Housing Aging & Older Adult Services Committee
Public Hearing on Proposed Assisted Living Regulations
September 18, 2008

Testimony presented by

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Representative Mundy and members of the House Aging and Older Adult Services Committee.
Thank you for the opportunity to address you concerning the proposed Assisted Living Regulations.

The Hickman is a licensed Personal Care Home in West Chester sponsored by the Religious Society of Friends (Quakers). We have 65 residents and have been providing personal care services to the elderly for 117 years. Over that time, The Hickman has committed to serve a low to moderate income population. Until just recently, 72% of our residents meet the Federal criteria of 60% or lower of the Area Median Income (AMI). Currently 55% of our residents meet this criteria.

In recent years two trends have challenged our ability to maintain our commitment to serve a low to moderate-income population. They are: the general cost of doing business, such as, insurances, utilities and labor cost and secondly, the cost of complying with regulations.

In over thirty hours of meetings, The Hickman's Legislative Committee, comprised of three staff members and nine residents, has studied Chapter 2800, Assisted Living Residence Regulations. We have collected the attached comments, feeling that in many cases the regulations are unduly strict or will lead to unnecessary expenditures.

Such regulations will likely put assisted living residences out of the financial reach of all but the wealthy, leaving the much larger group of low-to-medium income people unable to access them. Existing Personal Care Homes with plans to devote a floor or a wing or maybe just a set of rooms to assisted living may find implementing these regulations financially prohibitive.

It is important for you to understand, that a vital aspect of an assisted living residence is that it cares for the needs of all qualified people in a homelike, comfortable environment.

The proposed Assisted Living regulations represent another layer of oversight that will add additional cost. We understand the increased complexities associated with providing supplemental health care services and the need for more comprehensive and costly requirements. But we

would be negligent in not pointing out those regulations that, in our opinion, add to the cost without adding to the health, welfare or safety of our residents.

The requirement for 250 square foot rooms, (not including the bathroom and closet), along with the kitchen requirement is a particular concern. In our market area building cost are at $147.00 per square foot. A 250 square foot room with a 6'x 8' bathroom and a 2'x 6' closet equals 310 sq. ft. and will cost $ 45,570.00 to build. This cost will be passed on to the consumers adding to the ever-increasing cost of care. There is no doubt that many consumers will want this large or larger accommodation and will be able and willing to pay for it. But it is equally true that many consumers will not want that large a unit and will not be able or willing to pay for it. The market place will always accommodate those that can afford what ever they want.

Our concern is for those consumers who will be denied access to Assisted Living Residences because their income is too high for government subsidies but too low to afford private pay assisted living. A lower square foot requirement will allow more units to be built for the same amount of capital cost and will allow access and choice to those who either prefer or require lower cost.

The alternative is for government to subsidize the thousands of units that would be necessary to ensure access to ALR's for every Pennsylvanian in need.

Today you have heard from many fine individuals and groups each with their own concerns and points of view, what I would now like to do is ask you to consider the 1999 report titled, "Assisted Living: Long-Term Care and Services Discussion Session Findings". This report was drafted by the management consultant firm, Dostalik ET AL, under contract with the Pennsylvania Intra-Governmental Council on Long Term Care. Dostalic was commissioned to conduct a series of 12 structured discussion groups across the state. Hundreds of individuals participated, many of them elderly consumers of senior services.
In their report they stated that "Based on the consistency of messages heard, they believe this report is an accurate portrayal of what a cross-section of people across Pennsylvania think and want with regard to assisted living."

The report identified six issues around which the participants' messages were centered:

- Consumer choice
- Defining Assisted Living
- Aging in place
- Shared or negotiated risk
- Regulation and quality of care
- Funding

Act 56 represents much progress in addressing the above. I would like to briefly touch on three of the messages in hopes that we not lose sight of what these participants have told us.

Consumer Choice:
"In almost all cases, the philosophy of consumer choice drove the participants' responses. Time and time again, the aspect of consumers having control, making decisions for themselves, and taking responsibility for the consequences rose to the surface. In fact, for many participants the appeal of assisted living was based on the aspect of having choices, particularly when the Council's definitions of assisted living services and assisted living residence, which incorporate choice, were shared with the participants."
Clearly, consumers do not want a system that is so regulated and regimented that consumers are left with little or no choices.

Regulation & Quality of Care:
"The majority of participants believed that quality is best handled by a combination of consumers and government, with minimum regulation serving as a starting point and guiding, not dictating, quality of care. They believed that while this base of practical regulation is important, it is the consumers' feedback that should be the defining factor. There was over-whelming agreement that the nursing facility model for quality is not working , due to the experiences participants had with what they perceived as less than appropriate quality."
"Participants believed that regulation should provide a practical and sensible base-line from which consumer input and satisfaction feedback would then drive the level of quality."

I ask that you consider this feedback and avoid the temptation to regulate quality out of the assisted living system by prescribing for every possible resident type and scenario.

Funding:

"Participants of the discussion groups resoundingly felt that there must be a reallocatin of funds from the nursing facilities to community-base services. However, they also felt that mere reallocation would not be enough; there must be additional funding sources developed."

I can not stress enough my concern that we are creating a system of care that will serve a handful of very poor, those lucky enough to get a waiver, and the very rich. While the ever growing population of low to moderate income consumers will never be able to afford to live in an assisted living residence. By my calculations a new ALR's in South East PA will cost consumers somewhere between $5,000 to $7,000 per month or $60,000 to $84,000 per year.

The following comments are specific to individual sections of the regulations. I will not take your time to address each.

Thank you

John Schwab
The Hickman
September 18, 2008

Below please find our recommendations for changes to the proposed ALR regulations.

§4.Assisted living residence. Add: *Multiple buildings on the same premises are considered* ***one*** *Assisted Living Residence (ALR), covered by* ***one*** *license. Should the Department intend to have separate licenses for separate buildings on the same premises, they should say so here.*

§4.Cognitive Support Services. How does an ALR determine when a resident with cognitive weaknesses changes **significantly?** If "significantly" is left undefined, the decision may vary from inspector to inspector or from one day to another day. Let the decision be made by the ALR's clinical staff.

§4(ii).Informed consent-. No resident can sign such an agreement that puts another resident or other residents at risk. Unfortunately, both SB 704 and Act 56 included "another resident," and both should not have.

§11(c)(1).Procedural requirements for licensing ALRs. A $500 license application or renewal fee for an ALR seems unreasonably high, since a PCH has no such fee and even a NH's fee is only $250.

§11(c)(2).Procedural requirements for licensing ALRs. The annual **licensing fee** for ALRs has jumped to $105 per bed from the $15-$50 fee for PCHs. Likewise the $105 fee per bed fee is more than the $0-$75 for a NH. (The ranges refer to numbers of beds.) $105 is excessive, placing additional cost on each resident.

§16(a)(3).Reportable incidents and conditions. Delete "illness" from line 1. To include illness would be to include too many items to report. Things

like heart attacks and broken bones need to be reported, but not cataract care, urinary infections, infected teeth, etc.

§19(b).Waivers. Listing items that may not be waivered may simplify the Department's life, but limits an ALR's flexibility to make adaptations as circumstances require. The elements in this subsection are general and in some cases undefined, needing each element to be carefully defined and expanded, or better still, **the whole subsection eliminated**. Each person is different from the next; the same is true with ALRs, based on the population served. Flexibility is needed to be responsive to the varied needs and requests of residents.

§19.Waivers. Add subsection (g): The Department will notify residences within 30 days of their acceptance or rejection of each waiver request.

§25(b).Resident-Residence Contract. On line 4 change "14 days" to "30 days". There is no valid reason for a resident to terminate a contract within fewer days' notice than a residence.

§25(i).Contract. Line 2. Before "contract" insert "resident-residence". However, **supplemental health care services** must be contracted and priced separately as must any **other services.** This sounds as if an ALR resident may have one contract or two or three, contradicting line 2, which says "the" contract, meaning just one. It is not clear whether core services can be bundled in different combinations to suit individual resident preferences.

§30(c).Last line: after "other residents" insert "or staff". The expression "other residents or staff members", first used in §30(a)(1), later became "persons other than himself" or similar expressions in §30(d)(2). The wording should be consistent. We urge the use of "... or any person other than the resident."

§42(y).Top 2 lines. Specific rights: Delete the period after the last word, "provider", and insert "with the agreement of the licensee."

§56(a).Line 2. Administrator staffing. Requiring the administrator to spend 40 or more hours per week *in the residence* during each calendar month seems unreasonable, when his duties involve such out-of-residence activities as training, court hearings, vacations, fund-raising, marketing, etc. Spending an average of 20-25 hours a week in the residence during each

calendar month is manageable for an administrator in an ALR. **Alternatively,** add: "If two or more staff members of an ALR are Administrator-qualified, the 40 hours may be shared among them."

§96(a).Defibrillators are expensive, and multiple ones would be needed to meet the time window necessary in which to use them. It would require education of all staff, not just resident care, to make their usage efficient, since the time window in which to use them is so limited. Studies indicate that successful recovery from these treatments in a senior population is so low that this procedure seems extreme. Defibrillators are not always stand-alone treatments; CPR may also need to be done as well in these situations. We question the appropriateness of this item, even disregarding the added cost.

§96(a).First aid kit & §171(b)(5)Transportation. The first requires a first aid kit to include an automatic electronic defibrillation (AED) device, the second requires a vehicle to have a first aid kit, This means such a vehicle must carry an AED. This is a great and unnecessary expense, especially since it requires the driver of the vehicle to be trained in using an AED. It also prevents a coordinated transportation vehicle, such as a volunteer, from being used.

§101(b)(1).Line 2. Resident living units. **250 square feet** of floor space, exclusive of closets and bathrooms seems **excessive**. If 80 square feet suffices for a PCH, certainly 200 square feet is enough for an ALR, whose population is frailer and less mobile. Extra space may be needed in its closet(s) and bathroom, not in the main room. **Alternatively,** retain 250 square feet, but have it include bathroom and closet(s), allowing each ALR to select room, bathroom and closet sizes appropriate to the needs of residents.

§101(b)(2).Resident living units. Similarly, 175 square feet per living unit in exiting residences is excessive.

§101(d)(1). For new construction, **kitchen** space in **every** room seems excessive. Somewhere between 10% to 25% of rooms might reasonably be kitchen-supplied. A "country kitchen" would be enough for most residents' needs in either new or existing facilities. Although it specified "... with electrical outlets suitable for small cooking appliances such as a **microwave** oven", it did not say that a microwave oven should be included.

§101(d)(2)(ii). For existing facilities, "The residence shall provide a microwave oven in each living unit" seems incongruous with the last sentence in the previous item.

§101(j)(1).Resident living units. Requiring a fire retardant mattress deprives a resident of using the mattress that has given the most comfortable support in the past. Our experience is that all residents supply their own furniture, including mattresses. Given current fire prevention measures in place, this would be an unnecessary additional expense.

§123(d).Emergency evacuation. It is an annual nuisance and expense to obtain written approval by a fire safety expert of fire safety areas on the same floor as each resident with mobility needs. Re-approval should be required **only if the fire safety area has changed or if a new floor has residents with mobility needs.**

§124.Notification of local fire officials. It is a waste of time and money to notify the fire department whenever there is a new resident in need of assistance to evacuate in an emergency. Continuously up-to-date lists of such residents, kept by the Receptionist and by each Resident Care Office in the residence can be handed to firefighters on arrival. This residence's fire department has given written approval of such a plan. Indeed, our fire department prefers not to receive periodic updates.

§131(a)&(c).Fire extinguishers. Two extinguishers in every living unit is unnecessary and expensive. An extinguisher in a common kitchen (not one in a resident's living unit) is proper. In reality, how many assisted living residents – NH qualified people – can usefully handle a fire extinguisher? Our fire department's basic premise is: *Get the residents out of the building and let us fight the fire.*

§132(e).Fire drills. "A fire drill shall be held during sleeping hours once every 6 months."
Agreed, but only if each residence is free to determine its own sleeping hours.

§141(b)(1).Resident medical evaluation. Change "At least annually" to "Within a year and a month of the previous evaluation." **Reasons**: "At least annually" means *less than one year* after the preceding evaluation. Many

medical insurance policies require medical evaluations *after more than a year*. The proposal eliminates this conflict, satisfying both the regulation and insurance companies. It also provides leeway in avoiding weekends or holidays when MDs do not do evaluations, gives a cushion to allow for scheduling difficulties, and takes care of such situations as when the resident is ill and has to reschedule the appointment.

§171(d).Transportation. Add: "If the residence has more than one vehicle, only one of them need be accessible to resident wheelchair users, not all of them."

§181(d),Last sentence. We assume that the resident's lockable living unit suffices as a safe and secure location for medications, those medications already being stored out of sight.

§220(b)(6).Assisted living residence services. "Household services", not having been defined, should either be defined or described enough to determine what is meant by "services essential for the health, safety and comfort of the resident based upon the resident's needs and preferences."

§220(c)(7).Line 1.Supplemental services. After "escort service" insert "if needed". Requiring an ALR to provide or arrange for **escort services,** means sending a paid employee with the resident, be it the driver of an ALR vehicle or another employee when using some form of public transportation. This is an unnecessary expense when an ALR resident often prefers to be accompanied by a family member, a volunteer from church or elsewhere, or even a friend.

§226(c).Mobility criteria. While it is proper to report to the Department of a resident with mobility needs within 30 days after admittance, it's unnecessary and wasteful of time and money to report to the Dept every time a resident **develops** mobility needs. We request the Department to provide a reason for this section.

§227(b).Development of the support plan. Having both an LPN and an RN review and approve the support plan is an unnecessary expense. "An RN or an LPN under the RN's supervision **may** review and approve the support plan" is more appropriate. It would be less ambiguous to say, "A licensed practical nurse **may** review and approve the support plan under the supervision of a registered nurse."

§227(c).Development of the support plan. Reviewing each resident's support plan [and in an ALR that probably means **every** resident's] on a **quarterly** basis seems time-consuming and expensive. It makes more sense to review it only when the resident's **condition** changes. Depending on how many people are involved, such a review, including preparation time and meeting time is estimated to take up to a total of 8 staff hours, and cost up to $400 per resident.

§227(k). Rather than saying "the residence shall **give** a copy of the support plan to the resident and the resident's designated person" it would be more realistic to say "the residence shall **offer** a copy ..." Our experience in a PCH is that most residents do not want a copy when it is offered; when declined, time and money are saved. However, not on a quarterly basis as in the previous comment.

§228(b)(2).Lines 5-6.Transfer and discharge.. If the **resident arranges** for needed services and the needed services are not suitable or appropriate in the opinion of the ALR, the ALR should absolutely be allowed the option of rejecting them and continuing with the transfer or discharge. Vendors and family members often have unsuitable reasons for wanting, or not wanting, something for the resident, services that may provide unacceptable quality. There has to be some control for the provider to give quality care.

§228(h)(3).Transfer and discharge. It is unnecessary to involve the ombudsman when there is no disagreement about the transfer.

This says that you have to contact the ombudsman when you feel you can no longer manage a resident. Then the ombudsman notifies the department "which may take licensure action it deems necessary based upon the report of the ombudsman". Considering possible licensure action, we feel the ombudsman's report to DPW should, at the very least, be accompanied by a statement from the residence.

There seems to be no provision for the ombudsman to notify the **residence** of his decision **prior** to notifying the Department, in case the ombudsman misunderstands the facts. Also, the Department's option to "take any licensure action", should be allowed **only** if the residence has violated one or more of the provisions for discharge in §228(h)(4) through §228(h)(8).

§229(c)(3).Excludable conditions; exceptions. The Department's responding within 5 days to an exception request is too long a delay time. For instance, if a bed was found in another facility, within 5 days that bed may have found another occupant, requiring further search. Within 48 hours would be a more reasonable delay time, considering the availability of faxes, etc.

§231(c).Admission. 72 hours is too short a time within which to create a written cognitive preadmission screening form for a resident about to be admitted. Without knowing the reasoning behind the suggested 72 hours, 15-30 days is more acceptable, particularly not knowing how quickly an MD will respond to the request.

§231(e).Admission. On line 1, after "and" add "or". This is needed in case the applicant's dementia is so severe as to prevent his comprehending enough to agree.

General Comment: It is unfortunate that an ALR was called a *residence*, because of the confusing similar sound of *residents* or *resident's* or *residents'*. Although the Regulations have carefully replaced *home* with *residence*, the term *home* is really more appropriate, as it emphasizes that an ALR is not just a *residence,* a place for residents to live, but it is also their *home*, where their friends are, where their life goes on happily.