't have any facilities complete the survey and thus it remains unclear on a county by county basis if there will be sufficient AL capacity under the living unit square footage requirements found in both the proposed and final draft of the regulations. When considering the data, this may be even more of a concern in some of the most rural areas of the commonwealth.

Additionally, it will be very expensive for providers to build to the 250 square feet for new construction. In the comments submitted by PHCA/CALM on September 15, 2008 to the proposed regulations, we stated that based on a survey, the likely monthly charge to AL residents for a living unit of 250 square feet would be $4615. This would be for shelter and basic core services with the potential for additional charges for supplemental services. A charge this costly would only allow the well to do to afford the ALR setting for their long term living needs. The cost to build such large units would also be extremely costly hence putting a strangle hold on a budding long term living choice for consumers.

Finally, Act 56 of 2007 allows for an exception process for ALR's that don't meet the size of the living unit. Neither the proposed regulations nor the final draft regulations address this issue. PHCA/CALM recommends that the Department consider including a straight forward, expeditious and fully transparent exception process in the final regulations, and not rely solely on the waiver process as found in 2800.19, so that assisted living can be the long term living option of choice for Pennsylvanians who could otherwise be safely, effectively and affordable served in the ALR setting.

We recommend that the Department re-consider the size of living units both for current and new construction including the geographic distinctions within the population and current stock of personal care homes before publishing the final regulations. As stated above, we feel strongly that an exceptions process should also be included.

Kitchen capacity

PHCA/CALM believes that the clarifications made to kitchen capacity in existing facilities are an acceptable compromise. We would ask however that the Department consider adding language which would require an ALR to determine if a resident/potential resident could use cooking appliances such as a microwave oven safely before it is offered to a resident/potential resident.

2800.101 Resident Living Units

Requested Revision

2800.101(c)(2)(ii)(A) Upon entering the assisted living residence, PROVIDED IT HAS BEEN DETERMINED SAFE FOR THE RESIDENT, the resident or his designated person shall be asked if he wishes to have a cooking appliance. The cooking appliance shall be provided by the residence if desired by the resident or his designated person. If

the resident or his designated person wishes to provide their own cooking appliance, it shall meet the residence's safety standards.

The necessity for all newly constructed facilities to equip living units with a kitchen that possesses a sink with hot and cold running water, has the potential to present a serious barrier to the establishment of a vibrant assisted living sector in the commonwealth. We propose that the standard for new constructions be the same as that for existing construction.

Requests for Clarification

On July 16, 2009, PHCA/CALM submitted a request for clarification regarding administrator staffing and RN supervision regarding completion of assessments as listed below. As of the date of this writing, PHCA/CALM has not received clarification and therefore are resubmitting this language as part of our comments to the final draft regulations.

2800.56 - Administrator staffing –

It appears that this provision could be interpreted in two different ways when reading the plain language. If you read (a) and (b) together, the language seems to indicate that an administrator or designee would only need to be present 40 hours or more per week, in each calendar month and that when neither the administrator nor the designee were present, a staff person would be assigned to supervise the residence. However, if one reads (b) alone it appears that an ALR would need to have an administrator or administrator designee, i.e. someone with the same training required for an administrator - in the building 24 hours a day 7 days a week.

We believe that the Department does not seek to require an individual with the training of an administrator to be on site 24 hours a day, 7 days a week but rather that at all times an individual must be assigned to supervise the facility if the administrator or the administrator designee is not on site.

Requested Revision

Delete the definition of "designee" found in 2800.4 and add the definition of an "administrator designee"

Administrator designee – an individual that meets the following:

(i) has completed the administrator training requirements found in 2800.64(a)(1)(2)

(ii) is authorized in writing to fill the role of the administrator to meet the requirements of 2800.56 (a)

Additionally, section 2800.56 should be changed as follows:

(a) The administrator or administrator designee shall be present in the resident an average of 40 hours or more per week, in each calendar month. At least 30 hours per month shall be during normal business hours.

(b) The administrator shall [designate] assign a staff person to supervise the residence in the administrator's or administrator designee's absence. [The designee shall have the same training required for an administrator.]

2800.224 Initial assessment and preliminary support plan and 2800.225 Additional assessments

In both 2800.224(a)(1) and 2800.225(a), the language regarding who shall complete the initial assessment seems to suggest that a registered nurse must supervise the administrator or

administrator designee. We question if this was the intent or if the RN supervision was referring only to the LPN. If it refers only to the LPN we would suggest moving the comma from after LPN and placing it between "RN or a RN shall complete the assessment".

Requested Revision

2800.224(a)(1) The administrator or administrator designee, or licensed practical nurse [,] under the supervision of a registered nurse, or a registered nurse shall complete the initial assessment.

2800.225(a) The administrator or administrator designee, or licensed practical nurse [,] under the supervision of a registered nurse, or a registered nurse shall complete additional written assessments for each resident as follows:

Detailed Comments on Final Draft Regulation

In an attempt at brevity, PHCA/CALM will not submit detailed comments previously submitted if language hasn't been changed. However, following our detailed comments we will provide a list of the sections/subsections we submitted comment on from the proposed to final draft regulation that we suggest be considered in the development of the final regulation prior to publication.

2800.3(c) Abbreviated Survey

The law allows the Department to provide for an abbreviated annual licensure process. PHCA/CALM recommends that the language in the proposed regulation be retained, thus allowing the Department the ability to develop an abbreviated process in the future without having to revise the regulation.

Requested Revision

(c)The Department may conduct an abbreviated annual licensure visit if the assisted living residence has established a history of exemplary compliance.

2800.4 Definitions

Basic cognitive support services – PHCA/CALM feels that this new definition is much broader than what would be considered "basic cognitive support services" in an ALR setting. We recommend that subparagraphs (iv), (v), and (vi) be removed from this definition.

Common living area – This definition as written seems to indicate that an ALR would be required to have a swimming area. We believe this was an unintentional oversight and would recommend the following change

Requested Revision

(iv) swimming area, if present in the residence

Distinct Part – PHCA/CALM feels that the definition as drafted is too narrow and would not provide for true dual licensure thus enabling residents to have the ability to age in place with the least amount of disruption to their daily routine. We therefore recommend that the definition of distinct part be amended as indicated below. We feel that the recommended definition will alleviate the need for residents to have to relocate a significant distance from their personal care home room unlike the distinct part definition found in the final draft.

Requested Revision

Distinct Part – [A portion of a building that is visually separated] One or more clusters of living units located in the same building or on the same premise. A cluster is two or more contiguous rooms.

Exemplary Compliance – A definition should remain in the regulation. PHCA/CALM previously recommended a modification to the language found in the proposed regulation and recommends consideration of that amendment.

Poison – PHCA/CALM encourages the Department to provide a definition for poisons in order to avoid any inadvertent deprivation of a resident's right to possess personal toiletry items such as hairspray, deodorant, perfume and cologne.

Requested Revision

Any substance that causes injury, illness, or death when ingested. Personal hygiene and toiletry products—including, but not limited to, shampoo, toothpaste, hand sanitizer, and soaps—are exempted from this definition.

Specialized Cognitive Support Services – We recommend that the revisions contained in the basic cognitive support services definition that we ask to have deleted above be included in this definition.

Requested Revision

(vii) Measures to address wandering
(viii) Dementia-specific activity programming
(ix) Specialized communication techniques

2800.5 Access

PHCA/CALM believes that there is inconsistent language with regard to access to records between this section and subsections 2800.42(k) and 2800.254(c). We feel that the language in sections 2800.42 (k) and 2800.254 is appropriate and paragraph (5) of this section with regards to residents records is unnecessary.

Additionally, the language in subsection 2800.42(r) regarding resident rights to receive visitors gives sufficient access to the resident for legal representatives. Hence, all of paragraph (5) should be struck.

2800.11 Procedural requirements for licensure or approval of assisted living residences: special care designation and dual licensure

2800.11 (c) – Fees – Please refer to comments made at the beginning of this document.

2800.11(e) – PHCA/CALM suggests that clarifying language be added that would allow distinct parts located in multiple buildings on the same premises be eligible for a single license.

Requested revision

Multiple buildings located on the same premises may apply for a single assisted living residence license. Distinct Parts located in multiple building on the same premises may apply for a single assisted living residence license.

2800.11(g)(1)Since the proposed and final draft regulations do not allow for living units to be dually licensed as AL and PCH, in order for a resident to be eligible for Medical Assistance benefits they will need to reside in an ALR living unit. Hence a resident may be required to

transfer based on payment source, the language in (g) (1) would not allow for this transfer therefore we recommend the following revisions.

Requested revision-

Delete 2800.11(g)(1) and add

(h) An ALR shall not segregate residents based on payment source

2800.19 Waivers

2800.19(b) PHCA/CALM is pleased that this section was added. In an era of transparency, we would request that the following language also be added to this subsection

Requested addition

(b) Following receipt of a waiver request, the Department will post the waiver request on the Department's website with a 30-day public comment period prior to final review and decision on the requested waiver. All approved waivers shall be permanently posted on the Department's website.

2800.19(c) This provision as drafted would require qualified staff such as certified nursing assistants to repeat all of the required training even though their training exceeds the ALR requirements. Hence we ask that the Department eliminate staff training requirements from the items listed as exempt for waiver requests.

Additionally, we believe that "resident's family" be clarified to include only family members that the resident designates. Therefore information will not be shared with family members against the resident's wishes.

Requested revision

[(b)] (c) The scope, definitions, applicability or residents' rights, assisted living service delivery requirements, special care designation requirements, [staff training requirements,] disclosure requirements, complaint rights or procedures, notice requirements to residents or the resident's family as designated by the resident, contract requirements, reporting requirements, fire safety requirements, assessment, support plan or service delivery requirements under this chapter may not be waived.

2800.22 Application and admission

2800.22(a)(4) PHCA/CALM recommends that the word "final" be dropped as this could signify "last" when a support plan will be an evolving document during a resident's stay as their condition changes.

2800.22 (b.1) Since all ALR's may not provide supplemental health care services, we request that this section be modified to allow for arranged as well as provided services.

Requested Revision

A certification shall be made, prior to admission, that the needs of the potential resident can be met by the services provided or arranged by the residence.

2800.22(b.3) PHCA/CALM requests that this paragraph be deleted in consideration of Federal statutes such as; Fair Housing (**Sec. 804.c [42 U.S.C. 3604]**) and the Americans with Disabilities Act. This paragraph as written potentiates liability and gives rise to federal code violation(s) for providers. A written basis of denial is in direct conflict with the stated statues, does not meet the standards for permissible discrimination.

Requested Revision

~~22(b.3) A potential resident whose needs cannot be met by the residence shall be provided with a written decision denying their admission and provide a basis for their denial. The decision shall be confidential and may only be released with the consent of the potential resident or his designated person. The potential resident shall then be referred to a local appropriate assessment agency.~~

2800.22(e)(4)(i), (ii) and (iii) Please see the comments made earlier in this document regarding core service packages.

2800.25 Resident-Residence Contract

2800.25 (c)(2) Please see comments made earlier in this document regarding core services and other services which an ALR may provide at an additional charge to the resident.

2800.25(k) Per our comments at the beginning of this document, this subsection should be modified

Requested Revision

[(i)] (k) The resident-residence contract shall identify the assisted living services included in the core package the individual is purchasing,[and] the total price for those services, the ancillary services the resident is purchasing and the price for each service. Supplemental health care services shall be packaged, contracted and priced separately from the resident-residence contract. Services provided by or contracted for by the residence other than supplemental health care services must be priced separately from the service package in the resident-residence contract.

2800.30 Informed Consent – please see the comments made earlier in this document.

2800.42Specific rights

2800.42(z) Primary Care Physician – As stated earlier in this document, we are not opposed to allowing a resident to use their own primary care physician provided that the physician follow the policies and procedures of the ALR. If the physician does not comply with those policies/procedures, the ALR should assist the resident with finding a new primary care physician.

Requested Revision

2800.42(z) The resident has the right to choose his primary care physician provided that the physician complies with the policies and procedures of the residence.

2800.44 Complaint Procedures

2800.44(h) – The language in this subsection appears to promote litigation. Current state and federal law allows for arbitration provisions in resident-residence contracts and this statement conflicts with such provision. We ask that this subsection be deleted.

2800.51 Criminal History checks

2800.51(b)PHCA/CALM wants to avoid the need to revise the regulations simply if the hiring policies in accordance with the Older Adult Protective Services Act interim policy as it stands today should change or if at some point regulations are promulgated. We would ask that the Department seek to develop language that would require ALR's to follow the standard in place as it may change over time but would not require these regulations to be modified.

2800.54 Qualifications for direct care staff persons

2800.54(a)(4) PHCA/CALM believes that this addition could be read to mean that all staff would need to be fluent in every and all languages in order to comply. We don't believe that this was the Department's intent as no ALR would be able to meet this requirement. If this provision were to stay as it, it could severally limit the ability of some potential residents to find placement if no staff were available that could speak their particular language or dialect in the geographic area where they would like to live. We recommend deleting this section.

Requested Revision

~~(4) Be able to communicate in a mode or manner understood by the resident.~~

2800.60 Additional staffing based on the needs of the residents

2800.60(d) Many PHCA/CALM members already employ nurses round the clock in their Personal Care Homes and/or Skilled Nursing facilities. It is probable that this practice would continue from those organizations who may seek assisted living licensure. Our suggested language eliminates the redundancy of having a licensed nurse on-call if one is already present in the building.

Requested Revision.

60(d) In addition to the staffing requirements in this chapter, the residence shall have a licensed nurse available in the building or on call at all times. The ~~on-call~~ licensed nurse shall be either an employee of the residence or under contract with the residence.

2800.61 Substitute personnel

2800.61: Due to the overwhelming cost of utilizing "agency staff" many facilities routinely attempt to cover unanticipated staff absences with regular staff who meet the training requirements specific to this proposed regulatory package. In extreme cases though, agency staff may need to be utilized. By the very nature of the staffing emergency, it is impossible for ALR's to ensure that an agency employee contracted to cover one shift could be appropriately oriented. PHCA/CALM requests revision to the language in this section as well as portions of section 2800.65 as provided below

Requested Revision

2800.61 When regularly scheduled direct care staff persons are absent, the administrator shall arrange for coverage by substitute personnel who meet the direct care staff qualifications and substitute personnel training requirements as specified in §§ 2800.54 and 2800.65 (relating to qualifications for direct care staff persons; and staff orientation and direct care staff person training and orientation).

2800.64 Administration training and orientation

2800.64(b)(19) The language in this paragraph is unclear and depending on the intent, could mean training would have to occur nearly weekly as the demographics, medical needs and psychosocial needs of the resident population changes. PHCA/CALM recommends that this language be deleted.

Requested Revision

~~.64(b)(19) Training specific to the resident composition.~~

2800.65 Staff orientation and direct care staff person training and orientation

See explanation above regarding 2800.61 for this requested revision

Requested revision

2800.65 (b) Direct care staff persons, excluding substitute personnel shall complete an initial orientation program approved by the Department before providing direct care to residents.

2800.65 (d) Within 40 scheduled working hours, direct care staff persons,[ancillary staff persons, substitute personnel] and volunteers shall have an orientation training that includes the following:
(1) Resident rights.
(2) Emergency medical plan.
(3) Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P. S. §§ 10225.101--10225.5102).
(4) Reporting of reportable incidents and conditions.
(5) Safe management techniques.
(6) Core competency training that includes the following:
(i) Person-centered care.
(ii) Communication, problem solving and relationship skills.
(iii) Nutritional support according to resident preference.

Add
2800.65 (e) Within 40 scheduled working hours, ancillary staff persons and substitute personnel shall have an orientation training that includes (d)(1) through (4).

2800.65(c) The CPR requirement in this subsection conflicts with 2800.63(a). PHCA/CALM submitted a requested revision for 2800.63(a) earlier in this document. We request that 2800.65(c) be deleted.

2800.65([d](f)) PHCA/CALM recommends that the number of hours be removed from this section since it is yet unknown how many hours will be required in the Department-approved direct training course as specified in paragraph (2) of this section.

Requested Language

.65 (f) Direct care staff persons may not provide unsupervised assisted living services until completion of ~~18 hours of training~~ in the following ~~areas~~:

2800.65([e](g)) The annual training requirement found in this section, exceeds those of nursing assistants that provide direct care in a nursing home setting. Since many AL residents, will not need the extensive care of those in a nursing home; the addition of 4 more hours of training appears excessive. PHCA/CALM asks that this provision be changed back to the 12 hours as was included in the proposed regulations. Additionally, dementia care education should be required, but it should be included in the 12 hour yearly requirement.

Requested Revision

65(g)Direct care staff persons shall have at least [~~16~~]**12** hours of annual training relating to their job duties. [~~The training required in 2800.69 (relating to additional dementia-specific training) shall be in addition to the 12 hour annual~~

2800.101 Resident Living Units

The majority of PHCA/CALM's comments on this section are included earlier in this document, however we also wanted to comment specifically on 2800.101(h)(1)

Requested Revision

2800.101(h)(1) – A bed with a solid foundation and fire retardant mattress that is in good repair, clean and supports the resident. An exception will be permitted for residents who wish to provide their own mattresses provided that the mattresses are clean, pest free, in good repair, and the resident must provide proof that the mattress is fire retardant.

2800.131 Fire Extinguishers

2800.131(c): With the requirement that each living unit have kitchen capacity, it could be interpreted that fire extinguishers could still be required for each living unit that does contain kitchen appliances. To ensure clarity, PHCA/CALM suggests that language be added that specifies only kitchens in common areas be required to contain a fire extinguisher.

Requested Revision

131(c) A fire extinguisher with a minimum 2A-10BC rating shall be located in each common kitchen of the residence. The kitchen extinguisher must meet the requirements for one floor as required in subsection (a).

2800.141 Resident medical evaluation and health care

2800.141(a) PHCA/CALM continues to request that language be included allowing a medical evaluation on the prescribed form 30 days after admission. We feel that this is important especially for residents coming from hospitals, rehabilitation hospitals, nursing facilities, abusive situations or that have no alternative living arrangements. Section 2800.224 allow for initial assessment and preliminary support plans after admission under these circumstances.

2800.142 – Assistance with medical care and supplemental health care services - Please see the comments submitted earlier in this document.

2800.171 Transportation

2800.171(a) PHCA/CALM is concerned with the inclusion of personal social appointments in this provision. To mandate that the residence procure transportation to every personal social appointment that a resident may want will represent a serious administrative burden and not only divert allocation of resources away from care but increase the overall cost to all residents even though some may not ever use this service. PHCA/CALM recommends that the language be amended to include only social activities scheduled by the residence and provide the residence with the option of providing or arranging for personal social appointments.

Requested Revision

2800.171(a) A residence shall be required to provide or arrange for transportation to and from medical appointments and social appointments scheduled by the residence. A residence may provide or arrange for transportation to and from individual resident social appointments.

2800.171 (d)(1-4) and (e)(1-4) This provision as written does not allow for external factors such as weather or traffic situations which may delay the residence from being able to fulfill these requirements. We would suggest the following language.

Requested Revision

(d) If a residence supplies its own vehicles for transporting residents to and from medical and social appointments, a minimum of one vehicle used for this purpose shall be accessible to resident wheelchair users and any other assistive equipment the resident may need.

(1) The residence shall schedule a pick-up time to transport the resident to the medical appointment or social appointment. The residence shall **make every**

effort to pick-up the resident within 15 minutes before or after the scheduled pick-up time.

(2) The [~~resident may~~] **residence shall make every effort** not to [~~be~~] drop[~~ped~~] off **the resident** at the medical or social appointment more that 1 hour prior to the time of the appointment.

(3) The [~~resident~~] **residence** shall **make every effort to** [~~be~~] pick[~~ed~~] up **the resident** from the medical appointment no later than 1 hour after the medical appointment.

(4) The [~~resident~~] **residence** shall **make every effort to** [~~be~~] pick[~~ed~~] up **the resident** from the social appointment no later than 1 hour after the end of the social appointment.

(e) If a residence arranges for transportation for residents to and from medical and social appointments the following shall apply:

(1) The residence shall schedule a pick-up time to transport the resident to the medical or social appointment. The residence shall **make every effort to** pick-up the resident within 15 minutes before or after the scheduled pick-up time.

(2) The [~~resident may~~] **residence shall make every effort** not to [~~be~~] drop[~~ped~~] off **the resident** at the medical or social appointment more that 1 hour prior to the time of the appointment.

(3) The [~~resident~~] **residence** shall **make every effort to** [~~be~~] pick[~~ed~~] up **the resident** from the medical appointment no later than 1 hour after the medical appointment.

(4) The [~~resident~~] **residence** shall **make every effort to** [~~be~~] pick[~~ed~~] up **the resident** from the social appointment no later than 1 hour after the end of the social appointment.

2800.220 Service provision – please see our comments at the beginning of this document.

2800.220[(c)](d)(7) Escort services are a supplemental health care service. Therefore, PHCA/CALM recommends that the service only be required if it is medically indicated.

Requested Revision

2800.220[(c)](d)(7) Escort service if indicated in the resident's support plan[or requested by the resident] to and from medical appointments.

2800.224 Initial assessment and preliminary support plan– Please see our comments regarding clarification of RN supervision.

2800.224 (a)(3)(i) and (c)(2)(i)- PHCA/CALM believes that the provision regarding completing an initial written assessment within 15 days after admission should include other settings like rehabilitation hospitals and nursing homes.

Requested revision for both sub-sections

The resident is being admitted directly to the residence from an acute care hospital, a rehabilitation hospital, or a nursing home.

2800.224 (c)(3)While this language is sufficient in a personal care home setting where a residence is not allowed to provide supplemental health care services, as written this provision would require referrals as opposed to requiring residents to use providers of supplemental health care services approved or designated by the residence (see 2800.142 (b)(ii) of the final draft regulations)

Requested revision

(3) The written preliminary support plan shall document the [dietary, medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a residence to pay for the cost of these medical and behavioral care services.] assisted living services and supplemental health care services that will be provided or made available to the resident.

2800.225 Additional Assessments

2800.225(a) Please see our comments regarding clarification of RN supervision.

2800.227 Development of the Final Support Plan

2800.227 – PHCA/CALM recommends that the word "final" be dropped as this could signify "last" when a support plan will be an evolving document during a resident's stay as their condition changes.

2800.227(b) A registered nurse should also be able to review and approve the support plan.

Requested revision

(b) A residence may use its own support plan form if it includes the same information as the Department's support plan form. A licensed practical nurse[,] under the supervision of a registered nurse[,] or a registered nurse shall review and approve the support plan.

2800.227(k) While PHCA/CALM believes that residents should be fully aware of the services they will receive in the ALR, the attachment and inclusion of the support plan into the resident-residence contract is inappropriate. The Support Plan is about care and the contract is a legal and financial arrangement. The support plan should be available at all times to direct care staff so that appropriate care can be provided but business office staff do not need that information. On the other hand, direct care staff does not need to know the legal and financial information included in the contract. For the privacy of residents, the support plan and contract should be kept separate and only provided to those staff persons that need access to perform their job duties.

Revised Revision

227(k) The residence shall give a copy of the support plan to the resident and the resident's designated person. [~~The final support plan shall be attached to or incorporated into and serve as part of the resident-residence contract.~~]

2800.228 Transfer and Discharge– See comments at the beginning of this document.

Special Care Units

PHCA/CALM sees the introduction of the language regarding intense neurobehavioral rehabilitation (INRBI) as a new concept which we believe should go through the full regulatory process and not added to the final draft of this package. We would appreciate the Department removing this language so that it can receive further study and if appropriate and fully vetted included in these regulations at a later date.

2800.231 Admission

2800.231(e) The proposed revision doesn't take into account the limitations of a cognitively impaired person to legally enter into a binding contract and fully understand an agreement.

Requested revision

Each resident record must have documentation that the resident or potential resident and[,when appropriate,] their legal representative [the resident's designated person or the resident's family] have agreed to the resident's admission or transfer to the special care unit.

2800.251 Resident Records

2800.251(c) The language contained in the proposed paragraph appears to limit the residence's to the use of paper forms. PHCA/CALM would like to expand this provision to allow for electronic medical records.

Requested Revision

251(c) The residence shall use **a** standardized **method, whether paper or electronic** forms, to record information in the resident's record.

2800.251 (e) The language as written would allow any family member to request to see a resident's record even if the resident did not want that particular family member to have access to the record.

Revised revision

(e) Resident records shall be made available to the resident and the resident's designated person during normal working hours. Resident records shall be made available for inspection and review within ten business days upon written request to the resident and only [the] family members designated by the resident.

Previous comments for reconsideration

The following list includes provisions of the proposed regulation that PHCA/CALM commented on in the document submitted to the Department on September 15, 2008. The language in the final draft does not incorporate these requested revisions. PHCA/CALM asks that these comments be reconsidered prior to the publishing of the final regulations.

2800.3(b) Inspections and Licenses
2800.4 Definitions – Legal Representative
2800.4 Definitions – Exemplary compliance
2800.14(e) Fire Safety Approval
2800.16(a)(3) – Reportable incidents and conditions
2800.19(a) – Waivers
2800.22[(b)](e)Application and admission
2800.25(b) Resident-residence contract
2800.28(b) Refunds
2800.42(o) Resident Rights
2800.53(i) – Qualifications and responsibilities of the administrator – Requested additional language
2800.54(e) – Qualifications for direct care staff persons – Requested additional language
2800.64(g)Administrator training and orientation – Request that personal care home administrators also be added
2800.93(a) – Handrails and railings
2800.94(c)- Landings and stairs
2800.98(a) – Indoor activity space
2800.141(a) Resident medical evaluation and health care – see comment made earlier in this document
2800.161(g) – Nutritional adequacy

2800.162(f) – Nutritional adequacy
2800.191 Resident education
2800.202(4) Prohibitions
2800.222 Community social services
2800.227(c) – Development of the final support plan
2800.229 Excludable conditions; exceptions
2800.231(a)(1)(i) – Special care units
2800.234(d)(1) – Resident care

In conclusion, PHCA/CALM once again thanks the Department for allowing us to comment on the draft final regulations for Assisted Living. We continue our commitment to work with the Department and other stakeholders to develop an assisted living licensure regulatory package which will offer consumers an important housing and services alternative along the continuum of long term care.

Unfortunately, we have significant concerns that the final draft as written will likely prevent a significant assisted living industry from being created except for those with individuals with substantial financial means.

If you need clarification or would like to discuss any of our concerns please do not hesitate to contact me.

Sincerely,

Anne M Wantz
Chief Operating Officer
Pennsylvania Health Care Association
Center for Assisted Living Management