"The future of long term care"

PHCA
PENNSYLVANIA HEALTH CARE ASSOCIATION

Pennsylvania Health Care Association

#2712

September 15, 2008

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

RE: Regulation ID #14-514 (#2712)

Dear Ms. Weidman:

The comments outlined below are being submitted by the Pennsylvania Health Care Association on behalf of its members to the Proposed Assisting Living Licensure Regulations required under Act 2007-56 published in the Pennsylvania Bulletin on August 9, 2008. Additionally, some members may submit comments individually or collectively.

PHCA membership, comprising for-profit and nonprofit providers, offers services that range from integrated retirement communities and multi-level care campuses to freestanding nursing homes, assisted living/personal care homes, and ancillary care/home-care enterprises. Overall, PHCA represents nearly 300 long-term care and senior service providers that serve almost 31,000 elderly and disabled individuals across the state.

Introductory Comments

After more than a decade of discussion and debate, the Pennsylvania Legislature passed landmark Assisted Living legislation in the summer of 2007. Act 56, signed by Governor Rendell on July 25th, 2007, created the framework for a system of licensure and regulation that has the potential to provide consumers an important housing and services alternative along the continuum of long term living.

The Pennsylvania Health Care Association (PHCA) strongly and enthusiastically endorsed this Assisted Living Legislation along with many other providers, consumers, advocates, and legislative leaders. Studies by AARP and others have clearly demonstrated that Pennsylvanians want this new option along the continuum of long term care. In addition to providing a needed level of housing and services, assisted living also has the potential to save

the Commonwealth some limited dollars if care for some individuals can be safely and effectively delivered in an assisted living facility rather than in a nursing home.

Act 56 directed the Department of Public Welfare to adopt regulations establishing licensing standards as well as numerous other provisions. PHCA was part of a short term process in which many important issues concerning these regulations were discussed among providers, consumers, advocates, and government agencies. Unfortunately, the process, as designed, was of very limited duration and did not allow for consensus to be built by the represented constituencies around most of critical issues. Thus, significant, reality based, provider concerns were not addressed in the regulations as published.

Given the interest in these regulations among consumers and providers, and the extent of anticipated comments, we do not believe that the Department can complete its review of comments and publish final regulations by October 20th as the Department has proposed in its briefing to legislative staff. We are especially concerned that there are only 4 days between the time that the IRRC will submit its comments and the Department plans to issue its final regulations.

Few issues are as pressing as ensuring that our frail, elderly and disabled residents get quality care in the most appropriate place for them at each stage of their life. With our aging population, personal care homes have become a popular senior housing option. There are about 1500 licensed personal care homes serving approximately 50,000 residents in Pennsylvania. Likewise, the commonwealth currently has 730 nursing homes with 89,471 beds, and demand for nursing home services is growing.

These trends are sure to continue based on the demographic realities confronting Pennsylvania. Our commonwealth ranks third nationally by percentage of population age 65 or older, behind Florida and West Virginia, and fourth in the number of residents age 85 or older --- a segment of the population that comprises the most intensive users of nursing home care.

Nearly 70 percent of Pennsylvanians turning 65 this year eventually will require some form of long-term care. Right now, 2 million of our 12 million residents are age 65 or older. By 2020, more than 25 percent of our population, or some 3 million Pennsylvanians, will fall into that demographic. That is a 50 percent increase in a little more than a decade.

Not only do these demographics pose significant care planning challenges for families, caregivers and state agencies whose charge it is to safeguard the elderly and others, but they also require us to find new ways to accommodate the burgeoning ranks of older Pennsylvanians and others in need of some level of assistance in daily life.

- That is why the new category of Assisted Living is an important option for the consumers of Pennsylvania;

- That is why the Pennsylvania Health Care Association has been working tirelessly to see this program implemented in a manner that will encourage this sector to develop;

- That is why we will all be failing those who need assisted living, if we make the development of assisted living facilities arduous, impractical, and unattainable; and

- That is why, despite the optimism created by Act 56, the proposed regulations, published on August 9, 2008, are likely to suffocate development of assisted living and insure that the potential for a vibrant assisted living sector will **not** become a living reality, and assisted living will **not** become a significant option along the continuum of long term living for anyone except the most wealthy Pennsylvanians.

In fact, despite good intentions on the part of the Department of Public Welfare, the proposed regulations are likely to have the following impacts:

1. Few high quality personal care homes will convert to assisted living

2. Few, if any, new assisted living residences will be built.

3. Few, if any, Medicaid eligible individuals will become residents in these facilities because the physical plant/space/staffing/licensing fee mandates in the proposed regulations will require charges to the Medicaid program far in excess of what the Commonwealth is likely to pay, or the federal government is likely to approve.

4. Many nursing home eligible individuals on Medicaid currently living in personal care homes will be required to shift to nursing homes when they need certain healthcare services because of an inadequate supply (number) of assisted living facilities. This will impose unnecessary costs on the Medicaid program and frustrate the intent of Act 56.

5. An undesirable two tiered system of assisted living may become a living reality in which only the wealthy will be served.

We provide detailed section by section comments below on the proposed regulations below, but will highlight several overarching issues in this introduction.

1. The regulations, in many cases, do not conform to the statute and likewise exceeded stated legislative intent.

2. Similarly the proposed regulations, in many instances, were not clear on requirements for the Department or providers, thus allowing the Department to have significant discretion at a later time. The purpose of proposed regulations is to allow the public and the regulated community to understand and participate in the

rules governing them. These discretionary areas do not allow for public input and should be clarified in the final regulations after a stakeholder process which would allow input from the regulated community.

3. The requirements of 175 sq. feet for each living unit currently constructed will preclude many high quality personal care homes from becoming assisted living because they do not meet the 175 sq. foot standard, and will thus reduce access to this important care option. We suggest this requirement be 125 sq. feet which is in line with most other states.

4. The requirement of 250 sq. feet for each living unit newly constructed will result in few, if any, facilities being built that will be able to serve the Medicaid population. We are suggesting that a minimum requirement of 150 sq. feet be adopted by regulation, which is in line with most other states. If Pennsylvania were to adopt a requirement of a minimum of 250 sq. feet, Pennsylvania would have the highest sq. foot requirement in the nation. Please see data from the Assisted Living and CCRC State Regulatory Handbook 2008 in Appendix I.

   Our survey of likely charges per month (in 2008 dollars) to support a requirement for 250 sq. feet living units is about $4615 per month. At 200 sq. feet, the likely charge in 2008 dollars would be about $4150, and for $150 sq. feet, the likely charge would be about $3650. In the Philadelphia area, the charge would be $5250 for 150 sq feet, $5750 for 200 sq feet, and $6250 for 250 sq. feet in 2008 dollars. We suggest that the new construction requirement be 150 sq feet. Of course, these new facilities will not be built for several years so the dollars must be inflated. Appendix II of these comments includes data indicating these costs including the likelihood that a newly constructed facility with 250 sq. feet minimum in the Philadelphia area would likely charge almost $7000 per month in 2010. Historically, Medicaid reimbursement has not kept up with inflation, thus a two tiered system of assisted living is likely to be created.

5. The proposed licensing fees are excessive and will be a significant dis-incentive for providers to become assisted living providers. The proposed fee structure would make Pennsylvania among the highest in the country and far in excess of surrounding states. In fact, based on available data. The fee for a 100 bed facility in Pennsylvania would be higher than those of the surrounding states of Delaware, New Jersey, New York and Ohio combined.

6. Staffing Mandates are also excessive, and will impede the orderly training and management of staff and raise the costs significantly without any perceptible impact on quality of services provided.

7. The proposed requirements for informed consent agreements exceed the statutory requirements of Act 56 and likewise will discourage providers from participating in the assisted living program. It is our belief that providers of healthcare must have the flexibility to provide clinical services based on their best professional judgment. While consumer/resident input is necessary and appropriate, final clinical judgment must be in the hands of healthcare professionals. It is our belief that providers of healthcare must have the flexibility to provide clinical services based on their best professional judgment.

8. The proposed requirements for transfer and discharge of residents exceed the statutory requirements Act 56 and similarly will discourage providers from participating in the assisted living program. As with informed consent agreements, it is our belief that providers of healthcare must have the flexibility to provide clinical services based on their best professional judgment. While consumer/resident input is necessary and appropriate, final clinical judgment must be in the hands of healthcare professionals.

9. The proposed requirements for excludable conditions/exceptions exceed the statutory requirements of Act 56 and will also discourage providers from participating in the assisted living program. Consistent with the comments above, it is our belief that providers of healthcare must have the flexibility to provide clinical services based on their best professional judgment. While consumer/resident input is necessary and appropriate, final clinical judgment must be in the hands of healthcare professionals.

10. The concept of dual-licensure for facilities that are both personal care homes and assisted living facility explicitly called for in Act 56 is notably not included in the proposed regulations, and, finally,

11. While aging in place is a noble goal, it must be done safely and affordably. The proposed regulations, in many places, exceed the statutory language which permits aging in place by suggesting that aging in place is a mandate of the statute. The legislation is clear on this point! Providers cannot and should not be told or

compelled to provide services beyond what they desire to do or believe that they can do safely.

Below are outlined a detailed series of comments and suggestions which, if accepted, will create a vibrant and robust assisted living community in Pennsylvania which will be accessible to all, and protect the interests of both consumers and providers.

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Specific Comments and Proposed Revisions to Proposed Regulations follow:

§2800.1 Purpose

§2800.1(a)
No comment at this time.

§2800.1(b)
The proposed regulations state:

> (b) Assisted living residences are a significant long-term care alternative to allow individuals to age in place. Residents who live in assisted living residences that meet the requirements in this chapter will receive the assistance they need to age in place and develop and maintain maximum independence, self-determination and personal choice.

PROPOSED REVISION
(b) Assisted living residences [are a significant long-term care alternative to allow individuals to age in place. Residents who live in assisted living residences that meet the requirements in this chapter will receive the assistance they need to age in place and develop and maintain maximum independence, self-determination] provide housing and supportive services as needed to elderly and disabled individuals, allowing them to age in place, maintain their independence and exercise decision making and personal choice.

COMMENT
The regulatory standard proposed, "maintain maximum independence self-determination and personal choice" erroneously exceeds the standard established in the legislation which reads: "MAINTAIN THEIR INDEPENDENCE AND EXERCISE DECISION MAKING AND PERSONAL CHOICE".

Had the General Assembly wanted to impose such a standard of maintaining "maximum independence, self determination and personal choice," it would have done so. It reasonably decided not to adopt such an impractical standard. Additionally, how does one determine, who decides and what constitutes "maximum independence?"

The Department seeks to create a licensing standard that deviates from the plain text of the statute which is impossible to apply fairly, uniformly and consistently.

§2800.2 Scope
No comment at this time.

§2800.3 Inspections and licenses

§2800.3(a)
The proposed regulations read:

> (a)The Department will annually conduct at least one onsite unannounced inspection of each assisted living residence.

§2800.3(b)
The proposed regulations read:

> (b) Additional announced or unannounced inspections may be conducted at the Department's discretion.

PROPOSED REVISION
(b)Additional announced or unannounced inspections may be conducted by the Department upon receipt of reliable information suggesting the existence of harmful conditions at the facility.

COMMENT
The proposed regulation does not provide a standard establishing when the Department may or may not conduct an announced or unannounced inspection. By proposing a standard, the proposed revision provides consistency in the Department's use of its discretion.

The existence of a standard beyond at "random" decisions establishes clarity and consistency to the application of the regulations.

§2800.3(c) – (e)
No comment at this time.

2800.4. Definitions

Although we are in agreement with the majority of the definitions in this section, we would like to specifically highlight some areas where there are significant problems or significant potential problems.

Assistance

This term is used but is not defined.

PROPOSED DEFINITION

Assistance – Actions or conduct required by this chapter.

Cognitive support service

The proposed regulations state:

Cognitive support services—

(i) Services provided to an individual who has memory impairments and other cognitive problems which significantly interfere with his ability to carry out ADLs without assistance and who requires that supervision, monitoring and programming be available 24 hours per day, 7 days per week, in order to reside safely in the setting of his choice.

PROPOSED REVISION

Cognitive support services-

(i) Services provided to an individual who has memory impairments [and] or other cognitive problems which significantly interfere with his ability to carry out ADLs without assistance and who requires that supervision, monitoring and programming be available 24 hours per day, 7 days per week, in order to reside safely in the setting of his choice.

COMMENT

The addition of "or" provides clarification and tracks the legislation.

Exemplary compliance

The proposed regulations state:

Exemplary compliance—Three consecutive years of deficiency-free inspections.

PROPOSED REVISION

Exemplary compliance—Two [Three] consecutive years of inspections which are free of deficiencies that substantively and directly impact upon the health and welfare of the resident.

COMMENT

The goal of this provision is to streamline inspections for both the Department and the residence. Clearly, all deficiencies are not the same. It is important that Exemplary Compliance relate to deficiencies which directly and substantively impact the health and welfare of a resident.

Informed consent agreement

The proposed regulations state:

> *Informed consent agreement*—A formal, mutually agreed upon, written understanding which:
> (i) Results after thorough discussion among the assisted living residence staff, the resident and any individuals the resident wants to be involved.
> (ii) Identifies how to balance the assisted living residence's responsibilities to the individuals it serves with a resident's choices and capabilities with the possibility that those choices will place the resident or other residents at risk of harm.
> (iii) Documents the resident's choice to accept or refuse a service offered by or at the residence.

PROPOSED REVISION

Informed consent agreement—A formal, mutually agreed upon, written understanding which:
(i) Results after thorough discussion among the assisted living residence staff, the resident and any individuals the resident wants to be involved.
(ii) Identifies how to balance the assisted living residence's responsibilities to the individuals it serves with a resident's choices and capabilities with the possibility that those choices will place the resident or other residents at risk of harm.
[(iii) Documents the resident's choice to accept or refuse a service offered by or at the residence.]

COMMENT

The proposed section iii is not part of the definition of an informed consent agreement. Therefore it should be deleted.

Legal Representative

The proposed regulations state:

> *Legal representative*—An individual who holds a power of attorney, a court-appointed guardian or other person authorized to act for the resident.

PROPOSED REVISION

Legal representative—An individual who holds a power of attorney [,] or a court-appointed guardian. [or other person authorized to act for the resident.]

COMMENT

We believe that restricting the definition of "legal representative" to a person who holds a power of attorney or a court-appointed guardian is a clearer definition of "legal representative". To expand the definition to "any other person authorized to act for the resident" who may or may not have power of attorney makes it difficult for a provider to reasonably and consistently identify who is the resident's "legal representative". A provider should not be required to act as a referee among persons proclaiming to be the resident's "legal representative".

Special care designation

The proposed regulations state:

> *Special care designation*—A licensed assisted living residence or a distinct part of the residence which is specifically designated by the Department as capable of providing cognitive support services to residents with severe cognitive impairments, including dementia or Alzheimer's disease, in the least restrictive manner to ensure the safety of the resident and others in the residence while maintaining the resident's ability to age in place.

COMMENT

This definition does not track the language in Act 56. The legislation expressly provides that a "special care designation" means that an assisted living residence or distinct part thereof can provide cognitive support services to residents with severe cognitive impairments, "including, but not limited to" dementia or

Alzheimer's disease. It appears that the Department inadvertently dropped the language "including but, not limited to," which we think should be inserted to be consistent with the legislation. While we do not object to the proposed language, we believe that this section should be aligned with the legislation.

Supplemental health care services

The proposed regulations state:

> *Supplemental health care services*—The provision by an assisted living residence of any type of health care service **that allows residents to age in place**, either directly or through contractors, subcontractors, agents or designated providers, except for any service that is required by law to be provided by a health care facility under the Health Care Facilities Act (35 P. S. §§ 448.101—448.901). (emphasis added)

PROPOSED REVISION

Supplemental health care services—The provision by an assisted living residence of any type of health care service [that allows residents to age in place], either directly or through contractors, subcontractors, agents or designated providers, except for any service that is required by law to be provided by a health care facility under the Health Care Facilities Act (35 P. S. §§ 448.101—448.901).

COMMENT

The proposed definition substantially exceeds what the legislation adopted. The legislation does not mandate "aging in place".

The legislation reads as follows:

"Supplemental health care services" means the provision by an assisted living residence of any type of health care service, either directly or through contractors, subcontractors, agents or designated providers, except for any service that is required by law to be provided by a health care facility pursuant to the act of July 19, 1979 (P.L.130, No. 48), known as the "Health Care Facilities Act."

Consequently it is proposed that the words "that allows residents to age in place" be deleted from the proposed regulation.

The legislative language is explicit on this point.

§2800.5 Access
No comment at this time.

§2800.11 Procedural requirements for licensure or approval of assisted living residences.

§2800.11(a) – (b)
No comment at this time.

§2800.11(c)
The proposed regulations state:

> (c) After the Department determines that a residence meets the requirements for a license, the Department's issuance or renewal of a license to a residence is contingent upon receipt by the Department of the following fees based on the number of beds in the residence, as follows:
> (1) A $500 license application or renewal fee.
> (2) A $105 per bed fee that may be adjusted by the Department annually at a rate not to exceed the Consumer Price Index. The Department will publish a notice in the *Pennsylvania Bulletin* when the per bed fee is increased.

PROPOSED REVISION
(c)After the Department determines that a residence meets the requirements for a license, the Department's issuance or renewal of a license to a residence is contingent upon receipt by the Department of the following fees based on the number of beds in the residence as follows:

> ***(1) A $500 license application or renewal fee.***
> ***(2) A [$105] $10.00 per bed fee that may be adjusted by the Department annually at a rate not to exceed any increases in MA reimbursement. The Department shall publish a notice in the Pennsylvania Bulletin when the per bed fee is increased.***
> **(3) No Assisted Living Residence shall be required to pay more than $1000.00 when aggregating the $500.00 license application or renewal fee in paragraph (1) and the per bed fee of paragraph (2).**

COMMENT

We understand the necessity of establishing a licensing fee. However, the fees in the proposed regulations are unreasonably high and will only serve as a significant dis-incentive to the development of assisted living.

The proposed licensure fee structure is a severe change in policy from the system that has been used by personal care homes and nursing homes, and would cause significant burden on the provider. A $500.00 licensure fee, with a $105.00 assessment per bed would result in a 100 bed facility paying an annual licensure fee of $11,000.00. Under the proposed fee structure, Pennsylvania would be (based upon available data) more expensive than the costs of the surrounding states of Delaware, New Jersey, New York and Ohio combined. Quality assurance through licensure is a core function of government. These fees, which essentially aim to recoup the costs of regulating Assisted Living Facilities in the Commonwealth are unacceptable as drafted, and will take vital dollars away from resident care.

Additionally, changes to the licensure fees should be tied to increases to the MA assisted living waiver rates rather than to the Consumer Price Index ("CPI"). The CPI is likely to increase at a greater rate than the waiver rates to providers essentially creating an unfunded mandate.

§2800.11 (d)

No comment at this time.

§2800.12. Appeals

No comment at this time.

§2800.13 Maximum capacity

No comment at this time.

§2800.14 Fire safety approval

§2800.14 (a) – (d)

No comment at this time.

§2800.14(e)

The proposed regulations state:

(e) Fire safety approval must be renewed at least every 3 years, or more frequently, if requested by the Department.

PROPOSED REVISION

(e) Fire safety approval must be renewed at least every 3 years. [, or more frequently, if requested by the Department.]

COMMENT

The term "frequently" is undefined making the regulation unclear and susceptible to inconsistent and arbitrary application as proposed. A specific time frame establishes consistency, clarity and avoids ambiguity.

§2800.15 Abuse reporting covered by law.

No comment at this time.

§2800.16 Reportable incidents and conditions.

§2800.16 (a) (1) – (2)

No comment at this time.

§2800.16 (a) (3)

The proposed regulations state:

(a) A reportable incident or condition includes the following:

(3) An injury, illness or trauma requiring treatment at a hospital or medical facility. This does not include minor injuries such as sprains or minor cuts.

PROPOSED REVISION

(3) A serious bodily injury or trauma requiring treatment at a hospital or medical facility. [An injury, illness or trauma requiring treatment at a hospital or medical facility.] This does not include minor injuries such as sprains or minor cuts.

COMMENT

Although it is clearly acknowledged that certain incidents and conditions should be reported, excessive reporting requirement imposed on less significant or

impactful injuries creates administrative effort which detracts from care and attention devoted to the residents, and will also cause an extra administrative burden on the Department. For example, some residents in assisted living facilities will certainly be on dialysis. The proposed regulation would require that every visit to a hospital for dialysis treatment would require reporting. Visits often occur 3-4 times a week.

The proposed revision utilizes the standard for personal care homes which acknowledges that all injuries are not the same. There is no reason to deviate from that standard which has worked well.

The legislature acknowledged the closeness in the regulation of personal care homes and assisted living facilities. In fact it was the intent of the legislation to allow for the inspection of dually licensed personal care home / assisted living facilities. Thus, it makes common sense to have the standard identical for personal care and assisted living.

The legislation reads as follows:
(C) The Department shall have enforcement and licensure staff dedicated solely to assisted living residences. All inspections of residences dually licensed as assisted living residences and personal care homes shall be conducted by a team of surveyors comprised of both personal care home and assisted living residence surveyors.

The 2600 regulation achieves a balance between the importance of reporting important incidents and conditions and avoiding the imposition of an unnecessary administrative burden on providers.

§2800.16 (a)(4) – (20)(b)
No comment at this time.

§2800.16(20)(c) – (d)
The proposed regulations state:
(c) The residence shall report the incident or condition to the Department's assisted living residence office or the assisted living residence complaint hotline within 24 hours in a manner designated by the Department. Abuse

reporting must also follow the guidelines in § 2800.15 (relating to abuse reporting covered by law).

(d) The residence shall submit a final report, on a form prescribed by the Department, to the Department's assisted living residence office immediately following the conclusion of the investigation.

COMMENT
The manner in which a residence reports under this section should not be left to the complete discretion of the department, but rather should be part of a stakeholder process which includes the regulated community. The reporting process directly impacts the administration of the particular residence involved. Therefore the regulated community should be involved in the determination of this process.

Similarly, the regulated community should be involved in the development of the form used for the final report. Inasmuch as this also directly impacts on the administration of the residence.

§2800.16 (e) – (f)
No comment at this time.

§2800.16 Reportable incidents and conditions
The proposed regulations state:

(a) A reportable incident or condition includes the following:

(20) An absence of staff or inadequate staff to supervise residents.

(f) The residence shall keep a copy of the report of the reportable incident or condition.

PROPOSED REVISION

(20) An absence of staff such that residents receive inadequate care as defined by the respective support plans [or inadequate staff to supervise residents].

(f) The residence shall keep a copy of the report up to 7 years after the discharge of the resident of the reportable incident or condition.

COMMENT
We assume that as worded absence of staff is a reportable incident to the extent that it impacts upon the care of residents as defined in their respective support plans. We believe the proposed language clarifies the intent of this regulation.

As worded in the proposed regulations, there is no time frame given for the retention of documents. This poses an administrative burden not adding value to the care of the residents. The retention of documents requirement for assisted living facilities should be consistent with health care facilities which is seven (7) years after the discharge of the patient or resident.

§2800.17 Confidentiality of records.
No comment at this time.

§2800.18 Applicable laws.
No comment at this time.

§2800.19 Waivers.

§2800.19(a)
(a) A residence may submit a written request for a waiver of a specific requirement contained in this chapter. The waiver request must be on a form prescribed by the Department. The Secretary, or the Secretary's appointee, may grant a waiver of a specific requirement of this chapter if the following conditions are met:

COMMENT
The form for the waiver request should not be left to the complete discretion of the department, but rather should be part of a stakeholder process which includes the regulated community. Similar to the previously cited sections, this impacts directly upon the administration of a residence and therefore the regulated community should be involved.

§2800.19(a)(1) – (3)(f)
No comment at this time.

§2800.20 Financial management.
No comment at this time.

§2800.21 Offsite services.
No comment at this time.

§2800.22 Application and Admission

§2800.22(a)
No comment at this time.

§2800.22(b)
The proposed regulations state:

> (b) Upon application for residency and prior to admission to the residence, the licensee shall provide each potential resident or potential resident's designated person with written disclosures that include:
> (3)A copy of residence rules and resident handbook. The resident handbook shall be approved by the Department.

PROPOSED REVISION
(b) Upon [application for residency and prior to admission] the submission of signed formal application to the residence, the [licensee] residence shall provide each potential resident or potential resident's designated person with written disclosures that include:
(3)A copy of residence rules and resident handbook. [The] A resident handbook [shall be] not approved, by the Department within 10 working days will be deemed approved by the Department..

COMMENT
We support the transparency and openness of communication which is achieved by provision of documents to a potential resident. However, the efficient administration of a business would dictate the provision of such extensive documentation be provided to a person who is seriously considering becoming a resident as opposed to someone who is considering multiple facilities.

The provision of a time frame for the approval of the residence rules and handbook places the responsibility on the Department to review and approve (or

not approve) in a timely manner thus ensuring that residents are given consistent information in a timely manner.

§2800.23 Activities
No comment at this time.

§2800.24 Personal Hygiene
No comment at this time.

§2800.25 Resident-residence contract

§2800.25(a)
No comment at this time.

§2800.25(b)
The proposed regulation states:

> (b) The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees. The contract must run month-to-month with automatic renewal unless terminated by the resident with 14 days' notice or by the residence with 30 days' notice in accordance with § 2800.228 (relating to transfer and discharge).

PROPOSED REVISION
(b) The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees. The contract must [run] be month-to-month with automatic renewal unless terminated by the resident with 30 [14] days' notice or by the residence with 30 days' notice in accordance with § 2800.228 (relating to transfer and discharge).

COMMENT
The right to terminate and the notice of termination should be mutual. There is no reason, to have different standards for the residence and the resident regarding the right to terminate and the required notice of termination. Using the same standard provides clarity for both resident and residence.

§2800.25(c) – (d)
No comment at this time.

§2800.25(e)
The proposed regulation states:

> (e) The resident, or a designated person, has the right to rescind the contract for up to 72 hours after the initial dated signature of the contract or upon receipt of the initial support plan. The resident shall pay only for the services received. Rescission of the contract must be in writing addressed to the residence.

PROPOSED REVISION

(e) The resident, or a designated person, has the right to rescind the contract for up to 72 hours after the initial dated signature of the contract [or upon receipt of the initial support plan.]. The resident shall pay only for the services received. Rescission of the contract must be in writing addressed to the residence.

COMMENT

Seventy-two (72) hours is a typical time frame in Pennsylvania within which to cancel a contract from the time of initial execution.

§2800.25 (f) – (h)
No comment at this time.

§2800.25 (i)
The proposed regulation states:

> (i) The assisted living services included in the package the individual is purchasing shall be the contract price. Supplemental health care services must be packaged, contracted and priced separately from the resident residence contract. Services other than supplemental health care services must be priced separately from the service package in the resident-residence contract.

PROPOSED REVISION

(i) [The assisted living services included in the package the individual is purchasing shall be the contract price.] The resident-residence contract shall identify the assisted living services included in the package the individual is

purchasing and the total price for those services. ***Supplemental health care services [must] shall be packaged, contracted and priced separately from the resident residence contract. [Services other than supplemental health care services must be priced separately from the service package in the resident-residence contract.]***

COMMENT
The proposed regulatory language imposes a requirement beyond that which is expressed in the legislation. The legislation states that regulations for assisted living residences shall, "provide that supplemental health care services shall be packaged, contracted and priced separately from the resident agreement"

The revision we have proposed is consistent with what the legislation expresses regarding the "resident-residence" contract.

§2800.26 Quality management
No comment at this time.

§2800.27 SSI recipients.

§2800.27 (a) – (b)
No comment at this time.

§2800.27 (c)
The proposed regulations states:

> (c) The administrator or staff persons may not seek or accept any payments from funds received as retroactive awards of SSI benefits, but may seek and accept the payments only to the extent that the retroactive awards cover periods of time during which the resident actually resided in the residence and for which full payment has not been received.

PROPOSED REVISION
(c) The administrator or staff persons may [not] seek or accept [any] payments from funds received as retroactive awards of SSI benefits, but [may seek and accept the payments] only to the extent that the retroactive awards cover periods of time during which the resident actually resided in the residence and for which full payment has not been received.

COMMENT

The requirements for the residence to deal with SSI income of the residents proposed in these regulations is different from the standards utilized in the personal care 2600 regulations.

The legislation expressly authorizes facilities to be dually licensed as personal care homes and assisted living residences. (See 8(C) of Act 56 2007). The legislators foresaw instances where personal care home residents and assisted living residents would reside in the same building.

In section 2800.20 there are multiple provisions relating to the management of resident finances. These provisions are identical to the regulations governing resident finances in personal care homes. It is important, for the sake of the resident, to provide consistency and clarity regarding all financial management issues. This would include the management of SSI benefits.

For this reason, the proposed revision is identical to the comparable section in the 2600 personal care home regulations.

§2800.28 Refunds

§2800.28(a)

No comment at this time.

§2800.28(b)

The proposed regulations state:

(b) After a resident gives notice of the intent to leave in accordance with §2800.25(b) (relating to resident-residence contract) and if the resident moves out of the residence before the expiration of the required 14 days, the resident owes the residence the charges for rent and personal care services and supplemental health care services, or both, for the entire length of the 14-day time period for which payment has not been made.

PROPOSED REVISION

(b) After a resident gives notice of the intent to leave in accordance with § 2800.25(b) (relating to resident-residence contract) and if the resident moves out of the residence before the expiration of the required [14] 30 days, the

resident owes the residence the charges for rent and personal care services and supplemental health care services, or both, for the entire length of the [14] 30 - day time period for which payment has not been made.

COMMENT
The proposed revision makes this section consistent with 2800.25(b) which is referenced in this section.

§2800.28 Refunds

§2800.28(c) – (g)
No comment at this time.

§2800.29 Hospice care and services
No comment at this time.

§2800.30 Informed consent process.
The proposed regulations state:

(a) *Initiation of process.*

(1) When a licensee determines that a resident's decision, behavior or action creates a dangerous situation and places the resident, other residents or staff members at imminent risk of substantial harm by the resident's wish to exercise independence in directing the manner in which they receive care, the licensee may initiate an informed consent process to address the identified risk and to reach a mutually agreed-upon plan of action with the resident or the resident's designated person. 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 the resident receives care, the resident may initiate an informed consent process to modify the support plan and attempt to reach a mutually agreed upon plan of action with the licensee. A cognitively impaired resident shall be eligible for an informed consent agreement only if the resident's legal representative is included in the negotiation of the informed consent agreement and executes the agreement.

(b) *Notification.*

(1) When the licensee chooses to initiate an informed consent process, the provider shall do so by notifying the resident and, if applicable, the resident's designated person in writing and orally. The notification must include a statement that the long-term care ombudsman is available to assist in the process and include the contact information for the ombudsman. For cognitively impaired residents, the ombudsman shall be automatically notified by the licensee. Notification shall be documented in the resident's file by the licensee.
(2) When a resident or, if applicable, the resident's legal representative chooses to initiate an informed consent negotiation, the resident or the resident's legal representative shall do so by notifying the licensee in writing or orally. Notification shall be documented in the resident's file by the licensee.

(c) *Resident's involvement*. A resident who is not cognitively impaired shall be entitled, but is not required, to involve his legal representative and physician, and any other individual the resident wants involved, to participate or assist in the discussion of the resident's wish to exercise independence and, if necessary, in developing a satisfactory informed consent agreement that balances the resident's choices and capabilities with the possibility that the choices will place the resident or other residents at risk of harm.

(d) *Informed consent meeting.*
(1) In a manner the resident can understand, the licensee shall discuss the resident's wish to exercise independence in directing the manner in which he receives care. The discussion must relate to the decision, behavior or action that places the resident or persons other than the resident in imminent risk of substantial harm and hazards inherent in the resident's action. The discussion must include reasonable alternatives, if any, for mitigating the risk, the significant benefits and disadvantages of each alternative and the most likely outcome of each alternative. In the case of a resident with a cognitive impairment, the resident's legal representative shall participate in the discussion.

(2) A resident may not have the right to place persons other than himself at risk, but, consistent with statutory and regulatory requirements, may elect

to proceed with a decision, behavior or action affecting only his own safety or health status, foregoing alternatives for mitigating the risk, after consideration of the benefits and disadvantages of the alternatives including his wish to exercise independence in directing the manner in which he receives care. The licensee shall evaluate whether the resident understands and appreciates the nature and consequences of the risk, including the significant benefits and disadvantages of each alternative considered, and then shall further ascertain whether the resident is consenting to accept or mitigate the risk with full knowledge and forethought.

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

(f) *Unsuccessful negotiation*. If the parties do not agree, the licensee shall notify the resident, the resident's legal representative and the individuals engaged in the informed consent negotiation at the request of the resident. The residence shall include information on the local ombudsman or the appropriate advocacy organization for assistance relating to the disposition and whether the licensee will issue a notice of discharge.

(g) *Freedom from duress*. An informed consent agreement must be voluntary and free of force, fraud, deceit, duress, coercion or undue influence, provided that a licensee retains the right to issue a notice of involuntary discharge in the event a resident's decision, behavior or action creates a dangerous situation and places persons other than the resident at imminent risk of substantial harm and, after a discussion of the risk, the resident declines alternatives to mitigate the risk.

(h) *Individualized nature*. An informed consent agreement must be unique to the resident's situation and his wish to exercise independence in directing the manner in which he receives care. The informed consent agreement shall be utilized only when a resident's decision, behavior or action creates a situation and places the resident or persons other than the resident at imminent risk of substantial harm. A licensee may not require

execution of an informed consent agreement as a standard condition of admission.

(i) *Liability*. Execution of an informed consent agreement does not constitute a waiver of liability beyond the scope of the agreement or with respect to acts of negligence or tort. An informed consent agreement does not relieve a licensee of liability for violation of statutory or regulatory requirements promulgated under this chapter nor affect enforceability of regulatory provisions including those provisions governing admission or discharge or the permissible level of care in an assisted living residence.

(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.

PROPOSED REVISION
{THE FOLLOWING PROPOSED REVISION WOULD REPLACE THE PROPOSED SECTION 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.

COMMENT

The regulatory language proposed by the Department distorts the legislative language outlined in the statute, which was developed after lengthy and thoughtful discussions.

The proposed revisions follow both the legislative intent and language in the statute and outline a process that is equitable for the resident.

The proposed regulation imposes the extreme pre-condition on a residence to make a determine that residents or staff are at "imminent risk of substantial harm" before it may initiate actions to address a "dangerous" situation caused by a resident. This standard, which is similar to that used in involuntary commitments for mental health treatment, is simply too high a standard from a personal security safety perspective and liability perspective.

While a high threshold properly exists before someone may be subject to involuntary treatment, such a standard is assuredly inappropriate in the context of a residence's having to react promptly and effectively to a "dangerous" situation caused by a resident.

Our proposed revision provides the residence, which is ultimately responsible and potentially liable for actions occurring in the facility, the operational flexibility to address the presenting problem.

The proposed revision also reflects the statutory intent of the legislation as it relates to releasing the residence, "from liability for adverse outcomes resulting from actions consistent with the terms of the informed consent agreement".

The changes in the proposed revision not pertaining to liability serve to balance the rights of the residents, the residence and the residence's obligations to its other residents.

The proposed revisions support the belief that resident input is necessary and appropriate in this process, but any final clinical judgment, pertaining to the informed consent agreement, must be in the hands of the healthcare professionals.

RESIDENT RIGHTS

§2800.41 Notification of rights and complaint procedures.
No comment at this time.

§2800.42 Specific rights

§2800.42(a) – (n)
No comment at this time.

§2800.42(o)
(o)The proposed regulatory language states:

> A resident has the right to freely associate, organize and communicate with his friends, family, physician, attorney and other persons.

PROPOSED REVISION
(o)A resident has the right to freely associate, organize and communicate with others privately. [his friends, family, physician, attorney and other persons.]

COMMENT
We fully support the right of the resident to freely associate; however; for purposes of consistency and uniformity, because a facility could be dually licensed, it is important that the regulations relating to the rights of a resident to freely associate be identical to each other.
The proposed revision is identical to the standard for personal care homes concerning a resident's right to freely associate.

§2800.42(p) – (q)
No comment at this time.

§2800.42(r)
(r)The proposed regulatory language states:

> (r) A resident has the right to receive visitors at any time provided that the visits do not adversely affect other residents. A residence may adopt reasonable policies and procedures related to visits and access. If the

residence adopts those policies and procedures, they will be binding on the residents.

PROPOSED REVISION

(r) A resident has the right to receive visitors for a minimum of 12 hours daily, 7 days a week.

[at any time provided that the visits do not adversely affect other residents. A residence may adopt reasonable policies and procedures related to visits and access. If the residence adopts those policies and procedures, they will be binding on the residents.]

COMMENT

We fully support the resident's right to receive visitors; however, we believe that the standard should be identical to section 2600.42 for personal care homes. The probability of dual licensure necessitates using the same standard for both sets of regulations.

(s)No comment at this time.

§2800.42(s)

No comment at this time.

§2800.42(t)

(t)The proposed regulatory language states:

> (t) A resident has the right to file complaints on behalf of himself and others with any individual or agency and recommend changes in policies, residence rules and services of the residence without intimidation, retaliation or threat of discharge.

PROPOSED REVISION

(t) A resident has the right to file complaints [on behalf of himself and other] with any individual or agency and recommend changes in policies, residence rules and services of the residence without intimidation, retaliation or threat of discharge.

COMMENT

It is of upmost importance to create a peaceful environment for all residents without abridging the rights of the residents. The proposed revision is identical

to 2600.42(t) governing personal care homes, which has proven to be a workable standard. The proposed revision promotes uniformity and consistency for both residents and residences.

§2800.42(u) - (x)
No comment at this time.
§2800.42(y)
(y)The proposed regulatory language states:

> (y) To the extent prominently displayed in the written resident-residence contract, a residence may require residents to use providers of supplemental health care services as provided in § 2800.142 (relating to assistance with health care and supplemental health care services). When the residence does not designate, the resident may choose the supplemental health care service provider.

PROPOSED REVISION
(y) To the extent prominently [displayed] disclosed in the written resident-residence contract, a residence may require residents to use providers of supplemental health care services as provided in § 2800.142 (relating to assistance with health care and supplemental health care services). When the residence does not designate [,] specific supplemental health care service providers, the resident may choose the supplemental health care service provider. The actions and procedures utilized by a supplemental health care service provider chosen by a resident must be consistent with the residence's systems for caring for residents. This includes the handling and assisting with the administration of resident's medications, and shall not conflict with Federal laws governing residents.

COMMENT
The language in the proposed regulation exceeds statutory language which was carefully and thoughtfully discussed by the legislature. It is of paramount importance to ensure the quality of care and safety of the residents that there be consistency in the handling of medications and supplemental health care

§2800.43 Prohibition against deprivation of rights
No comment at this time.

§2800.44 Complaint procedures.
No comment at this time.

STAFFING

§2800.51 Criminal history checks.
No comment at this time.

§2800.52 Staff hiring, retention and utilization
No comment at this time.

§2800.53 Qualifications and responsibilities of administrators

§2800.53 (a) – (h)
No comment at this time.

§2800.53(i)
(i)No section in the proposed regulations

PROPOSED SECTION
53(i) The qualification requirements for an administrator do not apply to individuals hired or promoted to the position of Personal Care Home Administrator prior to _____ (effective date of the regulations).

COMMENT
It is appropriate to insert a grandfather clause exempting persons currently serving as Personal Care Home Administrators since the duties of both types of residences, personal care homes and assisted living, are almost identical.

As previously commented, this similarity is acknowledged within the legislation as it specifically provides for dual licensure.

§2800.54 Qualifications for direct care staff persons

§2800.54(a) – (d)
No comment at this time.

§2800.54(e)
(e)No section in the proposed regulation

PROPOSED SECTION
54 (e) The qualification requirements for direct care staff persons do not apply to individuals hired or promoted to the specified position prior to _____ (effective date of the regulations).

COMMENT
As previously stated in section 2800.53(i), the role and responsibility of the administrator of a personal care home is almost identical to what will be the role of an administrator of an assisted living residence. This is also the case with the direct care staff.

The proposed section would serve to create a grandfather clause for direct care staff persons of personal care home for assisted living residences. It is only reasonable to take account of the experience and expertise of the direct care staff for personal care homes in establishing what is appropriate and acceptable for assisted living residences.

§2800.55 Portability of staff qualifications and training
No comment at this time.

§2800.56 Administrator staffing
The proposed regulations state:

> (a) The administrator shall be present in the residence 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 a staff person to supervise the residence in the administrator's absence.
> The designee shall have the same training required for an administrator.

SUGGESTED LANGUAGE
(a) The administrator shall be present in the residence an average of [40]20 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 a staff person to supervise the residence in the administrator's absence. [The designee shall have the same training required for an administrator.] The designee shall have received training sufficient to fulfill the administrator's responsibilities in the event of the administrator's absence. [the same training required for an administrator.]

COMMENT

It is essential that all staff, including administrators, be well trained to care for residents. It is also important that administrators understand the needs of residents and be present in the facility a significant portion of their time.

The requirement in the proposed regulations that an administrator or a designee, with the same training as the administrator, be present 24/7 is unreasonable. The Chapter 2600 regulations impose a requirement that administrators be present in the facility for 20 hours or more a week. This standard has worked well in practice; we suggest that a similar requirement be applied to assisted living residences. It is important for an administrator to be present in the residence; however, this must be balanced with other important duties or responsibilities of an administrator. An administrator, for example, must meet his or her continuing education requirements and have the flexibility, where appropriate, to visit other residences in order to interact and learn from other administrators. The requirement in the proposed regulations of doubling the number of hours an administrator must be on site precludes administrators from Fulfilling all aspects of their position.

As previously stated, the two types of entities, personal care home and assisted living units can exist in one building. Our proposed revision concerning hours presents a standard identical to the requirement in the 2600 regulations governing personal care homes. This revision creates greater administrative flexibility and provides for greater quality of life care for the residents.

§2800.57 Direct care staffing

No comment at this time.

§2800.58 Awake staff persons

No comment at this time.

§2800.59 Multiple buildings
No comment at this time.

§2800.60 Additional staffing based on the needs of the residents

§2800.60 (a) – (c)
No comment at this time.

§2800.60 (d)
The proposed regulations state:

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

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

COMMENT
The proposed revision clarifies that a licensed nurse should be on call at all times.

§2800.2800.61 Substitute personnel
No comment at this time.

§2800.62 List of staff persons
No comment at this time.

§2800.63 First aid, CPR and obstructed airway training

§2800.63(a)
The proposed regulations state:

> (a) There shall be sufficient staff 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.

PROPOSED REVISION

(a) There shall be [sufficient] at least one staff person for up to 50 residents staff 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.

COMMENT

The proposed revision is identical to 2600.63 governing personal care homes. The proposed regulation provides a specific standard which ensures the safety of the residents and provides clarity for the expectations of the residence.

§2800.63 (b) – (d)

No comment at this time.

§2800.64 Administrator training and orientation

§2800.64 (a) – (c)

No comment at this time.

§2800.64 (d)

The proposed regulations state:

> 64(d) Annual training shall be provided by Department-approved training sources listed in the Department's assisted living residence training resource directory or, by an accredited college or university.

PROPOSED REVISION

64(d) Annual training shall be provided by Department-approved training sources listed in the Department's assisted living residence training resource directory or, by an accredited college or university[.], or courses approved for credit by NCERS/NAB or the Bureau of Professional and Occupational affairs in the Department of State.

COMMENT

Many administrators and staff attend conferences and symposia sponsored by the National Association of Boards of Examiners of Long Term Care Administrators (NAB) and the National Continuing Education Review Services (NCERS). Administrators and staff also attend classes that are sanctioned by the Bureau of Professional and Occupational Affairs and Department of State.

The proposed revision acknowledges the frequency with which administrators and staffs attend courses sponsored by these organizations and recognizes the value they add toward the intelligent care of the residents. Consequently, it would seem reasonable for the Department to accept credits from courses offered from these organizations as well as governmental departments.

§2800.64 (e) – (f)
No comment at this time.

§2800.64 (g)
(g)No such section in the proposed regulations

PROPOSED ADDITION
(g) A licensed nursing or personal care home residence administrator who is employed as an administrator prior to the effective date of these regulations, is exempt from the initial training and educational requirements of this chapter if the administrator continues to meet the applicable licensing requirements. A licensed nursing or personal care home residence administrator hired as an administrator after the effective date of these regulations shall complete and pass the Department-approved assisted living residence administrator competency-based training test.

COMMENT
The proposed regulation does not address the situation of a licensed nursing home or personal care home residence administrator regarding training and educational requirements.

We want to provide that the experience and training of licensed nursing home or personal care home residence administrator employed as such prior to the effective date of these proposed regulations warrants exemption from the above proposed educational requirements as long as he or she continues to meet the requirements of the appropriate department of the Commonwealth.

§2800.65 Direct care staff person training and orientation

§2800.65 (a) – (d)
No comment at this time.

§2800.65 (e)

The proposed regulation states:

> (e) Direct care staff persons shall have at least 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 training.

PROPOSED REVISION

(e) Direct care staff persons shall have at least 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 training.]

COMMENT

The addition of dementia care-centered education to the already mandated educational requirement removes staff from direct care duties. The goal of direct care staff receiving dementia care-centered education can be achieved through its inclusion in the 12 hour yearly allotment.

§2800.65 (f)

No comment at this time.

§2800.66 Staff training plan

No comment at this time.

§2800.67 Training institution registration

No comment at this time.

§2800.68 Instructor approval

No comment at this time.

§2800.69 Additional dementia-specific training

No comment at this time.

PHYSICAL SITE

§2800.81 Physical accommodations and equipment
No comment at this time.

§2800.82 Poisons
No comment at this time.

§2800.83 Temperature
No comment at this time.

§2800.84 Heat sources
No comment at this time.

§2800.85 Sanitation
No comment at this time.

§2800.86 Ventilation
No comment at this time.

§2800.87 Lighting
No comment at this time.

§2800.88 Surfaces
No comment at this time.

§2800.89 Water
No comment at this time.

§2800.90 Communication system
No comment at this time.

§2800.91 Emergency telephone numbers
No comment at this time.

§2800.92 Windows and screens
No comment at this time.

§2800.93 Handrails and railings

The proposed regulations state:

(a) Each ramp, interior stairway, hallway and outside steps must have a well-secured handrail.

PROPOSED REVISION

(a) Each ramp, interior stairway, [hallway] and outside steps must have a well-secured handrail. Hallways must be secure for the mobility of residents.

COMMENT

One of the many goals of an assisted living facility is to create a home-like environment for its residents. The proposed regulation calls for a "handrail" in the hallway. To require a formal "handrail" in the hallway detracts from a home-like setting by creating a more "institutionalized "atmosphere.

§2800.94 Landings and stairs

§2800.94(a) – (b)

No comment at this time.

§2800.94(c)

The proposed regulations state:

(c)Stairs must have strips for those with vision impairments.

PROPOSED REVISION

(c) Emergency exit [S]stairs must have strips for those with vision impairments.

COMMENT

We are concerned that those who are vision impaired are able to exit in an emergency; however, the use of strips, in non-exit areas, detracts from achieving a home-like atmosphere and institutionalizes the environment for the residents.

As stated in the comments for §2800.93(a), it is the goal of an assisted living facility to create a "home-like" atmosphere without compromising the safety of its residents.

§2800.95 Furniture and equipment
No comment at this time.

§2800.96 First aid kit
The proposed regulations state:

> (a) The residence shall have a first aid kit that includes an automatic electronic defibrillation device, nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

PROPOSED REVISION
(a) The residence shall have a first aid kit that includes [an automatic electronic defibrillation device,] nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers. An automatic electronic defibrillation device shall be located on the premises of the residence.

COMMENT
The proposed regulation is unclear as to whether or not every first aid kit must have an automatic electronic defibrillation device. The proposed revision clarifies the requirement of having an automatic electronic defibrillation device.

Many facilities elect to have more than one first aid kit on the premises which exceeds the present requirement in the 2600 regulations of one first aid kit per residence. When considering the average cost of an AED, ($2,300.00 according to the American Red Cross), it is important to specify the exact amount of AED's a residence is expected to possess.

§2800.96 (b) – (c)
No comment at this time.

§2800.97 Elevators and stair glides
No comment at this time.

§2800.98 Indoor activity space

§2800.98 (a)

The proposed regulation states:

> (a) The residence shall have at least two indoor wheelchair accessible common rooms for all residents for activities such as reading, recreation and group activities. One of the common rooms shall be available for resident use at any time, provided the use does not affect or disturb others.

PROPOSED REVISION

(a) The residence shall have at least [two] one indoor wheelchair accessible common room for [all residents for] activities such as reading, recreation and group activities. The common rooms shall be available for resident use at any time, provided the use does not affect or disturb others.

COMMENT

Practically, one indoor wheelchair accessible common room is sufficient such that all of the residents can enjoy and live comfortably in the residence.

The requirement of more than one indoor wheelchair accessible room does not add to the quality of life or increase the safety of the residents. This is why the proposed revision suggests one indoor wheelchair accessible room

§2800.98 (b) – (c)

No comment at this time.

§2800.99 Recreation space

No comment at this time.

§2800.100 Exterior conditions

No comment at this time.

§2800.101 Resident [bedrooms] living units

§2800.101(a)

No comment at this time.

§2800.101(b)(1)

The proposed regulations state:

(b)(1) For new construction of residences after (*Editor's Note*: The blank refers to the effective date of adoption of this proposed rulemaking.), each living unit for a single resident must have at least 250 square feet of floor space measured wall-to-wall, excluding bathrooms and closet space. If two residents share a living unit, there must be an additional 80 square feet in the living unit.
(2) For residences in existence prior to (*Editor's Note*: The blank refers to the effective date of adoption of this proposed rulemaking.), each living unit must have at least 175 square feet measured wall to wall, excluding bathrooms and closet space. If two residents share a living unit, there must be an additional 80 square feet in the living unit.

PROPOSED REVISIONS
(b)(1) For new construction of residences after (Editor's Note: The blank refers to the effective date of adoption of this proposed rulemaking.), each living unit for a single resident must have at least [250] 150 square feet of floor space measured wall-to-wall, excluding bathrooms and closet space. If two residents share a living unit, there must be an additional 80 square feet in the living unit.
(2) For residences in existence prior to (Editor's Note: The blank refers to the effective date of adoption of this proposed rulemaking.), each living unit must have at least [175] 125 square feet measured wall to wall, excluding bathrooms and closet space. If two residents share a living unit, there must be an additional 80 square feet in the living unit.

COMMENT
As stated in our introductory remarks, the new category of Assisted Living is an important option to the present and future elderly and disabled populations in Pennsylvania.

Unfortunately, the proposed regulation regarding the square footage requirements for living units, based on data outlined in Appendix II, will result in a two tiered system of assisted living which will preclude access to facilities for only those with considerable resources to pay.

In fact the proposed regulation requirements pose a serious barrier to the construction of new assisted living facilities and the conversion of existing personal care homes to assisted living facilities. The current market rate for

construction is not conducive to building or converting facilities in accordance with these requirements.

Also based on the best available data today (Assisted Living and CCRC State Regulatory Handbook: 2008), it is clear that the overwhelmingly majority of states require 100 square feet or less for a single occupancy living unit in an assisted living facility. This statistic includes Florida, a state which also has a large existing and growing elderly population. Florida's requirement is 80 square feet.

Assessing that same data further indicates that currently only 8 states have a requirement of greater than 150 sq. feet per single living unit.

If Pennsylvania were to adopt the proposed 250 sq. feet requirement it would place Pennsylvania at the top of the sq. foot requirements nationally. See Appendix I

From a cost perspective, and as outlined in Appendix II, at 250 square feet the likely charge in 2008 dollars for a unit would be approximately $4615 a month; at 200 square feet $4150 and at 150 square feet $3650. These numbers increase significantly for the Philadelphia area and of course do not take into account the inflation rate which would impact future construction.

We understand and appreciate the importance of residents living in comfortable home-like settings. However this important goal must be balanced with the equally important goal of effectively establishing an assisted living market that is affordable to more than those who are the wealthiest in the state.

The proposed revision presents a standard comfortable for residents and economically feasible and attainable for residences. It helps to ensure that there can and will be a strong assisted living market within the Commonwealth.

§2800.10 1(c)
No comment at this time.

§2800.10 1(d)
The proposed regulation states:

(d) Kitchen capacity requirements are as follows:

(1) *New construction*. For new construction of residences after _____ (*Editor's Note*: The blank refers to the effective date of adoption of this proposed rulemaking.),
the kitchen capacity, at a minimum, must contain a small refrigerator with a freezer compartment, a cabinet for food storage, a small bar-type sink with hot and cold running water and space with electrical outlets suitable for small cooking appliances such as a microwave oven. The cooking appliances shall be designed so that they can be disconnected and removed for resident safety or if the resident chooses not to have cooking capability in his living unit.

(2) *Existing facilities*. Facilities that convert to residences after _____ (*Editor's Note*: The blank refers to the effective date of adoption of this proposed rulemaking.), must meet the following requirements related to kitchen capacity:
(i) The residence shall provide a small refrigerator in each living unit.
(ii) The residence shall provide a microwave oven in each living unit.
(iii) The residence shall provide access to a sink for dishes, a stovetop for hot food preparation and a food preparation area in a common area. A common resident kitchen may not include the kitchen used by the residence staff for the preparation of resident or employee meals, or the storage of goods.

PROPOSED REVISION
(d) Kitchen capacity requirements for assisted living residences are as follows:

[(1) New construction. For new construction of residences after (Editor's Note: The blank refers to the effective date of adoption of this proposed rulemaking.), the kitchen capacity, at a minimum, must contain a small refrigerator with a freezer compartment, a cabinet for food storage, a small bar-type sink with hot and cold running water and space with electrical outlets suitable for small cooking appliances such as a microwave oven. The cooking appliances shall be designed so that they can be disconnected and removed for resident safety or if the resident chooses not to have cooking capability in his living unit.
(2) Existing facilities. Facilities that convert to residences after (Editor's Note: The blank refers to the effective date of adoption of this proposed rulemaking.), must meet the following requirements related to kitchen capacity:]

[(i)] (1)The residence shall provide a small refrigerator in each living unit.

[(ii)] (2) The residence shall provide a microwave oven in each living unit.

[(iii)] (3) The residence shall provide access to a sink for dishes, a stovetop for hot food preparation and a food preparation area in a common area. A common resident kitchen may not include the kitchen used by the residence staff for the preparation of resident or employee meals, or the storage of goods.

COMMENT

As stated in our comments regarding living units, the necessity for all newly constructed facilities to equip living units with a kitchen that possesses a sink with hot and cold running water, presents yet another serious barrier to the establishment of a vibrant assisted living market in the Commonwealth.

The proposed requirement will create an assisted living market only available to the wealthiest in the state and not to those with more modest means. The proposed revision presents a more workable standard, helping to ensure that assisted living residences are available to a broad economic cross section of future residents.

§2800.10 1(e) – (r)

No comment at this time.

§2800.102 Bathrooms

No comment at this time.

§2800.103 Food service

No comment at this time.

§2800.104 Dining room

No comment at this time.

§2800.105 Laundry

No comment at this time.

§2800.106 Swimming areas
No comment at this time.

§2800.107 Emergency preparedness
No comment at this time.

§2800.108 Firearms and weapons
The proposed regulation states:

(a) A residence shall have a written policy regarding firearms.

PROPOSED REVISION
(a) A residence shall have a written policy regarding firearms where firearms are on the premises or in possession of any resident or staff member. A residence is not required to permit firearms.

COMMENT
The proposed revision gives a residence the option of not having a written policy regarding firearms if they are barred from the premises.

§2800.108(b) – (d)
No comment at this time.

§2800.109 Pets
No comment at this time.

FIRE SAFETY

§2800.121 Unobstructed egress
No comment at this time.

§2800.122 Exits
No comment at this time.

§2800.123 Emergency evacuation
No comment at this time.

§2800.124 Notification of local fire officials

The proposed regulation states:

> The residence shall notify the local fire department in writing of the address of the residence, location of the living units and bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

PROPOSED REVISION

The residence shall notify the local fire department in writing of the address of the residence, location of the living units and bedrooms [and]. The residence shall provide annual notification to the local fire department of the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

COMMENT

The proposed revision adds clarity to the proposed regulation by specifying a time frame for the provision of notification to the local fire department without compromising the safety concerns of the residents.

§2800.125 Flammable and combustible materials

No comment at this time.

§2800.126 Furnaces

No comment at this time.

§2800.127 Space heaters

No comment at this time.

§2800.128 Supplemental heating sources

No comment at this time.

§2800.129 Fireplaces

No comment at this time.

§2800.130 Smoke detectors and fire alarms

No comment at this time.

§2800.131 Fire extinguishers

The proposed regulation states:

(a) There shall be at least one operable fire extinguisher with a minimum 2-A rating for each floor and living unit, including the basement and attic.

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

PROPOSED REVISION

(a)There shall be at least one operable fire extinguisher with a minimum 2-A rating for each floor [and living unit,] including the basement and attic.

(c) A fire extinguisher with a minimum 2A-10BC rating shall be located in each kitchen not a part of the living unit. [and in the living units.] The kitchen extinguisher must meet the requirements for one floor as required in subsection (a).

COMMENT

The safety of the residents, staff and residence from the hazards of fire is of upmost importance. However, the provision of fire extinguishers in every living unit poses the possible problem of misuse and risk of harm to self or other residents.

The National Fire Protection Association ("NFPA") recommends that a person not travel more than 75 feet to gain access to a portable fire extinguisher. NFPA also requires that only personnel who have received training use portable fire extinguishers. One reason for this requirement is that a person could use a fire extinguisher on the wrong type of fire and hurt him or herself and possibly spread the fire.

The proposed revision makes this section identical to the 2600 regulations which are consistent with what NFPA recommends, and given that many facilities will be dually licensed, makes logical sense.

§2800.131(b); (d) – (f)

No comment at this time.

§2800.132 Fire drills
No comment at this time.

§2800.133 Exit signs
No comment at this time.

RESIDENT HEALTH

§2800.141 Resident medical evaluation and health care

§2800.141(a)
The proposed regulation states:
a) A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission. The evaluation must include the following:

PROPOSED REVISION
a) A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

COMMENT
The proposed revision is identical to the 2600 regulations. It is in the best interest of the resident, due to the possibility of dual licensure, to achieve continuity between the 2600 and 2800 regulations. This particular provision has proven to work well among personal care home facilities and should therefore also be applied to assisted living facilities.

§2800.141 (a) (1) – (12)
No comment at this time.

§2800.141 (b)
No comment at this time.

§2800.142 Assistance with health care and supplemental health care services

§2800.142(a)

The proposed regulations state:

> (a) The residence shall assist the resident to secure medical care and supplemental health care services. 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. If the resident has health care coverage for the supplemental health care services, the approval may not be unreasonably withheld. The residence shall document the resident's need for the medical care, including updating the resident's assessment and support plan.

PROPOSED REVISION

§2800.142 Assistance with health care [and supplemental health care services] (a) The residence shall assist the resident to secure medical care. [and supplemental health care services.] To the extent prominently [displayed] disclosed in the written admission agreement, a residence may require residents to use providers of supplemental health care services approved or designated by the residence. [If the resident has health care coverage for the supplemental health care services, the approval may not be unreasonably withheld.] The residence shall document the resident's need for the medical care, including updating the resident's assessment and support plan.

COMMENT

The proposed regulation is inconsistent with and goes far beyond the text of the statute. Although a residence may assist a resident in securing medical care, by definition in the statute and regulations, "supplemental health care services" is the provision of health care. The statutory text does not give a resident the right to select a supplemental health care provider IF the residence elects to provide or select a supplemental health care services provider. The proposed regulation creates a right that does not exist in the legislation.

§2800.142(b) – (d)

No comment at this time.

§2800.143 Emergency medical plan

No comment at this time.

§2800.144 Use of tobacco
No comment at this time.

NUTRITION

§2800.161 Nutritional adequacy

§2800.161(a) – (f)
No comment at this time.

§2800.161(g)
The proposed regulation states:

> (g) Between-meal snacks and beverages shall be available at all times for each resident, unless medically contraindicated as documented in the resident's support plan.

PROPOSED REVISION
(g)Between-meal snacks and beverages as determined by the residence shall be available at all times [for each resident,] unless medically contraindicated as documented in the resident's support plan.

COMMENT
In order for the residence to ensure the quality and nutritional value of between meal snacks, the residence must have the ability to determine what is offered to the residents. Of course, the residents should have input into this process.

§2800.161(h)
The proposed regulation states:

> (h) Residents have the right to purchase groceries and prepare their own food in addition to the three meal plan required in § 2800.220(b) (relating to assisted living residence services) in their living units unless it would be unsafe for them to do so consistent with their support plan.

PROPOSED REVISION
(h) Residents have the right to purchase groceries and prepare their own food in addition to the three meal plan required in § 2800.220(b) (relating to assisted living residence services) in their living units unless it would be unsafe for them

to do so consistent with their support plan. Exercising this right will not substitute for or waive the resident's financial obligation e for meals as part of the resident agreement core services.

COMMENT
The proposed revision of the proposed regulation is offered for purposes of clarification. Any independent purchasing of groceries for the purpose of preparing meals should not replace the initial resident agreement which includes the provision of meals.

§2800.162 Meals

§2800.162(a) – (e)
No comment at this time.

§2800.162(f)
The proposed regulations state:

> (f) A resident shall receive adequate physical assistance with eating or be provided with appropriate adaptive devices, or both, as indicated in the resident's support plan.

PROPOSED REVISION
(f) A resident shall receive adequate physical assistance with eating or be provided with appropriate adaptive devices, or both, as indicated in the resident's support plan. In the event that providing such assistance exceeds the residence's ability to meet the resident's specific health care needs, the residence has the option of discharging the resident in accordance with §2800.228. Any fees incurred in providing assistance beyond standard eating accommodations may be passed on to the resident.

COMMENT
The residence must have the ability to safely and effectively provide for and meet the resident's health care needs. Consequently the residence must have the ability to discharge a resident when the needs of the resident exceed the capabilities of the residence. Likewise, if additional staffing and services are necessary beyond what is defined in the resident/residence agreement, the residence must have the ability to charge for the additional services.

§2800.162(g)
No comment at this time.

§2800.163 Personal hygiene for food service workers
No comment at this time.

§2800.164 Withholding or forcing of food prohibited
No comment at this time.

TRANSPORTATION

§2800.171 Transportation

§2800.171(a) – (b) (1) – (4)
No comment at this time.

§2800.171(b) (5)
The proposed regulation states:

> (5) The vehicle must have a first aid kit with the contents as specified in § 2800.96 (relating to first aid kit).

PROPOSED REVISION
(5) The vehicle must have a first aid kit with the contents as specified in § 2800.96 (relating to first aid kit). The inclusion of an automatic electronic defibrillation device in the first aid kit of a vehicle is optional.

COMMENT
Please refer to the comments applicable to §2800.96.

§2800.171(b) (6) – (7)
No comment at this time.

§2800.171(d)

The proposed regulations states:

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

PROPOSED REVISION

(d) If a residence supplies its own vehicle for transporting residents to and from medical and social appointments, [a] only the specific vehicle used for this purpose shall be accessible to resident wheelchair users and any other assistive equipment the resident may need. The residence may charge residents for transportation to certain medical and social appointments as specified in the fee schedule outlined in 2800.

COMMENT

Many residents who will be residing in an assisted living residence will not require the use of a vehicle that accommodates wheelchair users.
Clearly, the vehicle being used to transport residents MUST meet the requirements of this section. However, all vehicles owned by the residence need not meet these requirements.

MEDICATIONS

§2800.181 Self-administration

No comment at this time.

§2800.182 Medication administration

No comment at this time.

§2800.183 Storage and disposal of medications and medical supplies

No comment at this time.

§2800.184 Labeling of medications

No comment at this time.

§2800.185 Accountability of medication and controlled substances

No comment at this time.

§2800.186 Prescription medications
No comment at this time.

§2800.187 Medication records
No comment at this time.

§2800.188 Medication errors
No comment at this time.

§2800.189 Adverse reaction
No comment at this time.

§2800.190 Medication administration training
No comment at this time.

§2800.191 Resident education
The proposed regulations states:

The residence shall educated the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

COMMENT

If the Department were to involve itself in the manner in which the residence were to document resident education, the Department should consult with the regulated community before issuing any directive.

SAFE MANAGEMENT TECHNIQUES

§2800.201
No comment at this time.

§2800.202 Prohibitions

§2800.202(1) – (3)
No comment at this time.

§2800.202(4)

The proposed regulations state:

> (4) A chemical restraint, defined as use of drugs or chemicals for the specific and exclusive purpose of controlling acute or episodic aggressive behavior, is prohibited. A chemical restraint does not include a drug ordered by a physician or dentist to treat the symptoms of a specific mental, emotional or behavioral condition, or as pretreatment prior to a medical or dental examination or treatment.

PROPOSED REVISION

(4) A chemical restraint, defined as use of drugs or chemicals for the specific and exclusive purpose of controlling acute or episodic aggressive behavior, is prohibited. A chemical restraint does not include a drug ordered by a physician or dentist to treat the symptoms of a specific mental, emotional or behavioral condition, or as pretreatment prior to a medical or dental examination or treatment. Medication ordered pro re nata for treatment of specific conditions is permitted to be administered by unlicensed staff if accompanied by specific instructions from the ordering physician stating in what circumstances it may be administered.

COMMENT

The proposed revision is suggested for purposes of clarification. The administration of *pro re nata* medication by qualified staff, alleviating the anxiety of the resident, has been interpreted and documented as such in surveys as the use of a chemical restraint.

Consequently, violations have been cited where none existed. The proposed revision addresses this problem.

§2800.202(5) – (6)

No comment at this time.

§2800.203 Bedside rails

§2800.203(a)

§2800.203(b)

The proposed regulations state:

(a) Bedside rails may not be used unless the resident can raise and lower the rails on his own. Bedside rails may not be used to keep a resident in bed. Use of any length rail longer than half the length of the bed is considered a restraint and is prohibited. Use of more than one rail on the same side of the bed is not permitted.

(b) Half-length rails are permitted only if the following conditions are met:
(1) The resident's assessment or support plan, or both, addresses the medical symptoms necessitating the use of half-length rails and the health and safety protection necessary in order to safely use half-length rails.
(2) The residence has attempted to use less restrictive alternatives.
(3) The resident or legal representative consented to the use of half-length rails after the risk, benefits and alternatives were explained.

PROPOSED REVISION

(a)Bedside rails may not be used unless the resident can raise and lower the rails on his own. Bedside rails may not be used to keep a resident in bed. Use of any length rail longer than half the length of the bed is considered a restraint and is prohibited. Use of more than one rail on the same side of the bed is not permitted.

[(b) Half-length rails are permitted only if the following conditions are met:
(1) The resident's assessment or support plan, or both, addresses the medical symptoms necessitating the use of half-length rails and the health and safety protection necessary in order to safely use half-length rails.
(2) The residence has attempted to use less restrictive alternatives.
(3) The resident or legal representative consented to the use of half-length rails after the risk, benefits and alternatives were explained.]

COMMENT

The regulations concerning bed rails in personal care homes have worked well and served the needs of residents.

The half length rail provisions as written could be considered a restraint. We neither believe nor encourage the use of restraints as they are not appropriate in

assisted living residence, except under highly unusual circumstances. The proposed revision reflects this belief.

SERVICES

§2800.220 Assisted living residence services

The proposed regulations state:

(a) *Services*. The residence shall provide core services as specified in subsection (b). 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 services provided by the residence and shall not supplant them.

(b) *Core 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 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).

(c) *Supplemental 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 to and from medical appointments if transportation is coordinated by the residence.
(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.

PROPOSED REVISION
(a) Services. The residence shall provide core services as specified in subsection (b). 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 services provided by the residence and shall not supplant them. Core services may be itemized and separated or grouped together in accordance with the policy and practice of the residence. The residence will clearly state the pricing structure in the resident agreement. Supplemental services will be itemized in accordance with the policy and practice of the residence.

COMMENT
The provision of the option of bundling or unbundling core services provides the resident the greatest flexibility in making his or her own choices with regard to the core services that he or she needs or wants.

Act 56 supports the practice that core services may be itemized or unbundled. The legislation states the following regarding the admission agreement:

> (5) All residents sign a standard written admission agreement which shall include the **disclosure to each resident of the actual rent and other charges for services** provided by the personal care home or assisted living residence. (emphasis added)

We support a requirement that the residence make a reasonable attempt to accommodate the resident's desires. The proposed revision creates a manner in which this can be achieved concerning services by clearly establishing what

services are available, and at what fee, so the resident can make an informed choice or decision.

§2800.220(b) – (d)
No comment at this time.

§2800.221 Activities program

§2800.221(a)
The proposed regulations state:

> (a) The residence shall develop a program of daily activities designed to promote each resident's active involvement with other residents, the resident's family and the community. The residence shall encourage the residents' active participation in the development of the daily activities calendar.

PROPOSED REVISION
(a) The residence shall develop a program of daily activities designed to promote each resident's active involvement with other residents, the resident's family and the community. The residence shall [encourage] offer the opportunity for the residents' active participation in the development of the daily activities calendar.

COMMENT
Because the word "encourage" is NOT defined and subject to various (and different) interpretations, we have proposed a clarification which requires the residence to "offer the opportunity" to participate rather than "encourage."

§2800.221(b) – (c)
No comment at this time.

§2800.222 Community social services
The proposed regulation states:

> Residents shall be encouraged and assisted in the access to and use of social services in the community which may benefit the resident, including a county mental health and mental retardation program, a drug and alcohol

program, a senior citizens center, an area agency on aging or a home health care agency.

PROPOSED REVISION

Residents shall be [encouraged] offered the opportunity and assisted in the access to and use of social services in the community which may benefit the resident, including a county mental health and mental retardation program, a drug and alcohol program, a senior citizens center, an area agency on aging or a home health care agency.

COMMENT

The previous comment for section 2800.221 applies to the proposed revision for this section. Because the word "encourage" is NOT defined and subject to various (and different) interpretations, we have proposed a clarification which requires that the residents by "offered the opportunity" to participate rather than "encouraged."

§2800.223 Description of services

No comment at this time.

§2800.224 Preadmission screening

§2800.224(a)

The proposed regulations state:

(a) A determination shall be made by the administrator or designee within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the potential resident can be met by the services provided by the residence.

COMMENT

The determination of the preadmission screening form used should not be left to the discretion of the department, but rather should be part of a stakeholder process which includes the regulated community.

§2800.224(b)

The proposed regulations state:

> (b) 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 potential resident shall then be referred to a local appropriate assessment agency.

PROPOSED REVISION

(b) A potential resident whose needs cannot be met by the residence shall be informed by the residence of this decision (including the reason for the denial), and [be provided with a written decision denying their admission and provide a basis for their denial. The potential resident shall then] be referred to a local appropriate assessment agency.

COMMENT

The proposed revision emphasizes the importance of providing information to the potential resident and assuring that he/she is referred to a local assessment agency in an expeditious manner without excessive administrative requirements.

We believe that when a potential resident's needs cannot be met by a residence, it is of extreme importance and urgency to assist the individual in obtaining information on where his or her needs can best be met. The proposed revision addresses this need.

§2800.224(c) – (g)

No comment at this time.

§2800.225 Initial and annual assessment

The proposed regulations state:

> (a) A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or licensed practical nurse, under the supervision of a registered nurse, may complete the initial assessment.

PROPOSED REVISION

(a) A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator

or designee [licensed practical nurse, under the supervision of a registered nurse,] may complete the initial assessment.

COMMENT
The proposed language clarifies that the administrator of the facility has the flexibility to choose a designee. He or she may use their best judgment as to who is the appropriate employee to complete and document the initial assessment.

§2800.225(b) – (c)
No comment at this time.

§2800.226 Mobility criteria

§2800.226(a) – (b)
No comment at this time.

§2800.226(c)
The proposed regulation states:

> (c) The administrator shall notify the Department within 30 days after a resident with mobility needs is admitted to the residence or the date when a resident develops mobility needs.

PROPOSED REVISION
(c) The administrator or designee shall notify the Department within 30 days after a resident with mobility needs is admitted to the residence [or the date] and compile a monthly list of when a resident develops mobility needs.

COMMENT
Focus on the resident's health and well being is of paramount importance. At times administrative requirements can compromise this focus. The requirements of the proposed regulation present this possibility.

The proposed revision achieves a balance which permits the residence to focus on the resident without compromising administrative responsibilities

§2800.227 Development of the support plan

§2800.227(a)

No comment at this time.

§2800.227(b) – (c)

The proposed regulation states:

> (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, shall review and approve the support plan.
>
> (c) The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment. The residence shall review each resident's support plan on a quarterly basis and modify as necessary to meet the resident's needs.

PROPOSED 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,] shall review and approve the support plan.

(c) The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment. [The residence shall review each resident's support plan on a quarterly basis and modify as necessary to meet the resident's needs.]

COMMENT

A licensed practical nurse has the requisite knowledge and expertise to review and approve a support plan without the need for supervision by a registered nurse.

Although we agree that a support plan should be current, experience has demonstrated that the proposed revised requirement of revision of the support plan within 30 days upon completion of the annual assessment or upon changes in the resident's needs is more than sufficient to ensure the care and health of the resident.

§2800.227 (d) – (k)
No comment at this time.

§2800.228 Transfer and discharge
The proposed regulation states:

> (a) The facility shall ensure that a transfer or discharge is safe and orderly and that the transfer or discharge is appropriate to meet the resident's needs. This includes ensuring that a resident is transferred or discharged with all his medications, durable medical equipment and personal property. The residence shall 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, the resident's family or designated person and the referral agent citing the reasons for the transfer or discharge. This shall be stipulated in the resident-residence contract.
>
> (1) The 30-day advance written notice must be written in language in which 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.
> (iv) An explanation of the measures the resident or the resident's designated person can take if they disagree with the residence decision to transfer or discharge which includes the name, mailing address, and telephone number of the State and local long-term care ombudsman.
>
> (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. The residence shall demonstrate through support plan modification and documentation the attempts to resolve the reason for the transfer or discharge. The residence may not transfer or discharge a resident if the resident or his designated person arranges for

the needed services. Supplemental services may be provided by the resident's family, residence staff or private duty staff as agreed to by the resident and the residence. This shall be stipulated in the resident residence contract.

(3) Practicable notice, rather than a 30-day advance written notice is required if a delay in transfer or discharge would jeopardize the health, safety or wellbeing of the resident or others in the residence, as certified by a physician or the Department. This may occur when the resident needs psychiatric services or is abused in the residence, or the Department initiates closure of the residence.

(c) A residence shall give 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 tracked in a transfer and discharge tracking chart that the residence shall maintain and make available to the Department.

(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, and shall have the right to choose among the available alternatives after an opportunity to visit the alternative residences. 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 only grounds for transfer or discharge of a resident from a residence are for the following conditions:
(1) If a resident is a danger to himself or others and the behavior cannot be managed through interventions, services 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 under § 2800.229 (relating to excludable conditions; exceptions) or within the scope of licensure for a residence. In that case, the residence shall notify the resident, the resident's designated person and the local ombudsman. The residence shall provide justification for the residence's determination that the needs of the resident cannot be met. If a resident or the resident's designated person disagrees with the residence's decision to transfer or discharge, the residence shall contact the local ombudsman. If the residence decides to proceed with the transfer or discharge, the ombudsman shall notify the Department. The Department may take any appropriate licensure action it deems necessary based upon the report of the ombudsman. In the event that there is no disagreement related to the transfer or discharge, a plan for other placement shall be made as soon as possible by the administrator in conjunction with the resident and the resident's designated person, if any. If assistance with relocation is needed, the administrator shall 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 shall 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 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.

PROPOSED REVISION
{THE FOLLOWING PROPOSED REVISION WOULD REPLACE THE PROPOSED REGULATION}

PROPOSED 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.

COMMENT

The essential differences between the proposed regulation and the suggested revisions to the regulation are as follows:

1) Section .2800.228, throughout its several subsections, imposes unnecessary and unduly burdensome requirements on a residence before a resident can transfer or be discharged. The proposed revisions seek to provide a greater balance between the rights and interests of the resident and the residence, and simplify the process for both resident and residence.

2) The regulation as proposed does not allow for transfer or discharges in emergent circumstances. We have suggested a mechanism to do this.

3) Subparagraph "h" reflects our recommendation that the grounds for transfer and discharge include, but not be limited to, the 8 circumstances listed. There is no legitimate or compelling reason to limit the grounds for transfer and discharge of a resident. And, of course, a resident cannot be transferred or discharged for reasons that would violate otherwise applicable state and federal law.

The input of the consumer/resident is important, necessary and appropriate however, final clinical judgment must be rest in the hands of healthcare professionals who ultimately are responsible for the care of the resident.

§2800.229 Excludable conditions; exceptions

The proposed regulations state:

> (a) *Excludable conditions*. Except as provided in subsection (b), a residence may not admit, retain or serve an individual with any of the following conditions or health care needs:
>
> (1) Ventilator dependency.
>
> (2) Stage III and IV decubiti and vascular ulcers that are not in a healing stage.
>
> (3) Continuous intravenous fluids.
>
> (4) Reportable infectious diseases, such as tuberculosis, in a communicable state that requires isolation of the individual or requires special precautions by a caretaker to prevent transmission of the disease unless the Department of Health directs that isolation be established within the residence.

(5) Nasogastric tubes.

(6) Physical restraints.

(7) Continuous skilled nursing care 24 hours a day.

(b) *Exception*. The residence may submit a written request to the Department on a form provided by the Department for an exception related to any of the conditions or health care needs listed in subsection (a) or (e) to allow the residence to admit, retain or serve an individual with one of those conditions or health care needs, unless a determination is unnecessary as set forth
in subsection (e).

(c) Submission, review and determination of an exception request.

(1) The administrator of the residence shall submit the exception request. The exception request must be signed and affirmed by an individual listed in subsection (d) and accompanied by a support plan which includes the residence accommodations for treating the excludable condition requiring the exception request. Proposed accommodations must conform with the provisions contained within the resident-residence contract.

(2) The Department will review the exception request in consultation with a certified registered nurse practitioner or a physician, with experience caring for the elderly and disabled in long-term living settings.

(3) The Department will respond to the exception request in writing within 5 business days of receipt.

(4) The Department may approve the exception request if the following conditions are met:
(i) The exception request is desired by the resident or applicant.
(ii) The resident or applicant will benefit from the approval of the exception request.

(iii) The residence demonstrates to the Department's satisfaction that the residence has the staff, skills and expertise necessary to care for the resident's needs related to the excludable condition.
(iv) The residence demonstrates to the Department's satisfaction that any necessary supplemental health care provider has the staff, skills and expertise necessary to care for the resident's needs related to the excludable condition.

(v) The residence provides a written alternate care plan that ensures the availability of staff with the skills and expertise necessary to care for the resident's needs related to the excludable condition in the event the supplemental health care provider is unavailable.
(5) The Department will render decisions on exception requests on a case-by-case basis and not provide for facility-wide exceptions.

(d) *Certification providers*. The following persons may certify that an individual may not be admitted or retained in a residence:

(1) The administrator acting in consultation with supplemental health care providers.

(2) The individual's physician or certified registered nurse practitioner.

(3) The medical director of the residence.

(e) *Departmental exceptions*. A residence may admit, retain or serve an individual for whom a determination is made by the Department, upon the written request of the residence, that the individual's specific health care needs can be met by a provider of assisted living services or within a residence, including an individual requiring:

(1) Gastric tubes, except that a determination will not be required if the individual is capable of self-care of the gastric tube or a licensed health care professional or other qualified individual cares for the gastric tube.

(2) Tracheostomy, except that a determination will not be required if the individual is independently capable of self-care of the tracheostomy.

(3) Skilled nursing care 24 hours a day, except that a determination will not be required if the skilled nursing care is provided on a temporary or intermittent basis.

(4) A sliding scale insulin administration, except that a determination will not be required if the individual is capable of self-administration or a licensed health care professional or other qualified individual administers the insulin.

(5) Intermittent intravenous therapy, except that a determination will not be required if a licensed health care professional manages the therapy.
(6) Insertions, sterile irrigation and replacement of a catheter, except that a determination will not be required for routine maintenance of a urinary catheter, if the individual is capable of self-administration or a licensed health care professional administers the catheter.

(7) Oxygen, except that a determination will not be required if the individual is capable of self-administration or a licensed health care professional or other qualified individual administers the oxygen.

(8) Inhalation therapy, except that a determination will not be required if the individual is capable of selfadministration or a licensed health care professional or other qualified individual administers the therapy.
(9) Other types of supplemental health care services that the administrator, acting in consultation with supplemental health care providers, determines can be provided in a safe and effective manner by the residence.

(f) *Request for exception by resident*. Nothing herein prevents an individual seeking admission to a residence
or a resident from requesting that the residence apply for an exception from the Department for a condition listed in this section for which an exception must be granted by the Department. The residence's determination on whether or not to seek such an exception shall be documented on a form supplied by the Department.

(g) *Record*. A written record of the exception request, the supporting documentation to justify the exception request and the determination

related to the exception request shall be kept in the records of the residence. The information required by this subsection shall also be kept in the resident's record.

(h) *Decisions*. The residence shall record the following decisions made on the basis of this section.

(1) Admission denials.

(2) Transfer or discharge decisions that are made on the basis of this section

PROPOSED REVISION

§ 2800.229. Excludable conditions; exceptions.

(a) Excludable conditions. Except as provided in subsection (b), a residence may not admit, retain or serve an individual with any of the following conditions or health care needs:

(1) Ventilator dependency.

(2) Stage III and IV decubiti and vascular ulcers that are not in a healing stage.

(3) Continuous intravenous fluids.

(4) Reportable infectious diseases, such as tuberculosis, in a communicable state that requires isolation of the individual or requires special precautions by a caretaker to prevent transmission of the disease unless the Department of Health directs that isolation be established within the residence.

(5) Nasogastric tubes.

(6) Physical restraints.

(7) Continuous skilled nursing care 24 hours a day.

(b) Exception. The residence may submit a written request to the Department on a form provided by the Department for an exception related to any of the conditions or health care needs listed in subsection (a) or (e) to allow the

residence to admit, retain or serve an individual with one of those conditions or health care needs, unless a determination is unnecessary as set forth in subsection (e).

(c) Submission, review and determination of an exception request.

(1) The administrator of the residence shall submit the exception request. The exception request must be signed and affirmed by an individual listed in subsection (d) and accompanied by a support plan which includes the residence accommodations for treating the excludable condition requiring the exception request. All [P]proposed accommodations must conform with the provisions contained within the resident-residence contract.

(2) The Department shall have a CRNP or a physician with a minimum of 5 years of experience in caring for the elderly and disabled in long term living settings review and respond to the exception request. [will review the exception request in consultation with a certified registered nurse practitioner or a physician, with experience caring for the elderly and disabled in long-term living settings.]

(3) The Department will respond to the exception request in writing within [5 business days] 48 hours of receipt.

(4) The Department [may] will approve the exception request if the following conditions are met:

(i) The exception request is [desired] requested by the residence and the resident [or applicant].

[(ii) The resident or applicant will benefit from the approval of the exception request.]

(ii)The submitted exception request ensures that the residence has the staff, skills and expertise necessary to care for the resident in order to accommodate the exception request.

[(iii) The residence demonstrates to the Department's satisfaction that the residence has the staff, skills and expertise necessary to care for the resident's needs related to the excludable condition.]

(iii)In the event a supplemental service provider, per the agreement between the resident and residence and the supplemental service provider and that is documented in the support plan, is required to provide the necessary care, the supplemental service provider must have the necessary staff and demonstrate the appropriate expertise to care for the excludable condition.

[(iv)The residence demonstrates to the Department's satisfaction that any necessary supplemental health care provider has the staff, skills and expertise necessary to care for the resident's needs related to the excludable condition.]

(iv) the submitted exception request includes a written alternate care plan if the supplemental health care provider is unavailable that ensures the availability of the necessary staff, with skills and expertise necessary to care for the resident to accommodate the excludable condition.

[(v) The residence provides a written alternate care plan that ensures the availability of staff with the skills and expertise necessary to care for the resident's needs related to the excludable condition in the event the supplemental health care provider is unavailable.]

[(5) The Department will render decisions on exception requests on a case-by-case basis and not provide for facility-wide exceptions.]

(d) Certification providers. The following persons may certify that an individual may not be admitted or retained in a residence:

(1) The administrator acting in consultation with supplemental health care providers.

(2) The individual's physician or certified registered nurse practitioner.

(3) The medical director of the residence.

(e) Departmental exceptions. A residence may admit, retain or serve an individual for whom a determination is made by the Department, upon the written request of the residence, that the individual's specific health care needs can be met by a provider of assisted living services or within a residence, including an individual requiring:

(1) Gastric tubes, except that a determination will not be required if the individual is capable of self-care of the gastric tube or a licensed health care professional or other qualified individual cares for the gastric tube.

(2) Tracheostomy, except that a determination will not be required if the individual is independently capable of self-care of the tracheostomy.

(3) Skilled nursing care 24 hours a day, except that a determination will not be required if the skilled nursing care is provided on a temporary or intermittent basis.

(4) A sliding scale insulin administration, except that a determination will not be required if the individual is capable of self-administration or a licensed health care professional or other qualified individual administers the insulin.

(5) Intermittent intravenous therapy, except that a determination will not be required if a licensed health care professional manages the therapy.

(6) Insertions, sterile irrigation and replacement of a catheter, except that a determination will not be required for routine maintenance of a urinary catheter, if the individual is capable of self-administration or a licensed health care professional administers the catheter.

(7) Oxygen, except that a determination will not be required if the individual is capable of self-administration or a licensed health care professional or other qualified individual administers the oxygen.

(8) Inhalation therapy, except that a determination will not be required if the individual is capable of self administration or a licensed health care professional or other qualified individual administers the therapy.

(9) Other types of supplemental health care services that the administrator, acting in consultation with supplemental health care providers, determines can be provided in a safe and effective manner by the residence.

(f) Request for exception by resident. Nothing herein prevents an individual seeking admission to a residence or a resident from requesting that the residence apply for an exception from the Department for a condition listed in this section for which an exception must be granted by the Department. The residence will have the authority to deny such request. The residence's determination on whether or not to seek such an exception shall be documented on a form supplied by the Department.

(g) Record. A written record of the exception request, the supporting documentation to justify the exception request and the determination related to the exception request shall be kept in the records of the residence for up to 7 years. The information required by this subsection shall also be kept in the resident's record for up to 7 years.

(h) Decisions. The residence shall record the following decisions made on the basis of this section.

(1) Admission denials.

(2) Transfer or discharge decisions that are made on the basis of this section.

COMMENT

The proposed revised language presents a more definitive and reliable standard for the residence to meet the Department's requirements and reflects the statutory language and the intent of the legislation.

The proposed revision reflects the establishment of a specific process which further ensures the protection of the health and welfare of the resident.

This is achieved by requiring that the process for reviewing and determining exception requests is made expeditiously by qualified practitioners with experience specific to the population that would reside in assisted living facilities.

Again we acknowledge that resident input is necessary and appropriate but final clinical judgment must be in the hands of the healthcare professionals who ultimately are responsible for the health and welfare of the residents.

SPECIAL CARE UNITS

§2800.231 Admission

§2800.231(a)

The proposed regulation states:

> (a) This section and §§ 2800.232—2800.239 apply to special care units. These provisions are in addition to the other provisions of this chapter. A special care unit is a residence or portion of a residence that provides specialized care and services for residents with Alzheimer's disease or other dementia in the least restrictive manner consistent with the resident's support plan to ensure the safety of the resident and others in the residence while maintaining the resident's ability to age in place. Admission of a resident to a special care unit shall be in consultation with the resident's family or designated person. Prior to admission into a special care unit, other service options that may be available to a resident shall be considered.

PROPOSED REVISION

(a) This section and §§ 2800.232—2800.239 apply to special care units. These provisions are in addition to the other provisions of this chapter. A special care unit is a residence or portion of a residence that provides specialized care and services for residents with Alzheimer's disease or other dementia in the least restrictive manner consistent with the resident's support plan to ensure the safety of the resident and others in the residence while maintaining the resident's ability to age in place. Admission of a resident to a special care unit shall be in consultation with the resident's family or legal representative [designated person]. Prior to admission into a special care unit, other service options that may be available to a resident shall be considered.

COMMENT

We believe that the consultation with a family member or legal representative is a more effective and secure manner in which to make a decision concerning the admission of a resident to a special care unit.

§2800.231(b) – (d)

No comment at this time.

§2800.231(e)

The proposed regulation states:

(e) Each resident record must have documentation that the resident and the resident's designated person have agreed to the resident's admission or transfer to the special care unit.

PROPOSED REVISION

(e) Each resident record must have documentation that the resident did not object and the resident's designated person have agreed to the resident's admission or transfer to the special care unit. In the event that a resident is unable to indicate their acceptance, their physician must document such inability of sound judgment and order placement.

COMMENT

The proposed revision takes into account the limitations of the cognitively impaired to legally enter into a binding contract and fully understand and agreement.

The proposed revision takes into account the limitations a cognitively impaired resident would foreseeably encounter and provides a viable safeguard by requiring the involvement of their physician.

§2800.231(f) – (j)

No comment at this time.

§2800.232 Environmental protection

No comment at this time.

§2800.233 Doors, locks and alarms
No comment at this time.

§2800.234 Resident care

§2800.234(a) – (c)
No comment at this time.

§2800.234(d)
The proposed regulation states:

> (d) The support plan shall be reviewed, and if necessary, revised at least quarterly and as the resident's condition changes.

PROPOSED REVISION
(d)The support plan shall be reviewed, and if necessary, revised at least [quarterly] semi-annually and as the resident's condition changes.

COMMENT
The proposed regulation places a greater focus on administrative duties than service to aid in the health and welfare of the resident. The proposed revision creates a proper balance between the health and welfare of the resident and administrative responsibility.

§2800.234(e)
No comment at this time.

§2800.235 Discharge
No comment at this time.

§2800.236 Training
No comment at this time.

§2800.237 Program
No comment at this time.

§2800.238 Staffing
No comment at this time.

§2800.239 Application to Department
No comment at this time.

RESIDENT RECORDS

§2800.251 Resident records

§2800.251(a) – (d)
No comment at this time.

§2800.251(e)

(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 upon request to the resident and the family members.

PROPOSED 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 from the resident and/or designated person.

COMMENT
The proposed revision more clearly defines the relationship between the residence and the requesting resident or resident's designated regarding the request for records.

§2800.252 Content of resident records
No comment at this time.

§2800.253 Record retention and disposal
No comment at this time.

§2800.254 Record access and security
No comment at this time.

ENFORCEMENT

§2800.261 Classification of violations
No comment at this time.

§2800.262 Penalties and corrective action
No comment at this time.

§2800.263 Appeals of penalty
No comment at this time.

§2800.264 Use of fines
No comment at this time.

§2800.265 Review of classifications
No comment at this time.

§2800.266 Revocation or nonrenewal of licenses
No comment at this time.

§2800.267 Relocation of residents
No comment at this time.

§2800.268 Notice of violations
No comment at this time.

§2800.269 Ban on admissions
No comment at this time.

§2800.270 Correction of violations
No comment at this time.

Concluding Comment:

The Pennsylvania Health Care Association began these comments by indicating that we strongly and enthusiastically endorsed Act 56, signed by Governor Rendell on July 25th, 2007, which created the framework for a system of licensure and regulation that has the potential to provide consumers an important housing and services alternative along the continuum of long term living.

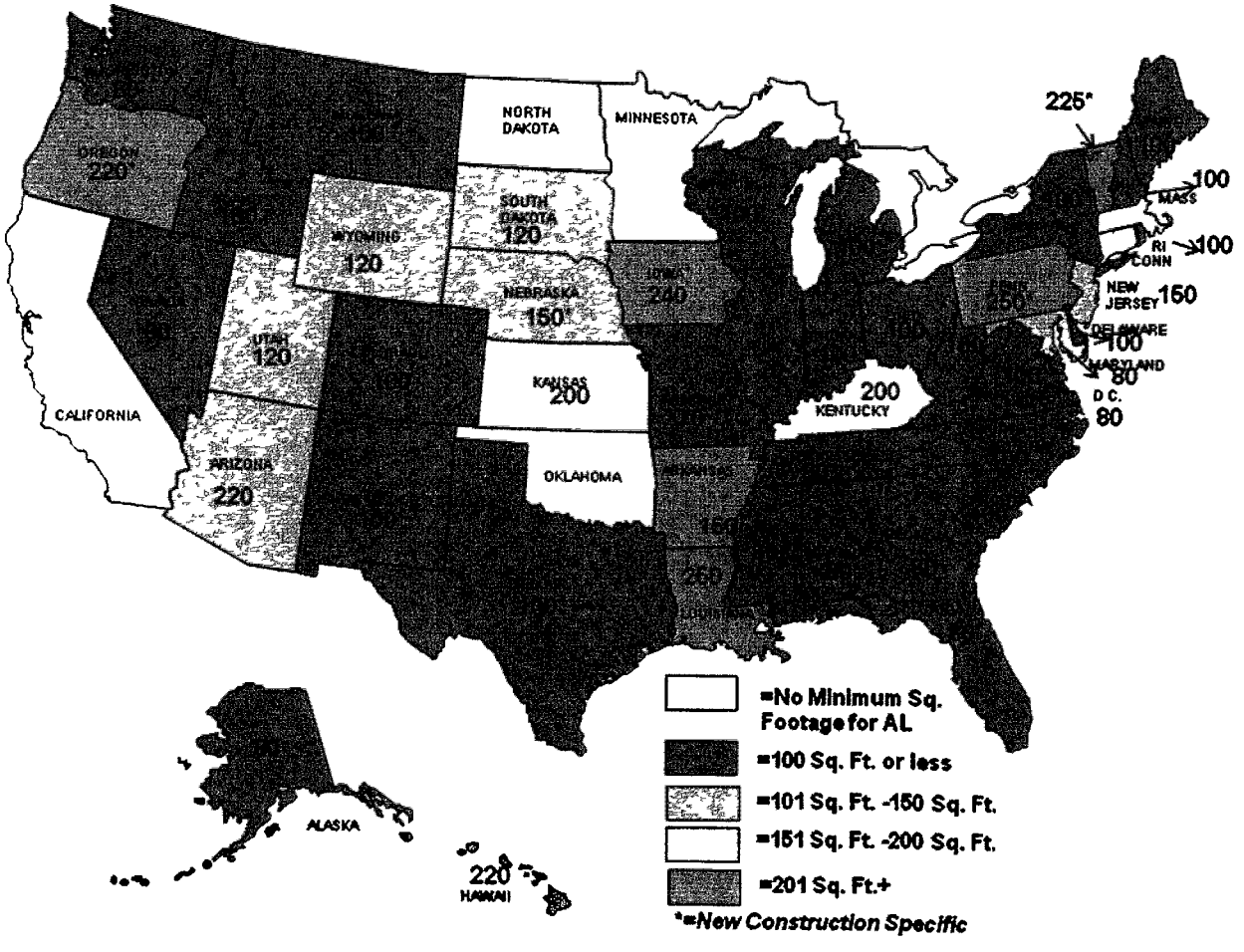
Unfortunately for potential consumers of assisted living, and despite the optimism created by Act 56, the proposed regulations, published on August 9, 2008, are likely to suffocate development of assisted living and insure that the potential for a vibrant assisted living sector will **not** become a living reality, and assisted living will **not** become a significant option along the continuum of long term living for anyone except the most wealthy Pennsylvanians.

PHCA, once again, extends the offer to the Department to assist in the development of assisted living regulations that will create a truly robust assisted living sector in Pennsylvania.

Sincerely,

Stuart H. Shapiro, M.D.
President and CEO
Pennsylvania Health Care Association

APPENDIX I


NORTH DAKOTA
MINNESOTA
OREGON 220*
SOUTH DAKOTA 120
WYOMING 120
NEBRASKA 150
UTAH 120
KANSAS 200
CALIFORNIA
ARIZONA 220
OKLAHOMA
KENTUCKY 200
225*
100
MASS
RI
CONN
100
NEW JERSEY 150
DELAWARE
100
MARYLAND
80
D.C.
80
ALASKA
220
HAWAII
=No Minimum Sq. Footage for AL
=100 Sq. Ft. or less
=101 Sq. Ft. -150 Sq. Ft.
=151 Sq. Ft. -200 Sq. Ft.
=201 Sq. Ft.+
*=New Construction Specific

APPENDIX II

Likely Charges in 2008 Dollars for Newly Constructed Assisted Living Facilities at 150, 200, 250 Square Feet

Respondents	150 Sq. Ft		200 Sq. Ft		250 Sq. Ft	
	Monthly	Daily	Monthly	Daily	Monthly	Daily
A	$3,300	$100	$3,700	$123	$4,400	$146
B	$3,480	$116	$3,840	$128	$4,200	$140
C	$3,150	$105	$3,960	$132	$4,290	$143
D	$4,678	$156	$5,123	$171	$5,568	$186
Average A-D in 2008 dollars	$3,652	$119	$4,156	$139	$4,615	$154
E (in Philadelphia)	$5,250	$175	$5,750	$191	$6,250	$208

Projected Charges in 2010 for Newly Constructed Assisted Living Facilities at 150, 200, 250 Square Feet using 5% Annual Inflation

Respondents	150 Sq. Ft		200 Sq. Ft		250 Sq. Ft	
	Monthly	Daily	Monthly	Daily	Monthly	Daily
Projected Average Charges in 2010 (A-D) at 5% Annual Increase	$4,026	$131	$4,582	$153	$5,087	$170
Projected Charges in Philadelphia (E) for 2010 at 5% Annual Increase	$5,788	$193	$6,339	$211	$6,891	$229