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14-540-280

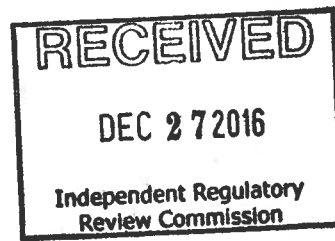
**Kroh, Karen**

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**From:** Mochon, Julie  
**Sent:** Wednesday, December 21, 2016 8:44 AM  
**To:** Kroh, Karen  
**Subject:** FW: REFERENCE REG. NO. 14-540  
**Attachments:** Emmaus Comments on Ch 6100.docx; img12202016\_0002.pdf  
**Importance:** High

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**From:** Dianna Prystash [<mailto:dprystash@emmauspgh.org>]  
**Sent:** Tuesday, December 20, 2016 4:21 PM  
**To:** Mochon, Julie  
**Subject:** REFERENCE REG. NO. 14-540  
**Importance:** High



*Dianna Prystash*

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*A Community that Serves Persons with Intellectual Disabilities and Autism and Promotes Public Awareness of Their Needs*

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# Emmaus Comments Template

## Chapter 6100

**Citation:** 6100.1. Purpose (a)

**Discussion:** wording is confusing

**Recommendation:**

*This chapter governs the provision of and payment for Home and Community Based Services (HCBS) and base-funded services to individuals with an intellectual disability or autism.*

**Citation:** 6100.2. Applicability

**Discussion:** Licensing and the regulations put forth here sometimes conflict.

**Recommendation:** Add "In the event of a conflict between the regulations set out in this Chapter and related but separate licensing regulations, the licensing regulations apply and supersede this Chapter."

**Citation:** 6100.3. Definitions

**Discussion:** There is no definition listed for "Persons Designated by the Individual" however this term is used continuously throughout the regulations

**Recommendation:** Add a definition and describe the role Persons Designated by the Individual

**Citation:** 6100.41. Appeals

**Discussion:**

**Recommendation:**

**Citation:** 6100.42. Monitoring compliance

**Discussion:** Having multiple AEs complete monitoring is time consuming and costly and frankly unnecessary. Re: corrective action plan: it does not seem

reasonable to be required to have a CAP for an “alleged violation” if the allegation turns out to be FALSE.

**Recommendation: Specify that only ONE AE should be allowed / required to complete provider monitoring**

**Do not require CAPs for false allegations.**

**Citation: 6100.43. Regulatory waiver**

**Discussion: When a waiver is requested it is very rarely due to a temporary condition. It is almost always due to a permanent need the individual has. An annual request is a costly and redundant exercise.**

**Recommendation: Allow waivers to renew automatically UNLESS there is a life changing event that warrants it's revocation.**

**Citation: 6100.44. Innovation project**

**Discussion:**

**Recommendation:**

**Citation: 6100.45. Quality management**

**Discussion: While quality management is important, the new chapter poses several nearly impossible requirements such as “individual and family satisfaction surveys and informal comments by individuals, families and others” or “analyzing the successful learning and application of training in relation to established core competencies.” (VERY general and VERY vague and VERY cumbersome) Providers have only had 3 years of experience under the newly required QM under Chapter 51. The extent of changes is not necessary.**

**Recommendation:** A provider will implement an evidenced based, quality improvement strategy that includes continuous improvement process, monitoring, remediation, measurement performance and experience of care.

**(a)** When developing a quality improvement strategy, a provider must take into account the following:

- (1)** The provider’s performance data and available reports in Department’s information reporting system.
- (2)** The results from provider monitoring and SCO monitoring.
- (3)** The results of licensing and provider monitoring.
- (4)** Incident management data, including data on incident target(s), repeated or serious incidents, root cause analyses, and quarterly review of incidents.
- (5)** Results of satisfaction surveys and reviews of grievances.

**(b)** The provider will include the following tasks as part of its quality improvement strategy:

- (1)** Goals that measure individual outcomes, experience, and quality of care associated with the receipt of HCBS and related to the implementation of PSP. Absent criteria established by the U.S. Health and Human Services Secretary, providers will establish goals based on identified need within their programs.
- (2)** Target objectives that support each identified goal.
- (3)** Performance measures the provider will use to evaluate progress.
- (4)** The person responsible for the quality improvement strategy and structure supporting this implementation.
- (5)** Actions to be taken to meet the target objectives.

**(e)** A provider must review progress on the quality improvement strategy and update at least every 2 years.

**(f)** A provider will maintain a written copy of the quality improvement strategy to be available for the Department to review as part of provider monitoring.

**(g)** This section does not apply to an SSW provider and to a provider of HCBS in the Adult Autism Waiver.”

**Citation:** 6100.46. Protective services

**Discussion:**

**Recommendation:**

**Citation:** 6100.47. Criminal history checks

**Discussion:**

**Recommendation:**

**Citation: 6100.48. Funding, hiring, retention and utilization**

**Discussion:**

**Recommendation:**

**Citation: 6100.49. Child abuse history certification**

**Discussion:**

**Recommendation:**

**Citation: 6100.50. Communication**

**Discussion: It is sometimes difficult, if not impossible, to truly ascertain whether or not, or how much an individual understands.**

**Recommendation: add language such as “Written, oral and other forms of communication with the individual, and persons designated by the individual, shall occur in a language and means of communication as *best and to the extent understood* by the individual or a person designated by the individual.**

**Citation: 6100.51. Grievances**

**Discussion: An employer, cannot and will not tolerate retaliation. However, and employer cannot “assure” that another employee or co-worker or family member or individual will not act in a retaliatory way. The types of grievances should be spelled out (addressed here and in the waiver).**

**Recommendation: Consider rewording to “will not tolerate....”**

**Re: 6100.51 (i) add “if known” (because the initiator might not be known)**

Re: 6100.51 (i) – add wording to prohibit the contents of written notice from violating anyone’s confidentiality. (those who file complaints sometimes demand or expect more information than they are entitled to)

**The department must address / spell out the types of grievances that this waiver intends. It is not uncommon across the state, for family members to refuse to accept services from staff person if they do not like the color of their skin or because of their sexual orientation. Family members must understand that by accepting a Medicaid waiver for their loved one, they must also adhere to federal law prohibiting discrimination.**

**Citation: 6100.52. Rights team**

**Discussion: Providers work very hard to honor and protect individuals’ rights. When someone’s rights are violated, an incident is reported and investigated. This new requirement cannot be implemented as written for the following reasons: The code states that each provider is “required to have a rights team” however all of the subsequent requirements make it clear that *each individual* has a rights team based on each incident. In fact the individual is ON the team. Thus a provider could potentially have dozens of rights teams – one for each individual who has a rights (or alleged rights or suspected rights) violation. To require the team to (iii) “discover and resolve the reason for an individual’s behavior” is antithetical to an understanding of human behavior (an individual’s behavior can be supported, understood, addressed, etc) but NOT RESOLVED. Additionally, with rights violations – a provider is most concerned with the *behavior* of the “target” – the person who violated someone else’s rights. No need to “blame the victim” – as if something in their behavior caused an incident or a rights violation. Meeting quarterly with the individual for something that happened in the past is not productive. Making the team a majority of persons who do not provide direct services is not helpful precisely *because* they are not involved in the day to day care of the individual and the dynamics between the individual and other staff or other individuals.**

**Recommendation:** Delete this section. There is no need to add a separate “Rights Team.” In associated licensing regulations, a long-standing and well-established process exists for the oversight and appropriate management for the use of any restrictive procedures, including restraint. The regulations have already established the “Restrictive Procedures Committee” and restrictive procedures process which is tasked with the same basic functions of the newly created team. By replacing a currently existing and appropriately operation expectation, unnecessary costs are added to the system. It is entirely unclear why the creation of a new “rights team” is necessary or adds any value to the actual protection of individuals’ rights, but rather only would add cost and administration burden. Individuals who are not satisfied with the follow up or corrective action plan have recourse to filing a complaint or grievance.

**Citation:** 6100.53. Conflict of interest

**Discussion:**

**Recommendation:**

**Citation:** 6100.54. Recordkeeping

**Discussion:**

**Recommendation:**

**Citation:** 6100.55. Reserved capacity

**Discussion:**

**Recommendation:**



**Citation:** 6100.81. HCBS provider requirements

**Discussion:** The regulation wording under provider requirements should more accurately match *the actual* requirement for provider enrollment (for example – a license from the Dept. of Health” is mentioned in 6100.81 (c) – but is NOT in fact required for most facilities. This is VERY important, because provider enrollment has historically been extremely slow and is often held up because providers miss one or two documents – that were NOT listed correctly / clearly in the published directions. This then caused LONG delays for providers and worse – for individuals waiting to receive services.

**Recommendation:** Include wording that matches the actual provider requirements:

*A provider enrollment application, on a form specified by the Department.*

*A medical assistance provider agreement, on a form specified by the Department.*

*A home and community-based waiver provider agreement, on a form specified by the Department.*

*Verification of compliance with § 6100.81(2) (relating to pre-enrollment provider qualifications).*

*Verification of compliance with § 6100.476 (related to criminal history background checks).*

*Documents required in accordance with the Patient Protection and Affordable Care Act (Pub. L. No. 111-148).*

*Verification of successful completion of the Department’s pre-enrollment provider training as specified in § 6100.142 (related to pre-enrollment training).*

*Monitoring documentation*

*Copies of current licenses, if applicable, as specified in § 6100.81(2) (relating to provider qualifications).*

*Verification of compliance with § 6100.46 (related to criminal history background checks).*

*Prior to applying for participation in the HCBS program, the applicant shall complete the Department’s pre-enrollment provider training.*

**Additionally:** 6100.81 (c) 1 & 2 seem to contradictory or confusing. Please clarify.

**Citation:** 6100.82. HCBS documentation

**Discussion:**

**Recommendation:**

**Citation:** 6100.83. Submission of HCBS qualification documentation

**Discussion:**

**Recommendation:**

**Citation: 6100.84. Provision, update and verification of information**

**Discussion:**

**Recommendation:**

**Citation: 6100.85. Ongoing HCBS provider qualifications**

**Discussion:**

**Recommendation:**

**Citation: 6100.86. Delivery of HCBS**

**Discussion:**

**Recommendation:**

**Citation: 6100.141. Annual training plan**

**Discussion:**

**Because of the unique needs of the many individuals served by providers – not ALL positions will require the same courses (6100.141 d(2), Some DSPs need a lot of training on aging issues, others on medical issues, and other on behavioral health issues – to name a few. there needs to be some flexibility. This requirement seems to be asking that every staff member has an annual training plan – that must – at a minimum cover certain topics.**

**Recommendation: Re; 6100.141(c) Please list the core competencies so that system wide expectations are clear.**

**Citation: 6100.142. Orientation program**

**Discussion: When a provider hires a consultant, it is usually because the consultant possesses some professional expertise that the provider does not have. Adding a training / orientation requirement for consultants will add hours and cost to consulting agreement. Additionally, the topics identified (abuse, rights, incident reporting and job related skills) are often (though not always) way outside of a consultant's responsibility. The provider is still ultimately left with the responsibility of reporting, addressing and following up on all such matters.**

**Recommendation: Consultants should not be required to receive such detailed orientation because 1. They are competent professionals 2) there is too much time and cost involved – and sometimes individuals and agencies need help quickly and 3) Consultants who are used by more than one agency – by this definition would need to be “orientated” by every agency they work for.**

**Recommend *the Department* develop and administer a training for consultants so that providers are not re-inventing the wheel – all mandated topics are statewide. This would mean NO COST to the providers.**

**Recommend that for all non-DSP / program staff – orientation and training focus on “Everyday Lives” – a code of ethics, and the “big picture” rather than on specific policies and procedures which they most likely will never have to act on.**

**Citation: 6100.143. Annual training**

**Discussion: As written, the regulations are confusing. It would make more sense to address orientation first, and then move on the annual training plan and annual training. It is “splitting hairs” to make these separate – since there is so much overlap.**

**Specifying that 8 of 12 hours must be on certain, listed topics is unnecessary, because the items that MUST be covered will take at LEAST 12 hours if done correctly.**

**Additionally, while the topics listed in the waiver are important and necessary – and presumably the rates will be built to meet the 12 & 24 hour requirement, providers are still required to cover many training topics that are not listed such as: medication administration (16 -24 hours alone!), fraud waste and abuse prevention, compliance issues, handling grievances and complaints, proper documentation of service**

delivery, safe vehicle use, safeguarding client resources, quality management, professionalism, interacting with family members, ODP monitoring requirements, emergency medical treatment, fire safety, first aid, CPR and more.

The Department must understand that providers are required – whether mandated by regulation – or by best practice – or by agency requirement, to provider extensive training that goes way beyond 24 hours of narrowly focused requirement. And must set rates accordingly. Compliance with bare minimum standards will not ensure system wide quality.

**Recommendation:** AWC and OHCDs should be removed from the regulations and that Transportation Trip and Unlicensed home and community based providers be excluded from 6100.143 as written. This list of training is geared strictly towards licensed providers and impedes the promotion of family support models of service delivery. A prescribed number of hours for training will not support appropriate training specific for the individual and does not afford the opportunity for families/participants and the unlicensed providers and Transportation trip providers that support them with the type and frequency of training that is needed for the individual. When there are established mandates to hours versus individuality, the quality is a lost and the opportunity to supporting the values of ODP and everyday lives is lost. The current unit rates will not support the increase in training requirements. Optimally, AWC and OHCDs providers will be removed from 6100 regulations and unlicensed providers and transportation trip providers should have separate training requirements that do not include a specific number of hours. See comment under 6100.141.

**Citation:** 6100.144. Natural supports

**Discussion:**

**Recommendation:**

**Citation:** 6100.181. Exercise of rights

**Discussion:** The language in 6100.181 (b) – is very vague: “shall be continually supported to exercise” his or her rights.

**Recommendation:** Please specify exactly what is meant by “continually supported to exercise” rights. Explain how that is done, how it is documented, how it is proven or measured.

**Citation:** 6100.182. Rights of the individual

**Discussion:** Re: 6100.182 (b) If individuals have the right to speak freely, then they should also have the right to be free from allegations of and investigations of verbal abuse every time they say something that offensive to another individual.

**Recommendation:** If this right is left as written, recommend adding that the individual will be held accountable for “speaking freely” if another individual, a staff person, a behavior specialist, or a consultant, feels that the speech is abusive or allegedly abusive.

Same recommendation for (e) – If a person makes a choice and “accepts” risks, then they should be free from accusations based on another individual’s interpretation of that behavior. Currently - as related to incident management – providers are being required to enter incidents based on the values and perceptions of staff and other “outside” individuals and NOT on the individuals’ words and actions or on the perceptions / understanding of the individual.

Recommend adding individuals have a right to be educated about the consequences for violating another’s rights (perhaps addressed in 6100.183)

**Citation:** 6100.183. Additional rights of the individual in a residential facility

**Discussion:** It needs to be made clear that individuals have the right NOT to exercise all of their rights (ie: they have a right not to have a lock on their door if they so choose) In an everyday life – we all have the right to vote – but many choose not to. Additionally – many individuals have limited financial management abilities. A “right” to unrestricted access to telecommunications – could be interpreted as a right to a data / coverage plan that one cannot afford.

In addition, the “right to manage” (d) conflicts with the role of the designated Social Security Rep payee,

*“A representative payee is a person or an organization. We appoint a payee to receive the Social Security or SSI benefits for anyone who can’t manage or direct the management of his or her benefits. A payee’s main duties are to use the benefits to pay for the current and future*

*needs of the beneficiary, and properly save any benefits not needed to meet current needs. A payee must also keep records of expenses. When we request a report, a payee must provide an accounting to us of how he or she used or saved the benefits.”*

<https://www.ssa.gov/payee/faqrep.htm>

**Recommendation: Make clear that individuals rights can not conflict with regulation, with others' rights, or with documented health and safety information in the ISP. (ie: access to food at any time is clearly contraindicated for a person with Prader Willi)**

**Review the 6100 regulations to ensure there are no conflicts/contradictions with other government entities regulations. Restate 6100-183 (d) to include something like “...has the right to manage, to the extent possible...”**

**Citation: 6100.184. Negotiation of choices**

**Discussion: The title here is mis-leading. The regulation is NOT referring to individuals' choices but rather to individuals' rights. Ie: the rights of one can not trump the rights of another.**

**In group home / living situations – negotiation of choice is not an isolated “event” or a single conversation...but rather an ongoing dialogue and constant revision and compromise. Choice negotiation is extremely subjective – and based on many many variables. No one procedure can be expected to resolve differences to everyone's satisfaction.**

**Recommendation: Since “rights” should be non-negotiable – the wording should reflect more accurately that which is intended by this regulation:**

**Suggest: Responsible exercising of rights**

**Citation: 6100.185. Informing of rights**

**Discussion:**

**Recommendation:**

**Citation: 6100.186. Role of family and friends**

**Discussion:** Family and friends are by definition “natural supports.” It is unreasonable to “regulate” that role. There is way too much variance in family roles / dynamics to mandate a provider role in “facilitating” and making “accommodations necessary.”

If all activity here is under the direction of the individual, then the provider has a very limited role to play – and again that role should NOT be regulated.

**Recommendation:** delete this section.

**Citation:** 6100.221. Development of the PSP

**Discussion:** An ISP is by definition a Person Centered Support Plan. The “plan” has undergone several title changes over the past 20 years, but the content remains virtually the same. Changing the language for the sake of a few updated / nuanced additions is un called for. Additionally it will required tremendous time and cost statewide at all levels.

**Recommendation:** Continue to call the plan an ISP. Update content as desired.

Define what the “service implementation plan” is. (ie: is this a separate “plan” from the ISP?)

Re: 6100.221 (e) – this should include “person designated by the individual”

Re: 6100.221 (f) – please define what constitutes a “current assessment”

**Citation:** 6100.222. The PSP process

**Discussion:** Please define how the individual “directs” the PSP process. Ie: What are they expected to do? How will they know what the PSP process is? What if they are not capable for directing the PSP process or they do not want to “direct” the process?

**Recommendation: Rewording is needed:**

**6100.222 (b) (1) ....A PSP process does not invite and include individuals....An individual must identify and include individuals. Please describe exactly WHO is doing (b) 1-11.**

**Citation: 6100.223. Content of the PSP**

**Discussion: More information is needed:**

**Recommendation: include information on behavioral supports needed.**

**Re: (14) – consider adding this to 6100.184 – re: negotiation of rights / balanced w/ risk. Or refer to THIS reg under .184.**

**Citation: 6100.224. Implementation of the PSP**

**Discussion:**

**Recommendation:**

**Citation: 6100.225. Support coordination and TSM**

**Discussion:**

**Recommendation: Change the word “assure” to “ensure”**

**Citation: 6100.226. Documentation of support delivery**

**Discussion: (b) as mentioned previously is confusing, what is implementation of the PSP vs service implementation plan?**



**Recommendation:** ODP should develop a statewide mandated form for use by all providers. This will greatly reduce “violations” due to variance among providers.

**Citation:** 6100.261. Access to the community

**Discussion:** Somewhere in this regulation – the department needs to make it clear that – as in all everyday lives – individuals have to plan community outings “according to their means” (ie: they may want / desire / chose to have season tickets to the Pirates, but they can only afford to go to 3 games per year. Additionally, ODP must be willing to pay for the staff portion of “access to the community” because of the required role in facilitating it....and keeping people safe.

**Recommendation:**

**Citation:** 6100.262. Employment

**Discussion:** Many of our individuals are living good long lives. Providers have been saying for years that folks should have the right to retire. There is no mention of people at or near retirement age.

**Recommendation:** Add a provision for retirement – which is a valid component of an “ Everyday life”

**Citation:** 6100.263. Education

**Discussion:** Higher education is very expensive.

**Recommendation:** Please describe where the funding comes from for (1-4)

**Citation:** 6100.301. Individual choice

**Discussion:**

**Recommendation:**

**Citation: 6100.302. Transition to a new provider**

**Discussion:**

**Recommendation:**

**Citation: 6100.303. Reasons for a transfer or a change in a provider**

**Discussion: Discussion 6100.303:**

This section is defined too narrowly to be practicable to the point that it contradicts other portions of the chapter and are unable to execute the residency agreement. There are many circumstances such as program closure, safety of others, Megan’s Law, eminent domain, court or other legal actions, eviction by a landlord of the provider, natural disasters, provider closure which may require transfer or change in spite of individuals’ wishes. This list is not exhaustive – they regulation needs to allow for unforeseen occurrences.

What if exercising rights impinge on others, is that grounds for transfer? What if rights place the individual or others at risk? 6100.184(a) states, “An individual’s rights shall be exercised so that another individual’s rights are not violated.”

**Recommendation: Change (a) to read: A change in provider, against the individual’s wishes will be made only in for serious reasons including:.....**

**Citation: 6100.304. Written notice**

**Discussion: There are 3 main parties involved in notice of a provider no longer being “willing or able” to provide a service: The SC, the individual / family, and the provider.” There are many PSP team members who do not need to be informed of a change in one provider of one service. The Department and the AE will find out about the change when a critical revision or update is made. Since they have NO role in the decision about he change – they do not need notice of it.**

**Recommendation:**

**Citation: 6100.305. Continuation of support**

**Discussion:** There is a fundamental lack of understanding on ODPs part as to why it is sometimes impossible for a provider to continue providing services. The workforce is simply 1) not large enough (too many vacancies) or 2) qualified enough. When individuals have complicated medical or behavioral healthcare needs - a provider cannot simply pull staff out of thin air. Nor can a provider force staff to stay in a situation that they feel unsafe in or unqualified for. Even with additional funding – the enormous amount of pre-service training that is required makes replacing staff a very long process.

**Recommendation:**

**Citation: 6100.306. Transition planning**

**Discussion:**

**Recommendation:**

**Citation: 6100.307. Transfer of records**

**Discussion:**

**Recommendation:**

**Citation: 6100.341. Use of a positive intervention**

**Discussion:**

**Recommendation:**

**Citation: 6100.342. PSP**

**Discussion:** Title “PSP’ here will be confusing when also referenced in 6100.221 This section is only about a very narrow piece of the PSP namely “dangerous behavior”

**Recommendation:** move this section to the PSP section

**Strongly recommend finding a different term than “dangerous behavior” – which sounds predatory and has a tone that harkens back to the days of institutionalization ....and society’s fears of people with IDD as “dangerous”**

**Consider: Risky behavior or potentially harmful behavior.**

**Citation:** 6100.343. Prohibition of restraints

**Discussion:** Title can be misleading to appear that no restraints are allowed, ever

**Recommendation:** Change title to “Prohibition of certain types of restraints.”

**Citation:** 6100.344. Permitted interventions

**Discussion:**

**Recommendation:**

**Citation:** 6100.345. Access to or the use of an individual’s personal property

**Discussion:**

**Recommendation:**

**Citation:** 6100.401. Types of incidents and timelines for reporting

**Discussion:** Med errors should not need to be reported w/in 24 hours, but rather 72 hours as listed in

**Recommendation: re: individual to individual incidents: Require incidents to reported not just on the victim but on the “target” – There are many individuals who are the initiators of incidents – yet their behavior and support and corrective action plans and ongoing need for therapy – is NEVER captured or recorded.**

**Citation: 6100.402. Incident investigation**

**Discussion: The Department already has a mandated training for certified investigators – and they are trained on who to ask and what to consider. The entire process is comprehensive and thorough. There is no need for an additional “type” of investigation – ie: with a small “i”. However – all incidents are indeed analyzed – both on an individual basis and quarterly – in relation to all other incidents.**

**Recommendation: Move 6100.405 to 6100.403 – do not use the word “investigating” in any other way than when intended as “Certified Investigation”....this is more practical and useful to providers.**

**Citation: 6100.403. Individual needs**

**Discussion:**

**Recommendation:**

**Citation: 6100.404. Final incident report**

**Discussion:**

**Recommendation:**

**Citation: 6100.405. Incident analysis**

**Discussion:**

**Recommendation:**

**Citation: 6100.441. Request for and approval of changes**

**Discussion:** There are many situations within which individuals would benefit from rapid placement. These situations include natural disasters, program closures, and removal from abuse. It is important that this chapter allow the department to develop an expedited capacity change process to accommodate individual's needs in their everyday lives.

**Recommendation:**

**Citation: 6100.442. Physical accessibility**

**Discussion:** This item can create remarkable costs. The department needs to develop capacity to compensate providers for these costs in their rate-setting process.

**Recommendation:**

**Citation: 6100.443. Access to the bedroom and the home**

**Discussion:** This proposed regulation, while presumably aimed at ensuring privacy, does NOT align in any way with an everyday life. Most citizens do not live in a house where they need a key to access their own bedroom. Additionally – in meeting individuals every day needs, staff may need to enter bedrooms many times per shift for many many non-emergency or non “life safety” reasons: helping to get dressed, assisting with bed making, collecting laundry or putting away clean clothes, helping to fix someone’s hair, assisting with bed time routines or personal hygiene. Staff are always expected to treat the entering of individuals’ rooms with respect – to ensure dignity and privacy – but to prohibit entry without “express permission” for each incidence of access – demonstrates a serious lack of understanding of the amount of personal assistance our staff are providing on a daily – hourly basis. Further, documenting or proving that “Required express permission of each incidence of access” was granted or denied will be impossible....and if not impossible – it makes a homelike environment seem very much like an institution. Staff who enter bedrooms on a regular basis are not strangers to the individuals. They are kind, caring and dedicated Direct Support Professionals who spend their hours, days, weeks and years building relationships with the individuals they support in a dignified manner.

**Recommendation:** If an individual desires, chooses or requests that a lock be put on their bedroom door, then a provider will ensure that it happens.

**Re: (e)** Please specify who decides who is “authorized” – by name? by title? By position? **Recommend language:** The rights of the individual to privacy in his/her bedroom should be respected in accordance with sections 6100.181-183, with consideration for the needs of the health, safety, and welfare of the individual as determined in the PSP, or as needed in an unforeseen or emergency circumstance.

**Recommend – addressing individual complaints or accusations of violation of privacy – as needed.**

**Recommend working to reflect language from the Community Rule:** Each individual has privacy in their individual sleeping or living unit: Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.

**Citation:** 6100.444. Lease or ownership

**Discussion:** It is necessary under the Community Rule that individuals have a legally enforceable document that offers the same responsibilities and protections from eviction as our prevailing law. To that point, 6100.444(a) is clear and direct. 6100.444(b) while describing reasonable limits, inadvertently refers to providers as “landlords” and to individuals as “tenants” and their units as “leased space”. The rights conferred under the rule and as cited in 6100.444(a) do not make providers landlords. Having the same protections as provided by law does not make individuals tenants nor their spaces “leased”. This language distinction is important in that we need to preserve the American Disability Act’s protection of community residences as homes rather than businesses which can be excluded from residentially zoned areas. This distinction will also be crucial if/when the state develops guiding language or uniform formatting for the residency or room and board agreements in the future.

**Additionally – it has already been made clear in regulation 6100.303 regarding the conditions that are grounds for transferring (ie: discharging) an individual.**

**Recommendation:** Remove reference to the Landlord and Tenant Act of 1951. It is not nuanced enough for the actual purpose of an enforceable agreement between a provider and an individual with IDD.

**Citation:** 6100.445. Integration

**Discussion:**

**Recommendation:**

**Citation:** 6100.446. Facility characteristics relating to size of facility

**Discussion:** It is not clear whether or not this new regulation is legal or not. The use of a maximum number seems – by the Department’s own admission – completely arbitrary, and should therefore be omitted. Capping a number of participants working or living near one another seems contrary to ADA and Everyday Lives. The Community Rule does not specify an absolute cap on program size and so neither should Pennsylvania.

**Recommendation:** Do not place an arbitrary maximum number of participants into the regs.

**Citation:** 6100.447. Facility characteristics relating to location of facility

**Discussion:** 6100.447 (a) 1 & 2 & 5 are redundant

It seems that someone with compromised health, or aging needs, or a chronic behavioral or physical healthcare need –could benefit from living in “close proximity” to a hospital. No need to disallow it. Lots of people *without* disabilities live in close proximity to hospitals and nursing facilities – people with IDD should be “allowed” to too. Otherwise – expressly define “close proximity” as it is extremely vague – and could mean one thing in an urban area and another thing in a rural area.

The system has been moving away from institutionalization and segregated living for decades. As more and more programs and services open up IN the COMMUNITY – there will be closer proximity to one another. It seems that this regulation is trying to fix something that is NOT broken. Unless the Department can provide evidence that people are being served in super-congregate settings, or show some evidence based research / data that shows the trend is heading that way, then COMMUNITY providers should have more flexibility in where they develop COMMUNITY based services.

Additionally – regarding the waiver renewal and the addition of people with Autism, the Department should be aware of a movement TOWARDS congregate living – in an effort to foster acceptance and share resources (see <http://www.ahdcp.org/>)

The regs should be careful not to single out people with IDD as SO DIFFERENT than everyone else – that this set of regs could never apply to another population.....especially while purporting to reflect the values of Everyday Lives.



**Recommendation: Consider how discriminatory and limiting this regulation is.**

**Citation: 6100.461. Self-administration**

**Discussion:**

**Recommendation:**

**Citation: 6100.462. Medication administration**

**Discussion: Discussion: Medication Administration**

There are two extremely important issues concerning the proposed new regulations pertaining to medication administration. These need to be addressed to prevent unintended negative consequences.

1. Codifying content that requires modifications over time into regulations will lock a crucial component of service provision into temporal practices which will become obsolete as new information, prevailing practices and technology emerge. Duplicating content which is as detail-specific as the proposed five-and-a-half pages of regulation across 5 sets of regulations when the state already has an externally -accepted training module invites discrepancy between the regulations and the training manual and prohibits the training module from staying current as new information, prevailing practices and technology emerge.

2. Requiring 6500 LifeSharing providers to complete and adhere to ODP's Medication Administration Module is a new and counterproductive requirement which is in direct contract to Everyday Lives principals and the Department's stated intent to develop more integrated and natural life opportunities for individuals.

As a ready example of the problem with codifying material which requires change over time, an area has been identified in which the proposed regulations are at odds with prevailing practices as detailed by Title 49 of the State Nursing Board. 49 PA. CODE CH. 21 explicitly provides for Licensed Practical Nurses to accept oral orders for administering medication. The proposed 6100.465 provision only allows this practice for Registered Nurses.

This discrepancy is instructive both to the specific issue regarding LPN's and to the process issue of codifying Nursing Practices content which changes from time to time according to authorities outside of the Department. It is noted that the provider system needs LPN's to be able to do all that state law provides for them to do. In the second case, we need regulations which do not lock providers to standards which may soon become obsolete due to new and emerging best practices and advances. A second example of the problem with trying to maintain this content in multiple places is that there are already discrepancies between the proposed 6100's and the

**Department's Approved Medication Administration Training. The training's required checklist for medication self-administration has discrepancies with the proposed regulation. There is also a notable practice discrepancy regarding pre-pouring of medications. We should avoid such confusion by maintaining this content in just one place, namely the Medication Administration Training module and not regulations.**

**Recommendation: Keep the current medication policies and procedures in place.**

**Do NOT cover 6500s in this regulation.**

**Citation: 6100.463. Storage and disposal of medications**

**Discussion: If it isn't broken, don't fix it. It is unclear why there are so many changes recommended under the medication section. It is also unclear as to how these changes will, if at all, improve or enhance quality.**

**Recommendation: Keep the current medication policies and procedures in place.**

**Citation: 6100.464. Labeling of medications**

**Discussion: If it isn't broken, don't fix it. It is unclear why there are so many changes recommended under the medication section. It is also unclear as to how these changes will, if at all, improve or enhance quality.**

**Recommendation: Keep the current medication policies and procedures in place.**

**Citation: 6100.465. Prescription medications**

**Discussion: If it isn't broken, don't fix it. It is unclear why there are so many changes recommended under the medication section. It is also unclear as to how these changes will, if at all, improve or enhance quality.**

**Recommendation: Keep the current medication policies and procedures in place.**

**Citation: 6100.466. Medication records**

**Discussion: If it isn't broken, don't fix it. It is unclear why there are so many changes recommended under the medication section. It is also unclear as to how these changes will, if at all, improve or enhance quality.**

**Recommendation: Keep the current medication policies and procedures in place.**

**Citation: 6100.467. Medical errors**

**Discussion: If it isn't broken, don't fix it. It is unclear why there are so many changes recommended under the medication section. It is also unclear as to how these changes will, if at all, improve or enhance quality.**

**Recommendation: Keep the current medication policies and procedures in place.**

**Citation: 6100.468. Adverse reaction**

**Discussion: If it isn't broken, don't fix it. It is unclear why there are so many changes recommended under the medication section. It is also unclear as to how these changes will, if at all, improve or enhance quality.**

**Recommendation: Keep the current medication policies and procedures in place.**

**Citation: 6100.469. Medication administration training**

**Discussion: If it isn't broken, don't fix it. It is unclear why there are so many changes recommended under the medication section. It is also unclear as to how these changes will, if at all, improve or enhance quality.**

**Recommendation: Keep the current medication policies and procedures in place.**

**Citation: 6100.470. Exception for family members**

**Discussion: Family members should however, be expected to administer medications in the proper way (correct dose, route, time/s, etc. ) failure to do so sometimes both compromises the individuals' health and also puts the provider – which knowledge of such mistakes (or intentional decision to not follow doctor's orders)...at risk. Elderly parents often forget...or sometimes have different ideas of what their child / relative actually needs. Or might believe in cutting the pills in half to make them last longer (like they do for themselves). Or they have been given "discretion" by the doctor to "up" or "down" the dose according to observations...etc. Discretion that our staff do not have. This is a difficult situation for providers. Some clarification would be helpful here.**

**Recommendation:**



# Emmaus Community of Pittsburgh

*A Community that Serves Persons with Intellectual Disabilities and Autism and Promotes Public Awareness of Their Needs*

December 20, 2016

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Karen D. Jacobsen  
*Executive Director*

Ms. Julie Mochon

Human Service Program Specialist Supervisor

Office of Developmental Programs

Room 502, health and Welfare Building

625 Forster Street

Harrisburg PA 17120

Dear Ms. Mochon:

Thank you for the opportunity to submit comments on the proposed Chapter 6100 regulations, "Support For Individuals With an Intellectual Disability or Autism." I have been working in the field for more than 20 years, and I am happy to participate in this process.

The Emmaus Community of Pittsburgh is dedicated to providing high quality services to people with Intellectual Disability and Autism, and we look forward to helping the Office of Developmental Programs live out the mission of providing individuals with "Everyday Lives."

Sincerely,

Dianna Prystash

Director of Client Financial Services

2821 Sarah Street  
Pittsburgh, PA 15203  
Phone: 412-381-0277  
Fax: 412-431-8653

[www.EmmausPgh.org](http://www.EmmausPgh.org)



## Kroh, Karen

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**From:** Mochon, Julie  
**Sent:** Wednesday, December 21, 2016 8:44 AM  
**To:** Kroh, Karen  
**Subject:** FW: 2380 comments  
**Attachments:** Comments on Chapter 2380 12-20-16.pdf

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**From:** Joseph Birli [<mailto:jbirli@friendshipcommunity.net>]  
**Sent:** Tuesday, December 20, 2016 4:24 PM  
**To:** Mochon, Julie  
**Cc:** Gwen Schuit  
**Subject:** 2380 comments

Greetings Julie,

Attached you will find comments about the 2380 proposed regulations.

*Joseph Birli, Ed.D., LPC, MCC*  
Director of Operations

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# Impacting the World with Capabilities

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December 20, 2016

Julie Mochon  
Human Service Program Specialist Supervisor  
Office of Developmental Programs  
Room 502, Health and Welfare Building  
625 Forster Street  
Harrisburg, PA 17120

## Re: Friendship Community's (FC's) Comments on Chapter 2380

### KEY for reviewing FC Comments on Chapter 2380:

Strikethrough = text suggested to be deleted. (Text that the Department proposes to delete has also been stricken for consistency and ease of reading).

Blue text = text suggested to be added.

## CHAPTER 2380. ADULT TRAINING FACILITIES

### GENERAL PROVISIONS

#### § 2380.3. Definitions.

##### **Comment and Suggestion 2380.3.**

See comment and suggestion under Chapter 6100.3. Comment is identical unless otherwise noted. All modifications, deletions, and additions of definitions should match those in Chapter 6100.

In the definition for *adult training facility*, what is the Department's rationale for excluding persons who are 60 years of age or older?

"Provider" should replace use of the term "facility" where applicable.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

Adult—A person 18 years of age or older.

Adult training facility or facility—A building or portion of a building in which services are provided to four or more individuals, ~~who are 59 years of age or younger and~~ who do not have a dementia-related disease as a primary diagnosis, for part of a 24-hour day, excluding care provided by relatives. Services include the provision of functional activities, assistance in meeting personal needs and assistance in performing basic daily activities.

~~[Content discrepancy—A difference between what was determined at the ISP meeting by the plan team and what is documented in the written ISP.]~~

~~[Documentation—Written statements that accurately record details, substantiate a claim or provide evidence of an event.]~~

Fire safety expert—A local fire department, fire protection engineer, State certified fire protection instructor, college instructor in fire science, county or State fire school, volunteer fire person trained by a county or State fire school or an insurance company loss control representative.

~~[ISP—Individual Support Plan—The comprehensive document that identifies services and expected outcomes for an individual.]~~

~~—Individual—An adult with disabilities who receives care in an adult training facility and who has developmental needs that require assistance to meet personal needs and to perform basic daily activities. Examples of adults with disabilities include adults who exhibit one or more of the following:~~

~~—(i) A physical disability such as blindness, visual impairment, deafness, hearing impairment, speech or language impairment, or a physical handicap.~~

~~—(ii) A mental illness.~~

~~—(iii) A neurological disability such as cerebral palsy, autism or epilepsy.~~

~~—(iv) An intellectual disability.~~

~~—(v) A traumatic brain injury.~~

~~[Outcomes—Goals the individual and individual's plan team choose for the individual to acquire, maintain or improve.~~

~~—Plan lead—The program specialist or family living specialist, as applicable, when the individual is not receiving services through an SCO.~~

~~—Plan team—The group that develops the ISP.]~~

## GENERAL REQUIREMENTS

§ 2380.17. – 2380.19. Incident Management.

<p><b>Comment and Suggestion for 2380.17 – 2380.19 Incident Management:</b> See Comment and Suggestion under Chapter 6100 Incident Management; 6100.401 – 6100.405. Comment is identical unless noted otherwise.</p>
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§ 2380.21. ~~[Civil]~~ Individual rights.

**Comment and Suggestion 2380.21.**

See Comment and Suggestion under Chapter 6100 Individual Rights (6100.181 – 6100.185).  
Comment is identical unless noted otherwise.

**§ 2380.26. Applicable laws and regulations.**

The facility provider shall comply with applicable Federal, State and local laws, regulations and ordinances.

**STAFFING**

**§ 2380.33. Program specialist.**

**Comment and Suggestion 2380.33.**

Text is suggested for purpose of clarity.

(a) At least ~~[one]~~ 1 program specialist shall be assigned for every 30 individuals, regardless of whether they meet the definition of individual in § 2380.3 (relating to definitions).

(b) The program specialist shall be responsible for the following:

- ~~[(1) Coordinating and completing assessments.~~
- ~~—(2) Providing the assessment as required under § 2380.181(f) (relating to assessment).~~
- ~~—(3) Participating in the development of the ISP, including annual updates and revisions of the ISP.~~
- ~~—(4) Attending the ISP meetings.~~
- ~~—(5) Fulfilling the role of plan lead, as applicable, under §§ 2380.182 and 2380.186(f) and (g) (relating to development, annual update and revision of the ISP; and ISP review and revision).~~
- ~~—(6) Reviewing the ISP, annual updates and revisions under § 2380.186 for content accuracy.~~
- ~~—(7) Reporting content discrepancy to the SC or plan lead, as applicable, and plan team members.~~
- ~~—(8) Implementing the ISP as written.~~
- ~~—(9) Supervising, monitoring and evaluating services provided to the individual.~~
- ~~—(10) Reviewing, signing and dating the monthly documentation of an individual's participation and progress toward outcomes.~~

~~—(11) Reporting a change related to the individual's needs to the SC or plan lead, as applicable, and plan team members.~~

~~—(12) Reviewing the ISP with the individual as required under § 2380.186.~~

~~—(13) Documenting the review of the ISP as required under § 2380.186.~~

~~—(14) Providing the documentation of the ISP review to the SC or plan lead, as applicable, and plan team members as required under § 2380.186(d).~~

~~—(15) Informing plan team members of the option to decline the ISP Review documentation as required under § 2380.186(e).~~

~~—(16) Recommending a revision to a service or outcome in the ISP as provided under § 2380.186(e)(4).~~

~~—(17) Coordinating the services provided to an individual.~~

~~—(18) Coordinating the training of direct service workers in the content of health and safety needs relevant to each individual.~~

~~—(19) Developing and implementing provider services as required under § 2380.188 (relating to provider services).]~~

(1) Coordinating the completion of assessments.

(2) Participating in the PSP process, PSP development, PSP team reviews and the implementation of the PSP in accordance with this chapter.

(3) ~~Providing and supervising~~Coordinating and facilitating activities for the individuals in accordance with the PSPs.

(4) Supporting the integration of individuals in the community.

(5) Supporting individual communication and ~~involvement~~relationships with families and friends.

(c) A program specialist shall have one of the following groups of qualifications:

(1) A master's degree or above from an accredited college or university and 1 year of work experience working directly with persons with disabilities.

(2) A bachelor's degree from an accredited college or university and 2 years of work experience working directly with persons with disabilities.

(3) An associate's degree or 60 credit hours from an accredited college or university and 4 years of work experience working directly with persons with disabilities.

(4) A minimum of 8 years of direct work experience with individuals who have an intellectual disability or autism and has supervisory experience.

**§ 2380.35. Staffing.**

(a) A minimum of one direct ~~service workers~~ support professional for every six individuals shall be physically present with the individuals at all times individuals are present at the facility, except while staff persons are attending meetings or training at the facility.

(b) While staff persons are attending meetings or training at the facility, a minimum of one staff person for every ten individuals shall be physically present with the individuals at all times individuals are present at the facility.

(c) A minimum of two staff persons shall be present with the individuals at all times.

(d) An individual may be left unsupervised for specified periods of time if the absence of direct supervision is consistent with the individual's assessment and is part of the individual's [ISP] PSP, as an outcome which requires the achievement of a higher level of independence.

(e) The staff qualifications and staff ratio as specified in the [ISP] PSP shall be implemented as written, including when the staff ratio is greater than required under subsections (a), (b) and (c).

(f) An individual may not be left unsupervised solely for the convenience of the facility provider or the ~~direct service~~ direct support worker.

**§ 2380.36. [Staff] Emergency training.**

~~a) The facility shall provide orientation for staff persons relevant to their responsibilities, the daily operation of the facility and policies and procedures of the facility before working with individuals or in their appointed positions.~~

~~—(b) The chief executive officer shall have at least 24 hours of training relevant to human services or administration annually.~~

~~—(c) Program specialists and direct service workers who are employed for more than 40 hours per month shall have at least 24 hours of training relevant to human services annually.~~

~~—(d) Program specialists and direct service workers shall have training in the areas of services for people with disabilities and program planning and implementation, within 30 calendar days after the day of initial employment or within 12 months prior to initial employment.~~

~~—(e)]~~ (a) Program specialists and ~~direct service~~ direct support workers shall be trained before working with individuals in general firesafety, evacuation procedures, responsibilities during fire drills, the

designated meeting place outside the building or within the fire safe area in the event of an actual fire, smoking safety procedures if individuals or staff persons smoke at the facility, the use of fire extinguishers, smoke detectors and fire alarms, and notification of the local fire department as soon as possible after a fire is discovered.

~~[(f)]~~ (b) Program specialists and ~~direct-serviced~~ direct support workers shall be trained annually by a firesafety expert in the training areas specified in subsection ~~[(f)]~~ (a).

~~[(g)]~~ (c) There shall be at least ~~[one]~~ 1 staff person for every 18 individuals, with a minimum of ~~[two]~~ 2 staff persons present at the facility at all times who have been trained by an individual certified as a trainer by a hospital or other recognized health care organization, in first aid, Heimlich techniques and cardio-pulmonary resuscitation within the past year. If a staff person has formal certification from a hospital or other recognized health care organization that is valid for more than 1 year, the training is acceptable for the length of time on the certification.

~~[(h) Records of orientation and training, including the training source, content, dates, length of training, copies of certificates received and staff persons attending, shall be kept.]~~

(Editor's Note: Sections 2380.37—2380.39 are new and printed in regular type to enhance readability.)

#### § 2380.37. - 2380.39. Training.

**Comment and Suggestion 2380.37 – 2380.39 Training.**

See Comment and Suggestion under Chapter 6100 TRAINING (6100.141 – 6100.143).

Comment is identical unless noted otherwise.

2380.40 is suggested to be added, as noted below, consistent with Chapter 6100.

#### § 2380.40. Natural supports.

Sections 2380.37—2380.39 (relating to annual training plan; orientation program; and annual training) do not apply to natural supports.

#### § 2380.121. – 2380.129. Medications

### MEDICATIONS

**Comment and Suggestion § 2380.121. - 2380.129. Medications**

See Comment and Suggestion under Chapter 6100 MEDICATION ADMINISTRATION (6100.461 – 6100.469). Comment is identical unless noted otherwise.

#### § 2380.151. – 2380.155. Positive Intervention

### ~~[RESTRICTIVE PROCEDURES]~~ POSITIVE INTERVENTION

**Comment and Suggestion § 2380.151. - § 2380.155. Positive Intervention:**

See Comment and Suggestion under Chapter 6100 POSITIVE INTERVENTION (6100.341 – 6100.345). Comment is identical unless noted otherwise.

§ 2380.156. ~~[Staff training.]~~ Rights team.

**Comment and Suggestion 2380.156.**

See Comment and Suggestion under Chapter 6100 Rights Team. (6100.52.). Comment is identical unless noted otherwise.

§§ 2380.157—2380.165. (Reserved).

## RECORDS

§ 2380.173. Content of records.

Each individual's record must include the following information:

(1) Personal information including:

(i) The name, sex, admission date, birthdate and ~~[social security]~~ Social Security number.

(ii) The race, height, weight, color of hair, color of eyes and identifying marks.

(iii) The language or means of communication spoken or understood by the individual and the primary language used in the individual's natural home, if other than English.

(iv) Religious affiliation.

(v) A current, dated photograph.

(2) ~~[Unusual incident]~~ Incident reports related to the individual.

(3) Physical examinations.

(4) Assessments as required under § 2380.181 (relating to assessment).

~~[(5) A copy of the invitation to:~~

~~(i) The initial ISP meeting.~~

~~(ii) The annual update meeting.~~

~~(iii) The ISP revision meeting.~~

~~(6) A copy of the signature sheet for:~~

- ~~—(i) The initial ISP meeting.~~
- ~~—(ii) The annual update meeting.~~
- ~~—(iii) The ISP revision meeting.~~
- ~~—(7) A copy of the current ISP.~~
- ~~—(8) Documentation of ISP reviews and revisions under § 2380.186 (relating to ISP review and revision), including the following:~~
  - ~~—(i) ISP review signature sheets.~~
  - ~~—(ii) Recommendations to revise the ISP.~~
  - ~~—(iii) ISP revisions.~~
  - ~~—(iv) Notices that the plan team member may decline the ISP review documentation.~~
  - ~~—(v) Requests from plan team members to not receive the ISP review documentation.~~
- ~~—(9) Content discrepancies in the ISP, the annual update or revision under § 2380.186.]~~
- (5) PSP documents as required by this chapter.
- ~~[(10) Restrictive procedure protocols and]~~ (6) Positive intervention records related to the individual.
- ~~[(14)]~~ (7) Copies of psychological evaluations, if applicable.

## PROGRAM

### § 2380.181. Assessment.

#### **Comment and Suggestion 2380.181.**

The recommended language in 2380.181 (b) is intended to distinguish between the need for a full assessment and a partial assessment.

2390.181 (f) has been amended to provide additional time to enable a program specialist to better prepare an informed assessment.

\* \* \* \* \*

(b) If the program specialist ~~is making~~ makes a recommendation to revise a service or outcome in the ~~[ISP as provided under § 2380.186(c)(4) (relating to ISP review and revision)]~~ PSP, the individual shall have an assessment specific to that recommendation completed as required under this section.



\* \* \* \* \*

(f) The program specialist shall provide the assessment to the SC ~~[or plan lead]~~, as applicable, and ~~[plan]~~ PSP team members at least 3015 calendar days prior to ~~[an ISP meeting for the development, annual update and revision of the ISP under §§ 2380.182, 2390.152, 6400.182 and 6500.152 (relating to development, annual update and revision of the ISP)]~~ a PSP meeting.

§2380.182 – 2380.186. Person-Centered Support Plan.

<p><b>Comment and Suggestion 2380.182 – 2380.186. Person-centered Support Plan.</b> See Comment and Suggestion under Chapter 6100.221 – 6100.224. Comment is identical unless noted otherwise.</p>
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§ 2380.187. ~~[Copies.]~~ (Reserved).

~~[A copy of the ISP, including the signature sheet, shall be provided to plan team members within 30 calendar days after the ISP annual update and ISP revision meetings.]~~

§ 2380.188. ~~[Provider services.]~~ (Reserved).

~~[(a) The facility shall provide services including assistance, training and support for the acquisition, maintenance or improvement of functional skills, personal needs, communication and personal adjustment.~~

~~—(b) The facility shall provide opportunities and support to the individual for participation in community life, including work opportunities.~~

~~—(c) The facility shall provide services to the individual as specified in the individual's ISP.~~

~~—(d) The facility shall provide services that are age and functionally appropriate to the individual.]~~

