RULES AND REGULATIONS

Title 55—PUBLIC WELFARE

DEPARTMENT OF PUBLIC WELFARE

[55 PA. CODE CH. 2800]

Assisted Living Residences

The Department of Public Welfare (Department) adopts Chapter 2800 (relating to assisted living residences) to read as set forth in Annex A under the authority of sections 211, 213 and Article X of the Public Welfare Code (code) (62 P. S. §§ 211 and 213 and 1001—1087). Notice of proposed rulemaking was published at 38 Pa.B. 4459 (August 9, 2008).

Purpose of the Final-Form Rulemaking

The purpose of this final-form rulemaking is to fulfill the statutory requirement in the act of July 25, 2007 (P. L. 402, No. 56) (Act 56) that requires the Department to adopt regulations establishing minimum standards for building, equipment, operation, care, program and services, staffing qualifications and training, and for the issuance of licenses for assisted living residences (ALR) operated in this Commonwealth. See section 1021(a)(2)(i) of the code (62 P. S. § 1021(a)(2)(i)).

Background

Prior to Act 56, there was not a legal definition of "assisted living residence" in this Commonwealth. Act 56 directed the Department to adopt regulations establishing the minimum licensing standards for ALRs which "meet or exceed" standards established for personal care homes (PCH) under Chapter 2600 (relating to personal care homes). See section 1021(a)(2)(i) of the code.

Act 56 was intended to recognize that ALRs are a significant long-term care alternative Nationwide. ALRs are a combination of housing and supportive services, as needed. They are widely accepted by the general public because they allow people to age in place, maintain their independence and exercise decision making and personal choice. In enacting Act 56, the General Assembly found that it is in the best interests of the residents of this Commonwealth that a system of licensure and regulation be established for ALRs to ensure accountability and a balance of availability between institutional and home-based and community-based long-term care for adults who need this type of care. See Act 56, Legislative Findings and Declarations.

Act 56 further directed the Department to develop regulations for ALRs in consultation with industry stakeholders, consumers and other interested parties. See section 1021(d) of the code. As described more fully in the preamble to the proposed rulemaking, the Department convened a group of industry stakeholders, consumers and other interested parties and held numerous meetings over a period of many months to carefully consider the viewpoints of the groups and individuals that have a stake in this new licensure program. See 38 Pa.B. 4459. Following the notice of proposed rulemaking, the Department continued to consult with industry stakeholders, consumers and other interested parties which culminated in issuance of a draft final-form regulation on June 24, 2009. The purpose of the release of the draft final-form regulation was to solicit additional input as recommended by the Independent Regulatory Review Commission (IRRC) and commentators.

Affected Individuals and Organizations

Individuals who choose to live in ALRs are affected by this final-form rulemaking. ALR providers are also affected.

Accomplishments and Benefits

This final-form rulemaking establishes the minimum standards for licensure of ALRs to allow individuals to age in place. This final-form rulemaking protects consumers' health and safety, privacy and autonomy, while at the same time balancing industry stakeholders' concerns related to costs, liability and individual choice.

Fiscal Impact

The Department estimates a net administrative cost to implement this change at $0.437 million State funds in Fiscal Year (FY) 2010-2011. In the out years, costs will be covered by fee revenues.

Costs are expected to be incurred by the regulated community beginning in FY 2010-2011 ranging from $0.006 million to $0.403 million per ALR based on a 75-bed ALR. At a minimum, ALRs would be required to pay a licensure fee amounting to the $0.006 million on average. This cost assumes a flat application or renewal fee of $300 per home, an additional fee of $75 per bed and for those facilities granted a special care designation, a third fee of $150. It is assumed these fees will remain constant in the subsequent years. Additional costs may be incurred, which when added to the licensing fee brings the total potential cost up to the maximum estimated average cost of $0.403 million in the first year. These costs may or may not be incurred depending upon each facility's current status in relation to potential new costs imposed by the regulation. The majority of the costs relate to additional personnel expense in administering medication, enhanced reporting and additional administrative costs for resident care. It is assumed that those facilities that choose to apply for ALR licensure will already comply with the facility structural requirements of the proposed rulemaking, so no costs are assumed for structural modifications. It is assumed that 50 ALRs will incur these costs in FY 2010-2011.

Paperwork Requirements

The final-form rulemaking does require some additional paperwork by the Commonwealth and ALRs. However, there is no reasonable alternative to the increased paperwork.

Required forms will be developed by the Department in cooperation with the ALRs and will be shared in draft form with external stakeholders for review and comment prior to implementation. With respect to the initial assessment form and the preliminary and final support plans (§§ 2800.224, 2800.225 and 2800.227 (relating to initial assessment and preliminary support plan; additional assessments; and development of the final support plan)), the ALR may use its own forms as long as all the required information in the Department's standard forms is included. The Department will also work with stakeholders to develop sample policies and procedures to assist ALRs to comply with the final-form rulemaking. ALRs are also required to develop a residence handbook which is to be approved by the Department.

Public Comment

Written comments, suggestions and objections regarding the proposed rulemaking were requested within a

30-day comment period following publication of the proposed rulemaking. The Department received 222 public comment letters as well as comments from legislators and IRRC. The Department also testified at a public hearing on September 18, 2008, convened by the House Aging and Older Adult Services Committee regarding the proposed rulemaking. In addition, the Department held individual meetings with industry stakeholders, consumers and other interested parties following the proposed rulemaking. Finally, as previously mentioned, in response to a recommendation of IRRC, the Department issued a draft final-form regulation on June 24, 2009, to solicit further comment. IRRC posted this draft regulation on its web site at http://www.irrc.state.pa.us/Regulations/RegInfo.cfm?IRRCNo=2712. The Department received 79 additional comment letters in response to this draft final-form regulation.

The Department received comments from every sector of the community that will be affected by the final-form rulemaking including industry stakeholders, consumers and other interested parties, IRRC and the majority and minority chairpersons and members of the House Aging and Older Adult Services Committee and the Senate Public Health and Welfare Committee.

The Department has continued to consult with and meet with industry stakeholders, consumers and interested parties to help ensure that this final-form rulemaking will achieve a balance between the competing interests of all parties in the regulatory review process. The Department carefully considered the comments it received in response to the proposed rulemaking and the draft final-form rulemaking. The Department would like to thank the many industry stakeholders, consumers and other interested parties for their expertise and consultation in the development of this final-form rulemaking. The Department appreciates the many thoughtful comments submitted. Many of the suggestions and recommendations made by commentators have been incorporated into this final-form rulemaking.

Discussion of Comments and Major Changes

The Department finds that IRRC summarized the major comments noted by commentators. As a result, the Department will use IRRC's comments as a "blueprint" for discussion of the major comments received. The Department has filed a separate comment and response document, which includes the comments received, with IRRC, the legislative committees, the Legislative Reference Bureau and commentators along with this final-form rulemaking. This preamble also includes responses to the major comments received as a result of the release of the draft final-form regulation on June 24, 2009.

Legislative comments

IRRC recommended that the Department carefully consider the comments from legislators.

Response

The Department agrees with this recommendation and appreciates the high level of interest that this final-form rulemaking has generated from the General Assembly, IRRC and the public. Many of the concerns expressed by members of the General Assembly were echoed in the public comment letters as well as in IRRC's comments and are included in this preamble and are reflected in the comment and response document which has been filed separately along with this final-form rulemaking.

General—A. Distinction between ALRs and PCHs

IRRC posed several questions regarding the implementation of Act 56 through the proposed rulemaking. IRRC stated that it would review the Department's response to its questions as part of its determination of whether the final-form rulemaking is in the public interest. IRRC requested the Department explain the difference between an ALR and a PCH.

IRRC specifically asked for an explanation of the statutory language in Act 56 that allows PCHs to "assist residents in obtaining health care services" versus the requirement that ALRs be "required to provide supplemental health care services." It also asked "If a PCH offers many of the same services as an ALR, what will stop consumers from contracting with PCHs when there is no statutory protection for 'supplemental health care services' or 'aging in place' at a PCH?" IRRC also inquired about the implications of the differences between an ALR and a PCH, including how these differences will affect residents and licensees in the future.

Finally, IRRC inquired about the fact that the current statutory provision for Act 56 regarding special care designation does not reference the existing PCH regulations in §§ 2600.231—2600.239 (relating to secured dementia care units). IRRC commented that the definition of "special care designation" in Act 56 only refers to ALRs.

Response

The Department submits that this final-form rulemaking is in the public interest for a number of reasons. Implementation of Act 56 through this final-form rulemaking provides another choice for consumers who are searching for a residential care option to meet the rising demand for this Commonwealth's rapidly growing population of older adults as well as individuals with disabilities who wish to have another alternative to nursing facility care or a PCH. Assisted living is a new model of care for this Commonwealth in three basic ways: 1) the concept of aging in place; 2) the types of care offered to consumers; and 3) the design and construction of the facility. While there are similarities between ALRs and PCHs, there are also distinctions between the two types of licensure categories. As the following more fully describes, there are clear differences between PCHs and ALRs regarding the kinds of service offered to the residents, the physical site requirements for individual living units and the conditions for licensure. In addition, assisted living offers an opportunity for the Commonwealth to seek Medicaid waiver funding.

As the Department noted in the preamble to the PCH final-form rulemaking ". . . the demand for residential care options is increasing." See 35 Pa.B. 2499 (April 23, 2005). For consumers, an ALR is another choice in the array of long-term care alternatives in this Commonwealth. This final-form rulemaking accords with the legislative intent behind Act 56 to "allow people to age in place, maintain their independence and exercise decision making and personal choice." (Act 56, Legislative Findings and Declarations.) Implementing the final-form rulemaking will fulfill the legislative intent to provide a "significant long-term care alternative" to residents of this Commonwealth and to "ensure a balance of availability between institutional and home-based and community-based long-term care for adults who need such care." (Act 56, Legislative Findings and Declarations (1) and (3).)

To address IRRC's specific concerns regarding the provision of supplemental health care services in an ALR, Act 56 defines an "ALR" as:

any premises in which food, shelter, personal care, assistance or supervision *and supplemental health care services are provided* for a period exceeding twenty-four hours for four or more adults who are not relatives of the operator and who require assistance or supervision in such matters as dressing, bathing, diet, financial management, evacuation from the residence in the event of an emergency or medication prescribed for self-administration.

Section 1001 of the code (62 P. S. § 1001). (Emphasis added.)

The definition of a PCH, while similar to the definition of an ALR, does not contain the key phrase "supplemental health care services are provided." Hence, a distinction between an ALR and a PCH is that an ALR is required by law to provide "supplemental health care services," whereas under Act 56 a PCH may not provide supplemental health care services, but, instead, may assist residents in obtaining health care services in the manner provided by §§ 2600.29, 2600.142 and 2600.181—2600.191 (relating to hospice care and services; assistance with health care; and medications). See section 1057.3(a)(13) of the code (62 P. S. § 1057.3(a)(13)).

There is a major difference between requiring a facility to actually provide supplemental health care services and having a facility merely assist with securing health care. While one is mandatory, the other is permissive. A PCH can choose whether it wants to assist the resident to secure health care, but an ALR has no choice in the matter. An ALR must provide supplemental health care as defined in Act 56 or it will not meet the minimum licensure standard to operate as an ALR.

Requiring that an ALR provide supplemental health care services supports another core concept of an ALR, that is, an ALR allows individuals to age in place. Act 56 defines "age in place" or "aging in place" as "receiving care and services at a *licensed assisted living residence* to accommodate changing needs and preferences in order *to remain in the assisted living residence*." (Emphasis added.) See section 1001 of the code.

Rather than having to move out of a PCH when a resident's acuity needs become too great for the PCH to meet, an ALR is designed to allow a resident to age in place to accommodate changing needs as well as preferences of the resident. As stated in the preamble to the PCH final-form rulemaking, "Personal care homes are not licensed as medical facilities and are not required to hire licensed, certified or registered medical professionals. Although some personal care homes employ doctors, registered nurses, certified nursing assistants, certified registered nurse practitioners and licensed practical nurses to assist in service provision for the residents, this is not mandated." See 35 Pa.B. 2499, 2502.

This leads to a discussion of another significant difference between ALRs and PCHs. A PCH is restricted in the type of care that it can provide. A PCH, by statute, is not permitted to serve individuals who "require the services in or of a licensed long-term care facility." See section 1001 of the code. This was emphasized in the preamble to the PCH final-form rulemaking at 35 Pa.B. 2499: "Personal care homes are designed to provide safe, humane, comfortable and supportive residential settings for adults *who do not require the services in or of a licensed long-term care facility*, but who do require assistance or supervision with activities of daily living (ADL) or instrumental activities of daily living (IADL), or both." (Emphasis added.) Indeed, the preamble to the PCH final-form rulemaking emphasized "Commonwealth law prohibits a personal care home from housing and serving residents whose care needs would qualify them for nursing facility care. This distinction is made in the statutory definition of 'personal care home' in section 1001 of the Public Welfare Code (62 P. S. § 1001), which provides that an individual who needs the level of care of a long-term care facility, or nursing home, cannot be served in a personal care home." See 35 Pa.B. 2499, 2502.

To reinforce the distinction between an ALR and a PCH, Act 56 provides that prior to admission, an initial screening must be done to determine whether the potential resident requires the services provided by an ALR or a PCH. See section 1057.3(a)(1)(ii) and (iii) of the code. According to section 1057.3(a)(1)(iii) of the code, "a resident who currently does not require assistance in obtaining supplemental health care services, but who may require such services in the future or who wishes to obtain assistance in obtaining such services or reside in a facility in which such services are available, may be admitted to the ALR provided the resident is only provided service required or requested by the resident. Where services are required, the ALR shall develop a support plan as defined in 55 Pa. Code Chapter 2600 (relating to personal care homes) and any other regulations applicable to assisted living residences."

Thus, the level of care for an ALR resident can vary widely, ranging from an individual: who does not require supplemental health care services at the time of admission to the ALR, but who may require services in the future; or who wishes to obtain assistance with obtaining such service; or who wants to live in a facility in which such services are available.

By contrast, the screening for a PCH provides that the screening will be done "to determine that the potential resident does not require the services in or of a long-term care facility and whether the resident requires the services of a personal care home, and if so, the nature of the services and supervision necessary." See section 1057.3(a)(1)(ii) of the code.

The screening requirements in this final-form rulemaking clearly exceed the preadmission screening currently in place for PCHs. See §§ 2800.224, 2800.225 and 2800.227. This should further allay concerns that there will be confusion in the minds of potential residents as to the appropriate place to live, whether it be a PCH or an ALR. The screening and assessment process for an ALR will allow an individual and his family, if applicable, to know up front whether or not the ALR can meet his care needs and preferences and what those care needs are through the assessment process.

Furthermore, Act 56 provides that some services that would traditionally be offered in a skilled nursing facility may be offered by an ALR. For example, although Act 56 contains a prohibition against allowing a consumer with certain excludable conditions to be admitted, retained or served in an ALR, the law permits an exception to be granted by the Department upon the request of the ALR. These excludable conditions defined in Act 56 include skilled nursing care needs such as ventilator dependency, stage III and IV decubiti and vascular ulcers that are not in a healing stage, continuous intravenous fluids, reportable infectious diseases in a communicable state, nasogastric tubes, physical restraints and "continuous skilled nursing care twenty-four hours a day." See section 1057.3(e) of the code. Nevertheless, if an exception is granted by the Department, an ALR may care for an individual whose health care needs fall within these

excludable conditions, some of which would ordinarily be provided in a skilled nursing facility. See section 1057.3(f) and (g) of the code. Again, this accords with the legislative intent of Act 56 that consumers who choose an ALR be allowed to "age in place" and receive care that is beyond the level that a PCH is authorized to provide.

The concept of allowing an ALR to provide for "aging in place" is also reinforced by the provisions of Act 56 that require the regulations for ALRs to create "standards for transfer and discharge that require the ALR to make reasonable accommodations for aging the place and that may include service from outside providers." See section 1026(a)(1)(viii) of the code (62 P. S. § 1026(a)(1)(viii)). Finally, with respect to informed consent agreements, Act 56 provides that the Department's regulations must create standards for informed consent agreements that promote aging in place. See section 1026(a)(1)(vii) of the code. Including the concept of informed consent in promoting the ability of an individual to age in place is yet another distinction between PCHs and ALRs.

In addition, in further response to IRRC's request that the Department explain the difference between an ALR and a PCH, the Department would point out that a key distinction between PCHs and ALRs relates to "bricks and mortar." As stated in the preamble to Act 56 "[a]ssisted living residences are a combination of housing and supportive services, as needed." (Act 56, Findings and Declarations.) While PCHs are required under § 2600.101 (relating to resident bedrooms) to have bedrooms for residents, there is not a requirement that the PCH resident have a private bathroom, living space or kitchen capacity in his own room. Furthermore, the regulations for PCHs permit up to four residents per bedroom. Bathrooms in a PCH may be shared and § 2600.102 (relating to bathrooms) provide specific ratios for residents for matters such as toilets, sinks and bathtubs or showers. On the other hand, Act 56 mandates that the regulations issued by the Department require that an ALR provide a resident with the resident's own living unit. See section 1026(a)(2)(ii) of the code. Act 56 further provides that a licensee may not require residents to share a living unit, but two residents may voluntarily agree to share one unit, provided that the agreement is in writing and contained in each of the residency agreements of those individuals. See section 1026(a)(2)(ii) of the code.

A living unit in an ALR must contain a ". . . private bathroom, living and bedroom space, kitchen capacity, which may mean electrical outlets to have small appliances such as a microwave and refrigerator, closets and adequate space for storage and a door with a lock, except where a lock or appliances in a unit under special care designation would pose a risk or be unsafe." See section 1021(a)(2)(iv) of the code. Under no circumstances may a resident be required to share a living unit in an ALR. See section 1021(a)(2)(ii) of the code. By law, the Department is required to establish the minimum square footage requirements for individual living units. See section 1021(a)(2)(v) of the code. Clearly, the characteristics of the accommodations that are provided in a PCH versus an ALR are distinguishable.

The physical site requirements for an ALR provide for greater privacy and freedom for the individual to exercise decision making and personal choice. Residents in an ALR will have more options regarding their personal preferences in their living units, such as meal planning and preparation, since kitchen capacity is required for the living units in an ALR.

Further, the minimum square footage for resident bedrooms versus living units is distinguishable between PCHs and ALRs. The minimum square footage for a single resident bedroom in a PCH is 80 square feet. Each PCH shared bedroom must have at least 60 square feet per resident with up to four residents sharing a bedroom. See § 2600.101. The Department also notes that for individuals with mobility needs, the square footage requirement for PCHs is 100 square feet for the individual's bedroom. See § 2600.101(c). This final-form rulemaking requires for ALRs, however, at a minimum, 160 square feet for single person living units for existing facilities that wish to convert to ALR licensure, and 225 square feet for single person living units in an ALR which is built after the effective date of this proposed rulemaking. Since the requirement that the living unit must not only provide space for a resident's bedroom, but must also contain living space and kitchen capacity to allow for the individual a private place to relax, entertain family and friends and possibly prepare meals (if the resident chooses to have appliances in his living unit), adequate square footage must be provided to accommodate all of these activities.

Additionally, as the Legislature made clear in enacting Act 56, "No person, organization or program shall use the term 'assisted living' in any name or written material, except as a licensee in accordance with this chapter." See section 1057.3(i) of the code. Hence, only those ALRs licensed under this final-form rulemaking will be authorized to advertise themselves as an ALR. When comparing potential long-term living options, prospective residents will have the assurance that the facility that they are considering is licensed as an ALR by the Department. This should further reduce the confusion that has been expressed by commentators as to explaining the difference between an ALR and a PCH.

In response to IRRC's inquiry about how residents and licensees will be affected by the statutory differences between ALRs and PCHs, an existing licensed PCH is neither required to seek licensure as an ALR, nor meet the new licensure requirements in Chapter 2800. It is a business decision by a facility whether to seek licensure as an ALR or remain licensed as a PCH. This final-form rulemaking is designed to fulfill the statutory requirement that the Department establish minimum licensure requirements for an ALR. It does not dictate that an existing PCH convert to an ALR. The Department did, however, take into account that there are many existing PCHs that are interested in becoming licensed as ALRs. Therefore, the Department, with the advice and consultation of the stakeholders, made provision in the final-form rulemaking to allow existing PCHs to convert to ALR by providing decreased square footage for living units and lower kitchen capacity requirements for existing facilities. In addition, the Department amended the language in § 2800.53(a)(6) (relating to qualifications and responsibilities of administrators) to provide for a PCH administrator to be qualified as an ALR administrator if certain conditions are met.

Finally, as to IRRC's inquiry about the fact that the statutory provision for Act 56 regarding "special care designation" does not reference the existing PCH regulations in §§ 2600.231—2600.239, the Department finds that there is not a restriction in Act 56 that would preclude a PCH from continuing to provide secure dementia care in accordance with the PCH regulations cited by IRRC.

General—B. Resident population

IRRC inquired about what population will be served by an ALR. Specifically, IRRC asked how the care in an ALR differs from the care currently provided by long-term care facilities and PCHs. IRRC commented that this distinction is vital to potential residents and their families in their evaluation of which path best fits their current and future health care needs and the ability to pay and promotes happiness and wellness. IRRC further inquired what would be the advantages and disadvantages of choosing one over the other.

Response

Since ALRs provide for residents to age in place, the population of an ALR will vary widely. Prospective residents include adults who require assistance or supervision in matters such as dressing, bathing, diet, financial management, emergency evacuation and self-administration of medication. With respect to the provision by the ALR of supplemental health care services, some consumers may not require assistance in obtaining supplemental health care services currently, but may require such services in the future. Some may wish to obtain such services or reside in a facility in which supplemental health care services are available. It is apparent that the legislature wanted to provide flexibility to consumers by requiring that the ALR screening process would determine the individual's needs regarding provision of supplemental health care services. The distinction between ALRs and PCHs is that ALRs are a long-term care alternative that allow individuals to age in place, maintain independence and exercise decision making and personal choice. Note that a PCH is not defined in Act 56 as a long-term care alternative. Instead, as previously discussed, the definition of a "PCH" specifically excludes individuals who require the services in or of a licensed long-term care facility. ALRs are designed to provide a home-like environment where residents have an opportunity to have their own private living unit complete with a private bathroom and kitchen capacity which gives the residents an area to prepare their own meals if they choose to do so. As stated previously, as a long-term care alternative, an ALR is required to provide supplemental health care services; by contrast, a PCH is merely permitted to assist the resident in obtaining health care service as provided in the PCH regulations under §§ 2600.29 and 2600.181—2600.191. A PCH may not provide supplemental health care services to residents. See section 1057.3(a)(13) of the code.

The distinction between an ALR and a long-term care facility is that a long-term care facility provides "nursing care and related medical or other health services" to individuals who need care. See section 1001 of the code. In § 2800.22(b)(1) and (d) (relating to application and admission), the Department clarified that an adult who requires the services of a licensed long-term care nursing facility may reside in the ALR, if certain conditions are met. These include: the needs of the potential resident can be met by the ALR; the appropriate supplemental health care services are provided to the resident; and the design, construction, staffing and operation of the ALR allow for a safe emergency evacuation of the resident.

In choosing between a PCH, an ALR and a long-term care facility, an individual or the individual's family will have to examine the individual's current health care needs, potential future health care needs and preferences for living environments. As previously noted, an ALR offers another choice for consumers as the demand for residential options for older residents and people with disabilities is increasing in this Commonwealth.

General—C. Affect on PCHs and their residents

IRRC noted that commentators are concerned that the new ALR licensure will affect Departmental policy concerning PCHs in a manner that disrupts current PCH residents receiving higher levels of care. For example, under existing PCH regulations, the permissible spectrum of care extends through hospice care. The Department was asked to explain how implementation of ALR licensure will affect PCHs and their residents, whether the proposed rulemaking will in any manner diminish the ability of licensed PCHs to continue providing the same levels of care as they do now, and how Departmental enforcement actions regarding PCHs and their current care will change as a result of this new category of licensure.

Response

PCHs are required in § 2600.1 (relating to purpose) to provide safe, humane, comfortable and supportive residential settings for adults who do not require the services *in or of a licensed long-term care facility*, but who do require assistance or supervision with tasks of daily living, such as dressing, bathing, diet, and financial management. (Emphasis added.) It is the Department's position that if a resident's needs are being safely met in a PCH, the resident should be permitted to remain in the PCH. However, it is the PCH's responsibility under § 2600.225(d) (relating to initial and annual assessment) to assess, on an ongoing basis, whether the resident is in need of a higher level of care, and to develop plan for placement as soon as possible.

General—D. What specifically does "aging in place" mean for the resident and the ALR?

Since aging in place allows a resident to remain in the ALR, IRRC inquired how the Department defines "residence." IRRC further inquired if a resident will remain in the same living unit or whether a resident will be moved to another area within an ALR as the resident' needs changed.

Response

The Department's interpretation of "residence" in the definition of "aging in place" refers to the ALR since aging in place is distinctly a new concept which applies to ALRs. As IRRC noted previously, a key distinction in Act 56 is the definition of "aging in place." "Aging in place" is defined as "receiving care and services at a licensed assisted living residence to accommodate changing needs and preferences in order to remain in the assisted living residence." See section 1001 of the code. Act 56 provides residences with the discretion to decide whether they designate portions or sections of the ALR for use only by residents not requiring supplemental health care services or whether they allow both those needing these services and those who do not need these services to reside within the same portions or sections of the ALR. See section 1057.3(h)(ii) of the code. This will be a major determining factor in whether or not a person will move when needs change.

Additionally, special care units are residences or portions of residences that provide specialized care and services for residents with Alzheimer's disease, dementia and brain injury. It is only in these special care units that specialized care can be provided to residences with these conditions. That is also another determinative factor in

whether a resident will move from one portion of an ALR to another area within the facility.

In the case of a dually-licensed facility which is licensed as both a PCH and an ALR, when a resident who currently resides in a PCH later requires the services of an ALR, there are a number of factors to consider whether the resident would need to transfer to the ALR portion of the facility. A requirement of dual licensure for a PCH and ALR is that ALR areas must be collocated in the same building and be a distinct part of the building. A "distinct part" is defined in § 2600.4 (relating to definitions) as a portion of a building that is visually separated such as a wing or floor, or sections or parts of floors. This provision is in the regulation because ALRs and PCHs have a number of significantly different physical site licensing requirements, such as room size, private bath and kitchen capacity. ALR living units must meet the square footage requirements of the ALR regulations; kitchen capacity must be provided to allow for resident meal choice; the living unit would have to be located in a distinct part of the facility and would have to meet all other ALR standards including the mandate to provide supplemental health care services. In other words, a PCH bedroom cannot automatically become an ALR living unit merely because the needs of its occupant change. If, however, a PCH bedroom qualifies as an ALR living unit by meeting the requirements of this chapter, and if the ALR chooses to designate it and increase its ALR capacity accordingly, the resident would be able to remain in the same room he occupied as a PCH resident.

General—E. Revision of existing PCH regulations

IRRC questioned whether the Department has a strategy for revising the existing PCH regulations.

Response

The Department's policy is to continually review its regulations as circumstances change. Once this final-form rulemaking is promulgated, the Department will give careful consideration to whether the PCH regulations should be amended.

General—F. Fiscal impact and the potential for Medicaid funding

IRRC and legislators questioned the fiscal impact of this final-form rulemaking and also the potential for Federal financial assistance through a Medicaid waiver program. IRRC requested that the Department explain how and when the Department intends to seek Medicaid waiver funding, including the anticipated Federal response. IRRC also inquired into how many rooms will be qualified to be licensed to provide ALR services. IRRC also requested an explanation on the availability of ALRs at a cost residents of this Commonwealth can afford.

Response

The Department intends to apply for a Medicaid waiver after this final-form rulemaking is published. The waiver application process consists of an application submitted to the United States Department of Health and Human Services' Centers for Medicare and Medicaid (CMS). Thereafter, CMS reviews the application, provides comment and can request additional information. This process may be repeated until final approval is obtained. At least 38 states have CMS-approved Assisted Living waivers in place. If approval for the waiver is granted, the Department would implement it in FY 2010-2011.

In October 2008, the Department conducted a survey of the 1,437 PCHs licensed in this Commonwealth. We received 723 responses to the survey. The 723 responses represented a total of 28,774 rooms. Of those rooms, 20,648 were indicated to have a bathroom and 5,409 with a kitchen or kitchen facilities. Using the originally proposed square footage of 175 square feet, the Department estimated that there were approximately 220 PCHs that had at least 90% of their rooms that would meet the square footage requirements under the ALR regulations. Using the same survey results, approximately 243 PCHs had 90% of their rooms that would qualify as to room size under a square footage requirement of 160 square feet. While these PCHs would meet the square footage requirements, it is unknown how many of them plan to pursue licensure as an ALR.

In terms of the availability of ALRs at a cost that people can afford, it is important to recognize how costly long-term care services are and to view that cost in the context of services provided in other settings, such as in nursing facilities. Medical Assistance is the primary payer for approximately 2/3 of those using nursing facility-based care.

Today, the older population in this Commonwealth at highest risk of needing nursing facility level of care lacks the personal financial resources to pay for that care. Eighty percent of this population has less than $100,000 in liquid assets and only 27% of those over 65 years of age have sufficient resources to cover 2 1/2 years of nursing facility care. The cost of nursing facility care is over $70,000 a year for a private payer (Health Affairs, Volume 22, Number 3, May/June 2003, http://www.healthaffairs.org). On the other hand, according to MetLife data, the average cost for assisted living Nationally is $3,000 a month, or $36,000 a year (http://www.metlife.com/assets/cao/mmi/publications/studies/mmi-market-survey-nursing-home-assisted-living.pdf).

By establishing a licensed ALR program in this Commonwealth, once a waiver is approved, persons with low income will have an opportunity to age in place and receive supplemental health care services at a much more affordable rate than they would in nursing facilities.

General—G. Dual licensure

IRRC, legislators and many other public commentators objected to the fact that the proposed rulemaking did not provide standards for dual licensure of PCHs and ALRs.

Response

The Department has provided for dual licensure for PCHs and ALRs in this final-form rulemaking. The dual licensure provisions are in §§ 2800.4 and 2800.11(g) (relating to definitions; and procedural requirements for licensure or approval of assisted living residences; special care designation and dual licensure). If the ALR and the PCH are collocated in the same building and are each located in a distinct part of the building, they may be dually licensed. See § 2800.11(g). As previously noted, a "distinct part" is defined as "a portion of a building that is visually separated such as a wing or floor, or sections or parts of floors." See § 2800.4.

Based on industry stakeholder input, the Department's intent in this language is to provide some flexibility in the configuration of what constitutes a distinct part to allow for the establishment of smaller, visually separated clusters of ALR-licensed living units.

General—H. Levels of care

IRRC questioned whether the final-form rulemaking provides a single level of care to residents. IRRC further commented that the Department should explain why the Department did not develop different ranges of require-

ments or levels of care to meet the unique needs of the different types of residents and also provide for choice and availability for consumers.

Response

The Department carefully weighed the competing concerns expressed by consumers versus industry stakeholders. Industry stakeholders suggested a "menu" approach whereby a few essential services such as personal care services, linen service, meals, housekeeping and supervision are required so-called core assisted living services. They recommended that other services be optional so that the resident could pick and choose from a menu containing a variety of services with different costs associated with each service option.

Consumers, however, were very concerned that it is difficult to compare and contrast one ALR from another if each offers an array of confusing add-ons to the basic core services. Further, there was concern that once an individual entered an ALR, the individual could be "nickeled and dimed" for various add-ons that would rapidly deplete his financial resources and increase the cost of care dramatically from the consumer's planned outlay for residing in an ALR. In the draft final-form regulation issued in June 2009, the Department attempted to reconcile these competing concerns by establishing two distinct levels of care: an independent core package and enhanced core package. See § 2800.220 (relating to service provision). The Department further modified these provisions of the final-form rulemaking to allow a consumer to opt-out of certain services in the two core service packages with a concomitant contract price adjustment. Further, to allay the concerns of consumers, the Department added much more depth and detail to assessment of a potential ALR resident to ensure that the needs of the potential resident are carefully assessed so that the type and cost of care that will be provided by the ALR will be known "up-front."

General—I. Further consultation and advanced notice of rulemaking

Although IRRC commended the Department for convening numerous meetings to consult with industry stakeholders, consumers and other interested parties in preparing the proposed rulemaking, IRRC recommended that the Department organize additional meetings with stakeholders and that the Department publish an advance notice of final rulemaking to allow the opportunity to resolve and review remaining issues prior to publication of the final-form rulemaking.

Response

The Department recognizes that in any new licensure program, there will be many voices to consider and viewpoints to reconcile. To expect that consensus can be achieved in all areas is not realistic or feasible. Nevertheless, the Department strived to be as inclusive and transparent in this final-form rulemaking as possible. The Department, following notice of proposed rulemaking, continued to meet with stakeholders, both in group settings as well as individually. In addition, the Department facilitated several meetings with representatives from major industry groups and a coalition of consumers for both the elderly and persons with disabilities. In some cases, the parties were able to come to mutual agreement regarding specific language changes and resolve several key issues in the final-form rulemaking.

Finally, the Department worked closely and collaboratively with stakeholders, IRRC and the legislative committees by issuing a draft final-form regulation that was released for public comment and posted on IRRC's website on June 24, 2009. Following the 30-day comment period, the Department carefully considered the additional 79 comment letters it received and participated in further meetings with stakeholders and legislators. The Department finds that it has identified the major concerns expressed on all sides of the regulatory debate and has attempted either to resolve the competing concerns by consensus or has struck a balance between what the industry stakeholders would like to see versus what consumers have advocated.

§ 2800.1. Purpose

§ 2800.2. Scope

IRRC commented that it believes that these sections did not sufficiently explain the proposed rulemaking. IRRC also commented that these sections should distinguish ALRs from PCHs.

Response

The Department finds that the two cited provisions are designed to be very general overall statements regarding the scope and purpose of the regulations. The language in these provisions is similar to the PCH regulations. See § 2600.1 and § 2600.2 (relating to scope). Further, the distinctions between an ALR and a PCH are more fully set forth previously in the discussion regarding the statutory distinctions between an ALR and a PCH.

§ 2800.3. Inspections and licenses

IRRC questioned how the abbreviated inspection process would work and how it would differ from a routine inspection. Also, IRRC asked what portions of the inspection the Department would waive during an abbreviated inspection.

Response

Act 56 provides that "while developing regulations under this act, the department may provide for an abbreviated annual licensure visit when a residence has established a history of exemplary compliance." (Emphasis added.) See section 211(l) of the code. After careful consideration, the Department decided to delete proposed § 2800.3(c) (relating to inspections and licenses). This issue will be the subject of a future rulemaking after the Department has had an opportunity to study and review the matter further and gain greater experience in licensing ALRs.

§ 2800.4. Definitions—Age in place or aging in place

IRRC questioned why the definition did not mirror the statutory definition.

Response

The Department amended the definition to conform to the statutory definition.

§ 2800.4. Definitions—Commercial boarding residence

IRRC questioned the inclusion of this definition and noted that it was found in the exclusions in § 2800.2(b) (relating to scope).

Response

The proposed definition contained an error. The Department's intent was to conform to the definition and the exclusion in the PCH regulation since ALR regulations must "meet or exceed" the PCH regulations under section 1021(a)(2)(i) of the code. The definition has been corrected to be a "commercial boarding home" and the exclusion relates to a "commercial boarding home" to be consistent with the PCH regulations in § 2600.4.

§ 2800.4. Definitions—Designated person and legal representative

IRRC asked for an explanation of these terms. IRRC suggested that the terms are confusing. IRRC requested the Department explain why different terms are needed and appropriate. IRRC further questioned the intent of the phrase "or other person authorized to act for the resident" in the definition of "legal representative."

Response

A "designated person" is a broader term than "legal representative" and may be a family member, close friend or relative who is to be notified in exigent circumstances, such as an emergency or closure of an ALR. See § 2800.4. Although in some situations a resident may choose a legal representative as a "designated person," it is not required for a resident to have a legal representative fulfill this role. In contrast, a "legal representative" has powers beyond those of a designated person and is "an individual who holds a power of attorney, a court-appointed guardian or other person legally authorized to act for the resident." See § 2800.4.

Since not every type of legal representation can be identified, the definition left open the possibility of other types of authorization being included in the definition of "legal representative." The Department did, however, clarify the definition to include "other person legally authorized to act for the resident."

§ 2800.4. Definitions—Exemplary compliance

IRRC questioned the use of this term and inquired how the 3-year history of exemplary compliance was established. IRRC further inquired into what would constitute a "deficiency."

Response

As noted previously, the Department decided to withdraw this provision and will consider it for a future rulemaking.

§ 2800.4. Definitions—Informed consent agreement

IRRC questioned why the regulatory and statutory terms differed. The regulatory definition included additional language in subparagraph (iii) and IRRC recommended its deletion.

Response

The Department agreed and made the change so that the two definitions mirror each other.

§ 2800.4. Definitions—Supplemental health care services

IRRC questioned why the regulatory definition did not precisely mirror the statutory definition.

Response

The Department agreed and made the change so that the two definitions mirror each other.

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

IRRC and legislators commented the licensure fees for an ALR were excessive. IRRC requested that the Department provide detailed information on how the fees were established, how the fees cover the Department's costs in implementing quality assurance and how much the fees will increase costs to residents. IRRC also requested an explanation of whether an application to change maximum capacity requires payment of a fee and, if so, the amount of the fee. Finally, IRRC requested an explanation of how fees will be charged for dually licensed facilities.

Response

Based on the comments received, the Department reconsidered the fee structure for ALRs. The Department reduced the licensure application and renewal fee from $500 to $300 and reduced the per bed fee from $105 to $75. An application to change the maximum capacity will not require an additional licensure fee. It will, however, result in additional per bed fees to reflect the increased capacity. For dually-licensed facilities, the fee will be the same fee charged for a PCH license plus the licensing fee previously mentioned for an ALR. Dually-licensed facilities would continue to pay the PCH per bed fee for those beds in the licensed PCH parts of the facility and the ALR per bed fee for those beds in the licensed ALR parts of the facility. The Department also will charge an application fee of $150 for an ALR to request special care designation.

In terms of how the Department arrived at these fees, the initial intent was to make them reasonably related to the cost of regulating this care setting. The Department looked at the number of potential residences, approximated the number of beds per residence and calculated how much staff time it would take to license and oversee the program. The Department then looked at other states to make sure that the rates were not unduly higher or lower than others. When the proposed rulemaking was published, the Department received many comments from industry stakeholders stating that the fees that were proposed would be a disincentive for many of them to seek ALR licensure. Consequently, the fees were decreased. Attachment B of the Regulatory Analysis Form contains a comparative analysis of licensure fees between this Commonwealth and a number of other states.

§ 2800.19. Waivers

IRRC questioned the time frame for the Department to respond to waiver requests.

Response

The Department did not specify a time frame for responding to waiver requests. A review of the Department's other licensure chapters discloses that no other chapter provides for a time frame for responding to waivers. See §§ 2600.19, 3130.4, 3140.5, 3270.13, 3280.13, 3680.5, 3700.5, 3800.22, 5310.5 and 6500.12. Indeed, at the request of commentators, the Department has provided greater transparency in the waiver process in this final-form rulemaking than that which exists in other Department licensure regulations. Under the final-form rulemaking, waiver requests will be posted to the Department's website for a 30-day comment period prior to review and decision on the requested waiver. Given that the types of waivers requested may vary widely in scope and complexity, the Department is reluctant to bind itself to a specific time frame for responding to waiver requests. Furthermore, since there is no other precedent in Department licensure regulations for a deadline for responding to waiver requests, the Department will not establish a deadline in this final-form rulemaking.

§ 2800.22. Application and admission

IRRC questioned the application and admission procedures and raised a concern as to whether these procedures are completed quickly enough to protect a resident's health and to protect a resident who may later be rejected. The Department was also asked to explain how

it came up with the time frames for the various admission procedures and why those time frames are reasonable and protective of the public health, safety and welfare.

Response

The Department made several significant changes to the admission and assessment procedures to respond to the concerns expressed by IRRC and other commentators. Based on these comments, this final-form rulemaking now provides for an initial assessment, a preliminary support plan, final support plan and certification that the needs of a potential resident can be met by the services provided by the residence. Specifically, the admission process includes the following: a medical evaluation completed within 60 days prior to or within 15 days after admission; an initial assessment completed within 30 days prior to admission or within 15 days after admission; a preliminary support plan developed within 30 days prior to admission or within 15 days after admission; a certification that the needs of a potential resident can be met prior to admission; and a final support plan within 30 days after admission.

These preadmission and assessment procedures provide both the resident and the ALR with the information to determine whether a potential resident's needs can be met by the ALR prior to admission.

Further, to allow for flexibility, the final-form rulemaking provides exceptions to the medical evaluation, initial assessment and preliminary support plan timelines under certain circumstances. The medical evaluation, initial assessment and the preliminary support plan can be completed 15 days after admission if one of the following conditions applies: the resident is being admitted directly to the ALR from an acute care hospital; the resident is being admitted to escape an abusive situation; or there is a situation where the resident has no alternative living arrangement. See §§ 2800.22 and 2800.224.

In addition to additional preadmission requirements, the Department also added language to clarify both the certification process and the admission process. The final-form rulemaking now defines who is authorized to make a certification. The Department added language that potential residents who do not need supplemental health care services and also potential residents who require the service of a licensed long-term care nursing facility may be admitted to an ALR. This added language was based on the statutory language of Act 56. See section 1057.3(b) of the code.

§ 2800.25. Resident—residence contract

IRRC questioned whether assisted living services must be listed separately or whether they can be bundled or unbundled to meet a resident's needs. IRRC also questioned the relationship between this section and § 2800.220, regarding assisted living services.

Response

The Department clarified the language in this section. Subsection (c)(2) now provides that a contract must specify the "fee schedule that lists the actual amount of charges for each of the assisted living services that are included in the resident's core service package in accordance with § 2800.220 (relating to service provision)." As previously mentioned, the Department further amended § 2800.220 to provide for two core service packages: an independent core package and an enhanced core package. These two packages provide different services based on a resident's needs. Since the services are clearly identified in the resident-residence contract, a potential resident will be able to accurately compare the prices of assisted living services offered by different ALRs. In addition to the core service packages, an ALR must provide supplemental health care services and the supplemental health care services must be packaged, contracted and priced separately from the contract. See section 1026(b)(iii) of the code.

The Department also carefully considered the comments of industry stakeholders who argued that there were too many services listed in the two core service packages that consumers neither "want nor need" and expressed concern that the final-form rulemaking would require individuals to accept and pay for services that consumers could do for themselves. The two examples cited most often were meals and personal laundry service as being services that many consumers would prefer to do on their own or ask family or friends for assistance. The Department heeded these concerns and made provision for the resident to "opt-out" of three services in the core service packages with an accompanying requirement that the contract price be adjusted accordingly. See § 2800.25(c)(2) and (l) (relating to resident-residence contract) and § 2800.220(d). The three services that a resident may opt out of are meals, housekeeping and laundry service. See § 2800.220(c)(1)(ii)—(iv).

§ 2800.30. Informed consent process

IRRC questioned whether the informed consent process will discourage providers from participating in the process, but also pointed out that other commentators believe that the informed consent provisions do not provide sufficient protection for consumers. IRRC requested that the Department explain how it developed the informed consent process and why it represents the best alternative to accomplish informed consent agreements.

Response

While the informed consent process generated numerous comments, including suggestions that the process be omitted, the Department is, nevertheless, required by Act 56 to develop standards for an informed consent process. Act 56, however, was silent with respect to those standards. Thus, the Department, based upon recommendations by the American Association of Retired Persons during the meetings that included industry stakeholders, adopted the procedures from House Bill 1583, Printer's Number 2012 (2007 Session) introduced by Representative Mundy.

In the proposed rulemaking, the Department was criticized for including a provision that would involve the local ombudsman in the informed consent process as an investigator or mediator rather than as an advocate for the resident. The Department deleted those provisions in the final-form rulemaking. Instead, the notification provisions for the availability of the ombudsman are the only references remaining in the final-form rulemaking. A rescission provision that allows either the resident or the ALR to cancel the agreement was also added in the final-form rulemaking, which further protects the rights of residents and providers. The Department also listened to the concerns of consumers by including in the proposed rulemaking that informed consent agreements are entered into only by the residence and the resident when there was "imminent" risk of "substantial" harm to the resident. On reconsideration, however, and in response to objections made by other commentators, the Department decided to delete these terms and adhere strictly to the provisions in the statute, which does not qualify the level or immediacy of the risk to the resident.

The Department further limited the informed consent process to a resident who is competent unless a legal representative is involved in the process. Based upon these changes, the Department finds that it has struck a balance between the competing concerns of the parties while at the same time ensuring that the informed consent process meets the legislative intent and protects both the providers and consumers involved in the process.

§ 2800.51. Criminal history checks

IRRC questioned the requirements for criminal history checks of employees in light of *Nixon v. Commonwealth*, 789 A.2d 376 (Pa. Cmwlth. Ct. 2001). IRRC specifically inquired how the Department will enforce this provision without violating the Nixon rule.

Response

The Department clarified in the final-form rulemaking that it will follow the hiring polices in the Department of Aging's policy concerning the Older Adults Protective Services Act (OAPSA) (35 P. S. §§ 10225.101—10225.5102). This policy is available at http://www.dsf.health.state.pa.us/health/lib/health/dncf-ciunit/nixon case.pdf. This represents the official administration policy and, until there is legislative action to address the *Nixon* case, the Department is bound by the policy enunciated by the Department of Aging, which is responsible for OAPSA. This approach was suggested to the Department by Community Legal Services and we find that is a sound recommendation.

§ 2800.56. Administrator staffing—Administrator hours

IRRC commented that the number of hours for an administrator to be present at the facility is excessive and that there is ambiguity in the proposed rulemaking regarding the number of hours that an administrator or a designee shall be physically present at the facility. IRRC asked for an explanation of why the Department is setting stricter standards for ALRs than for other long-term care facilities and noted that other types of long-term care facilities may share an administrator. IRRC also asked the Department to explain how many administrators would be needed for a typical facility to meet the requirements in a typical year and the associated costs. IRRC also requested the Department explain how the administrator requirements will accommodate the need for an administrator to attend offsite training sessions and meetings.

Response

The basis for the requirement that an administrator or a designee be present 40 hours per week, with 30 of those hours during normal business hours was the Department's expectation that the acuity needs of the residents in ALRs will be substantially higher than for residents of PCHs. (There was an inadvertent error in the proposed rulemaking that provided that the administrator had to be present at the facility an average of 30 hours per "month" during normal business hours. This has been corrected to require that the administrator be present at least 30 hours per week during normal business hours.)

The Department, however, never intended that an administrator or the administrator designee be present at the facility 24 hours a day, 365 days per year. Instead, the administrator designee is to be available to fill the balance of the required hours per week that an administrator is absent. The Department clarified the language in the final-form rulemaking to reflect that the administrator is able to go offsite for temporary absences, such as vacation and training. During those temporary absences, the administrator designee is required to be present to fill the required administrator hours in subsection (a). The Department also clarified in the final-form rulemaking that during the administrator's and administrator designee's absences, a direct care staff person shall be in charge of the facility. During those times, the administrator or administrator designee shall be on-call.

In addition to these clarifying amendments, the Department also amended the hourly requirement for administrators to 36 hours per week. The PCH regulations require that administrators be present in the PCH on average at least 20 hours per week. Because of the higher acuity levels anticipated in ALR residents, the Department did not think this was adequate administrative coverage and instead initially set the ALR standard to be 40 hours a week. However, the Department received many comments from industry stakeholders who felt that meeting this requirement would be a challenge. They felt it would be difficult for them to conduct the functions of the position and to attend required training if they had to spend that amount of time at the residence. In response, the requirement was reduced to 36 hours and maintained that this change, coupled with the language added to clarify that administrator designees may provide some of the coverage, address the concerns raised.

Further, in § 2800.11, allowance has been made for administrator-sharing for dually licensed ALRs and PCHs. Finally, in response to the question regarding costs of administrators, the Department provided this information in its analysis in the Regulatory Analysis Form.

§ 2800.56. Administrator staffing—Administrator designee

IRRC commented on the provision requiring the same training for an administrator designee as for the administrator. Specifically, IRRC asked why the Department is setting this training requirement.

Response

Based on the comments received, the Department amended the language regarding the requirements for an administrator designee. The administrator designee is not required to meet the same training requirements as the administrator. Instead, in the final-form rulemaking, the administrator designee shall meet the qualification and training requirements of a direct care staff person, have 3,000 hours of direct operational responsibility and pass the Department-approved competency-based training test. A number of considerations went into development of this requirement. Industry stakeholders suggested that having 3,000 hours of direct operational experience, which is one criteria for being an ALR administrator in Ohio, would represent sufficient experience to be an ALR administrator designee. The Department accepted this recommendation but, to ensure resident health and safety, chose to add that administrator designees shall also meet direct care staff requirements and pass the Department-approved competency-based training test.

§ 2800.60. Additional staffing based on the needs of the residents

IRRC recommended that the level of nursing training for the on-call nurse be specified in the final-form rulemaking.

Response

The Department agrees and made the change that the on-call nurse had to be licensed. This would allow either a licensed practical nurse (LPN) or a licensed registered nurse (RN) to fulfill that requirement. The requirements

for licensure of either are in 49 Pa. Code Chapter 21 (relating to State Board of Nursing).

§ 2800.63. First aid, CPR and obstructed airway training

IRRC commented that the requirement for "sufficient staff" is vague and does not provide a standard for protection that can be understood and implemented.

Response

The Department agrees with the comment and specified a numeric ratio of 1 staff to 35 residents in the final-form rulemaking.

§ 2800.98. Indoor activity space—Square footage requirements

§ 2800.101. Resident living units—Square footage requirements

§ 2800.104. Dining room—Square footage requirements

IRRC questioned why § 2800.101 (relating to resident living units) does not allow for exceptions to the living unit size as specified in Act 56. IRRC further questioned why the Department specified square footage size requirements for indoor activity spaces such as common areas and dining rooms and pointed out that parallel provisions in the PCH regulations do not have this specificity.

Response

Written request for a waiver of a specific requirement can be made under § 2800.19 (relating to waivers). Since there is already a section that provides for requesting a waiver of a requirement, the Department did not find it necessary to include a specific waiver subsection within proposed § 2800.101. Nevertheless, in response to IRRC and stakeholder comment, the Department revisited this issue on final-form rulemaking and decided to amend this section to include the same language in Act 56 regarding allowing exception to the size of the living unit to be made at the discretion of the Department. See section 1021(a)(2)(v) of the code.

The Department consulted with the Housing and Finance Agency, which recommended specifying the square footage for the indoor activity and dining room space and the Department found that the recommendations were appropriate since they are clear, measurable and enforceable. Since the Department is directed to "meet or exceed" the standards in the PCH regulations, these square footage requirements build on the PCH regulations in § 2600.98 (relating to indoor activity space) which require that the combined living room or lounge areas must "accommodate all residents at one time."

§ 2800.101. Resident living units—Development of square footage requirements

IRRC questioned how the Department developed the square footage requirements for resident living units. IRRC also asked what study or research was relied upon for determining the minimum square footage selected and how they best implement Act 56. IRRC also asked why these specific square footage requirements are necessary to protect public health, safety and welfare.

Response

If an individual resides in an ALR, that individual's living unit will be that person's home. The Department finds that the General Assembly, in enacting Act 56, intended that the minimum square footage for living units an ALR must be sufficient for a variety of types of consumers with a variety of needs. To accommodate a home-like atmosphere, including the required living space, bedroom space and kitchen capacity, the Department determined that adequate square footage would be required.

During the development of the proposed rulemaking, the Department asked for feedback from industry stakeholders and consumers regarding minimum square footage requirements for resident living units. Industry stakeholders argued that the minimum square footage for living units for new facility construction should be 150 square feet and for existing construction, 125 square feet. In contrast, consumers expressed concern that 250 square feet was inadequate, particularly for wheelchair users. Individuals in ALRs, as they age in place or if they have a disability and use a wheelchair, require sufficient room to move about comfortably and to have visitors come to their living units. The Department also surveyed other states as to their square footage requirements for ALRs. A number of states that are at the forefront of the assisted living movement, including Vermont, Iowa, Louisiana, Oregon, Washington and Hawaii, have square footage requirements over 200 square feet for individual living units. The Department also finds that this level of square footage is the direction that the industry is moving towards.

Based on comments and further meetings with stakeholders, the Department decided, however, to reduce the minimum square footage for new construction from the proposed 250 square feet to 225 square feet. The 225 square feet requirement should meet the needs of the residents for adequate space to accommodate both their living needs and mobility needs but also balance the concerns expressed by industry stakeholders related to costs. The Department notes that, according to the survey it conducted regarding square footage, there are PCHs that are interested in pursuing licensure as ALRs that easily meet or exceed the minimum 225 square feet requirement. The Department also specified that if two individuals share a room, the minimum square footage must be 300 square feet in the living unit.

With respect to IRRC's other comment regarding existing facilities and the square footage requirements, IRRC recommended that the Department identify how many licensed PCHs there are in this Commonwealth and how many meet the proposed minimum standard of 175 square feet in each living unit. Per IRRC's recommendation, as previously mentioned, in October 2008, the Department conducted a survey of the 1,437 PCHs licensed in this Commonwealth. It received 723 responses to the survey. Using the originally proposed square footage of 175, the Department estimated that there were approximately 220 PCHs that had at least 90% of their rooms that would meet this requirement.

Although the survey results support the minimum square footage requirements in the proposed rulemaking for existing facilities, based on comments and additional meetings with stakeholders, the Department decided, however, to reduce the square footage for existing facilities from the proposed 175 square feet to 160 square feet. Based on survey results, this change will increase the number of PCHs to approximately 243 that had at least 90% of their rooms that would meet this requirement.

This standard should balance the competing interests between existing facilities that want to convert to an ALR and the interests of the consumers and other interested parties who have requested adequate living space for residents of ALRs. The Department also specified that if two individuals share a room, the minimum square footage shall for existing facilities be 210 square feet in

the living unit. Finally, as previously noted, the Department clarified the language in this section to provide that exceptions to the size of the living unit may be made at the discretion of the Department. This mirrors the language in Act 56. See section 1021(a)(2)(v) of the code.

§ 2800.101. Resident living units—Relationship between square footage, affordability and accessibility

IRRC asked that the Department explain how it researched and assessed existing licensed PCHs in setting the square footage requirements in the final-form rulemaking for ALRs. It asked the Department to consider the input from the Pennsylvania Health Care Association and the Pennsylvania Association of Non-Profit Homes for the Aging regarding their comment that the square footage proposed by the Department appears high when compared to other states and that some consumers may wish to have a smaller living unit to save money. Also, IRRC requested that the Department explain how the method of specifying square footage will best provide for affordability and accessibility of ALRs for the population of this Commonwealth.

Response

The Department assessed existing PCHs in this Commonwealth by conducting a survey, the results of which are previously stated. The Department also received numerous comments from long-term living trade associations and had numerous discussions with them on this topic. In addition to this input, in considering the minimum square footage requirements for ALRs, the Department looked at other states to assess their requirements and found that 11 states (Washington, Oregon, Iowa, Arizona, Wisconsin, West Virginia, Louisiana, Vermont, Kansas, Kentucky and Hawaii) have single room occupancy requirements of 220 or more square feet. The Department finds that many of these states have vibrant assisted living programs and when the Commonwealth's program is underway, it will be in the top 12 states in terms of ALR room size.

§ 2800.101. Resident living units—Square footage requirements for residences in existence prior to the effective date of the final-form rulemaking

IRRC asked that the Department determine how many PCHs in existence at the time of the proposed rulemaking that the Department thinks would qualify for the 175 square foot minimum square footage requirement.

Response

As previously stated, in October 2008, the Department conducted a survey of the 1,437 PCHs licensed in this Commonwealth which revealed that approximately 220 PCHs had at least 90% of their rooms that would qualify under the 175 square footage requirement. Based on comments from industry stakeholders, the Department chose to decrease the square footage requirement to 160 square feet. Using the same survey results, the Department finds that approximately 243 PCHs had at least 90% of their rooms that would qualify based on the revised square footage requirements.

§ 2800.101. Resident living units—Evaluation of the feasibility of existing licensed PCHs being able to change their licensure to assisted living

IRRC commented that it is clear that many existing PCH licensees want to be licensed as ALRs. The Department acknowledged this interest by providing for different square footage for living units for existing facilities. The Department should explain how it researched and assessed existing licensed PCHs in setting the requirements in the ALR regulations. IRRC asked how many facilities in existence did the Department determine would qualify as ALRs and how many would not? Also, IRRC asked how these limits would sufficiently meet the needs of ALR residents.

Response

Act 56 requires that ALR regulations must meet or exceed the PCH regulations. In anticipation that many existing PCHs would be interested in either converting to ALRs or becoming dually licensed, the Department decided to use the PCH regulations as a framework in which to construct the ALR regulations. Doing that, however, meant balancing the ease with which PCHs could convert to ALRs against the significant differences between the two types of facilities. Much of the Department's research was done by examining the PCH regulations closely and determining which were transferable to ALRs and which were not. The Department then set into place an extensive stakeholder input process to work out differences and, when that was not possible, to use that process to make informed decisions.

Based on the October 2008 survey previously described and using the originally proposed square footage of 175 square feet for existing facilities, the Department estimated that there were approximately 220 PCHs that had at least 90% of their rooms that would meet the square footage requirements. Approximately 243 PCHs had 90% of their rooms that would qualify under a 160 square footage requirement.

In terms of how the number of potentially qualifying PCHs will meet the need in this Commonwealth for ALRs, the Department maintains that this is a good start. As new facilities come on line, this Commonwealth has the potential to grow a healthy home and community-based option for older residents and those persons with disabilities.

§ 2800.101. Resident living units—Kitchen capacity

IRRC questioned how the Department came up with the requirements for kitchen capacity for the living units and asked a series of questions about kitchen capacity. First, IRRC questioned why the Department required refrigerators, microwave ovens and bar-type sinks for newly constructed living units when Act 56 only specified that the living units must have "kitchen capacity, which may mean electrical outlets to have small appliances such as a microwave and refrigerator." See section 1021(a)(2)(iv) of the code. IRRC further inquired why microwaves and refrigerators are required for new construction, but not for existing facilities, and also asked how much this requirement increases costs to a resident. If a resident does not wish to use these items, IRRC asked why should the resident pay for them?

IRRC also asked about a discrepancy in the regulations between existing facilities and new construction regarding the removal of appliances based on safety considerations that are included in the new construction requirements but not for existing facilities. As to other required items for a living unit, IRRC questioned the list of required items and asks if residents may opt out of having these items.

Response

The Department made several significant changes to the final-form rulemaking with respect to kitchen capacity. In recognition of consumer choice, for both new construction and existing facilities, an ALR will be required to offer the resident the option to have a cooking

appliance or a small refrigerator, or both. If the resident wishes to have a cooking appliance or small refrigerator, or both, the ALR shall provide the appliances, unless the resident wishes to bring his own appliances. For both new construction and existing facilities, the final-form rulemaking provides for the removal of an appliance for resident safety or if the resident chooses to not have the appliance.

As to the costs for new construction, the Department submits that having a bar sink in the living unit is designed so that the resident can exercise maximum choice and have privacy and autonomy in living arrangement. As previously mentioned, the assisted living model of residential living emphasizes resident self-determination and choice. For an individual who chooses to cook his own meals, a small sink is necessary to allow the resident to wash dishes in a separate area. Otherwise, the resident would have to use the bathroom sink to wash dishes. At the same time, the Department is mindful that some residents may no longer wish to cook or have a cooking appliance in their living unit. The resulting language in the final-form rulemaking accomplishes an appropriate balance because it is directed at putting the consumer "in the driver's seat" as to the choice he makes about the accommodations in the living unit. As to existing facilities, the Department adopted the recommendation of industry stakeholders that many existing PCHs provide residents with access to a "country kitchen," which is separate from the facility's kitchen area but near enough to resident bedrooms to allow residents to prepare meals or wash dishes. To minimize costs to existing facilities, the Department adopted this recommendation and finds that it is reasonable to minimize costs to existing facilities that may wish to pursue licensure as an ALR.

As to whether a resident may opt out of having some of the other items listed in § 2800.101(j) and (q), the Department is required by Act 56 to "meet or exceed" the requirements set forth in the PCH regulations. Section 2600.101 require certain furnishings that are intended to protect the dignity, well-being and privacy of residents.

§ 2800.102. Bathrooms

IRRC recommended deletion of the phrase "applicable local, state and federal laws and guidelines."

Response

The Department agrees and deleted this phrase. The requirement for compliance with applicable Federal, State and local laws, ordinances and regulations is already required under § 2800.18 (relating to applicable laws).

§ 2800.108. Firearms and weapons

IRRC questioned the threshold question of safety of firearms and weapons in an ALR. IRRC recommended allowing a facility to prohibit weapons and to require an ALR to disclose whether it allows firearms and weapons to prospective residents in its admissions procedures and documents. IRRC also recommended that the terms "living area" and "common living area" be reconciled. Finally, IRRC recommended use of consistent terminology to include "firearms, weapons and ammunition" throughout this section.

Response

The Office of Attorney General tolled the proposed rulemaking on the basis that the Department initially sought to ban firearms and weapons from ALRs as recommended by industry stakeholders, consumers and other interested parties who advocated a ban on weapons and firearms. As a result of the Attorney General's comments, the Department modified the proposed rulemaking to require that ALRs, instead, shall have a written policy regarding firearms. In the final-form rulemaking, the Department further clarified that an ALR have a written policy on firearms, weapons and ammunition and that an ALR is not required to permit these items. This policy will be included in the resident handbook so that the prospective resident is fully informed of the ALR's policy in this area.

The Department also made the technical changes recommended by IRRC regarding use of consistent terminology regarding "common living areas" and "firearms, weapons and ammunition" in the final-form rulemaking. The Department decided to continue to use the term "common living area" for conformity since the requirements for PCH use the same language. See § 2600.108 (relating to firearms and weapons).

§ 2800.131. Fire extinguishers

IRRC questioned why this section exceeded the PCH standard for fire extinguishers and reiterated concerns expressed by commentators as to costs and safety risks associated with having fire extinguishers in each living unit and in each kitchen.

Response

The Department amended this section and will require a fire extinguisher for each floor, including walkways and common living areas every 3,000 square feet. This change was recommended jointly to the Department by industry stakeholders, consumers and other interested parties and is a reasonable standard that will protect health and safety of the residents.

§ 2800.142. Assistance with medical care and supplemental health care services

IRRC questioned the use of the phrase "such approval may not be unreasonably withheld."

Response

The Department deleted this language from the final-form rulemaking.

§ 2800.162. Meals

IRRC questioned what is meant by "appropriate cueing" as it relates to encouraging residents to eat and drink. IRRC commented that the requirement is vague. IRRC also questioned how this would apply to individuals who are cooking and eating in their own living units. IRRC recommended deletion of this provision or relocating it to § 2800.227.

Response

The Department concurs with IRRC and other commentators that this issue is more appropriately dealt with based on the individual's support plan in § 2800.227(d) so that it is tailored to individuals who eat their meals either in a congregate setting or individually in their own rooms. As a result, the Department added the language "as indicated in the resident's support plan" in subsection (g) of this section to clarify this requirement.

§ 2800.171. Transportation

IRRC questioned whether, when a residence provides its own vehicle, all vehicles must be wheelchair accessible and provide for other assistive devices the resident may need.

Response

The Department revised this provision after further consultation with stakeholders. The Department clarified

in the final-form rulemaking that if an ALR provides transportation, a minimum of one vehicle furnished by the ALR must be wheelchair accessible and provide room for other assistive equipment residents may need.

§ 2800.225. Additional assessments

IRRC questioned why the Department did not include language from § 2600.225(d) from the PCH regulations in the ALR regulations regarding determinations of the resident's need for a higher level of care and referral to an appropriate assessment agency.

Response

IRRC correctly points out that Act 56 may limit ALRs from accepting residents with certain conditions and health care needs. However, Act 56 also allows a facility to seek an exception from the Department to allow it to serve individuals with certain "excludable conditions." See section 1057.3(e) and (g) of the code. Since the ALR regulation is distinguishable from the PCH regulations in this regard, the Department did not adopt the language in § 2600.225(d). An individual who may need skilled long-term care services may be served in an ALR according to the individual's preferences and according to whether the ALR wishes to provide this care by seeking an exception from the Department to provide this care. Requiring a higher level of care, therefore, is not a parallel concept for ALRs and PCHs since and ALRs allow for aging in place may serve individuals whose acuity needs change over time, and may, if an exception is granted for an excludable condition, actually serve an individual who would otherwise have to be transferred to a nursing facility. A PCH, however, may not serve an individual who "requires the services in or of a long-term care facility." See section 1001 of the code.

§ 2800.224. Initial assessment and preliminary support plan

§ 2800.227. Development of the final support plan

IRRC reflected the comments of many commentators who objected to the requirement that a licensed RN had to review and approve a support plan prepared by an LPN.

Response

The Department declined to make this change. In both nursing facilities and in home and community-based long-term living programs, RNs must review and approve support plans. Since we expect that ALRs will have residents with higher acuity levels than those in PCHs, the Department determined that use of RN expertise was needed.

§ 2800.228. Transfer and discharge

IRRC questioned how this section protects the rights of residents to be treated fairly and properly before a transfer or discharge occurs. IRRC also questioned the reliance on providing notice to an outside agency, in this case, an ombudsman. IRRC commented that it is not clear how the Department would be aware of whether the processes regarding notification of the ombudsman are being carried out in a timely manner. Also, as to the standards for admission or discharge, IRRC pointed out that the Department is required by regulation to establish the standards required for certification that a consumer may not be admitted or retained at an ALR. Finally, IRRC also asked how the Department can guarantee a timely and fair treatment of a consumer appeal.

Response

To protect an resident, the grounds for transfer or discharge from an ALR are limited to those specified in subsection (h). In addition, to ensure a resident is being treated fairly and properly, the Department has specifically detailed the transfer and discharge process, including a 30-day advance written notice to the resident, the resident's family or designated person. This notice must include the specific reason for transfer or discharge, the effective date of the transfer or discharge, the location that the resident will be transferred or discharged to, an explanation of the measures a resident or the resident's designated person can take if they disagree with the decision to transfer or discharge and the name, mailing address, telephone number of the State and local long-term care ombudsman. In addition, the Department added a provision that states that the notice must also provide the resident's transfer or discharge rights, as applicable. To ensure an ALR is abiding by these notice provisions, the Department requires the resident record to include the notice and also the reason for termination of services or transfer of a resident. See § 2800.252 (relating to content of resident records).

The Department agreed with IRRC's comment regarding the certification language regarding transfer or discharge. Therefore, the Department added this language in subsection (i).

The Department, however, is not in the position or granted the authority for establishing "expedited" resident appeals regarding transfer or discharge. The Department does not have jurisdiction under Article X of the code or Act 56 to adjudicate resident appeals. A resident's transfer or discharge is a contract matter between the resident and the ALR and, as such, the Court of Common Pleas has jurisdiction unless other provisions are made in the contract for dispute resolution, such as mediation or arbitration.

§ 2800.229. Excludable conditions; exceptions

IRRC asked why the certification language is limited to this section regarding excludable conditions. It stated that it is not clear that certification by a provider for a resident's admission or retention is limited to situations involving the excludable conditions listed in section 1057.3(e) of the code.

Response

The Department agrees with IRRC's comment that the certification requirement is not merely limited to excludable conditions and added language to § 2800.22 and § 2800.228 (relating to transfer and discharge) in accordance with Act 56.

Miscellaneous clarity issues

IRRC commented that various sections of the regulations provide for forms "as specified by the Department." IRRC further suggested that the Department take advantage of the stakeholder process in the development and content of these forms. IRRC also inquired how the Department will make these forms available.

Response

After publication of this final-form rulemaking, the Department intends to work closely with stakeholders during the 6-month interval between the publication date and the effective date of the final-form rulemaking in the development and content of these forms.

Additional changes to the final-form rulemaking

In addition to the comments submitted by IRRC and other commentators regarding the proposed rulemaking, as stated previously, the Department received 79 more comments from consumers, industry stakeholders and

other interested parties after the issuance of the draft final-form regulation on June 24, 2009. A number of those changes have been previously addressed. Additional changes were made to the final-form rulemaking based on these comments, including those described as follows.

Resident rights

Consumers commented that there are resident rights scattered throughout the regulations and requested that the residents rights be placed in one location.

Response

In response to this concern the Department has prepared an Appendix containing the resident rights in the regulations. See Appendix A.

§ 2800.54. Qualifications of direct care staff persons

Numerous commentators interpreted this section to mean that every direct care staff person must be able to communicate in all languages to meet the provision that states that they must "be able to communicate in a mode or manner understood by the resident."

Response

The Department's intent was never to require that staff persons must be able to communicate in all languages. The Department clarified in the final-form rulemaking that strategies that promote interactive communication be developed as part of a resident's support plan.

§ 2800.60. Additional staffing based on the needs of the residents

Numerous industry stakeholders questioned if they would be required to have a licensed nurse on call even if they already have one on staff.

Response

To address this concern raised by industry stakeholders, the Department changed this section to allow that a licensed nurse must be on call or in the building.

§ 2800.171. Transportation

Many industry stakeholders contended that transportation to medical appointments and social events should not be required unless they are scheduled by the residence. Many also objected that this section did not specify a limit on the distance they would be required to travel.

Response

The Department revised subsection (a) to require that residences shall provide or arrange transportation on "a regular weekly basis that permits residents to schedule medical and social appointments within a reasonable local area." This will allow residences the ability to manage their work schedules while also meeting the needs of residents to get to medical and social appointments. While the Department considered a specific radius of travel, given the differences in access to public transportation and geographical differences in this Commonwealth, specificity was not appropriate. The Department holds that a rule of reasonableness should apply.

§ 2800.53. Qualifications and responsibilities of administrators

§ 2800.64. Administrator training and orientation

Many comments were received from industry stakeholders advocating for the grandfathering of PCH administrators and nursing home administrators as ALR administrators. Many comments were received from others advocating that no grandfathering be allowed.

Response

The Department took both of these views into consideration. While recognizing that both PCH administrators and nursing home administrators are in a unique position based on their experience to transition to ALR administrators, they should also be qualified to address the broad range of needs of the populations served by ALRs. Subsequently, §§ 2800.53 and 2800.64 (relating to qualifications and responsibilities of administrators; and administrator training and orientation) have been amended, not to provide for grandfathering, but to allow each of these professionals to meet different sets of qualifications and training requirements while requiring passage of a competency test.

Regulatory Review Act

Under section 5(a) of the Regulatory Review Act (71 P. S. § 745.5(a)), on May 3, 2010, the Department submitted a copy of this final-form rulemaking to IRRC and to the House Committee on Aging and Older Adult Services and the Senate Committee on Public Health and Welfare (Committees) for review and comment.

Under section 5(c) of the Regulatory Review Act, IRRC and the Committees were provided with copies of the comments received during the public comment period, as well as other documents when requested. In preparing the final-form rulemaking, the Department has considered all comments from IRRC, the Committees and the public.

Under section 5.1(j.2) of the Regulatory Review Act (71 P. S. § 745.5a(j.2)), on June 2, 2010, the final-form rulemaking was deemed approved by the Committees. Under section 5.1(e) of the Regulatory Review Act, IRRC met on June 3, 2010, and approved the final-form rulemaking.

Findings

The Department finds that:

(1) Public notice of intention to adopt the administrative regulation by this order has been given under sections 201 and 202 of the Commonwealth Documents Law (45 P. S. §§ 1201 and 1202) and the regulations thereunder, 1 Pa. Code §§ 7.1 and 7.2.

(2) Adoption of this final-form rulemaking in the manner provided by this order is necessary and appropriate for the administration and enforcement of the code.

Order

The Department, acting under sections 211, 213 and Article X of the code, orders that: (a) The regulations of the Department, 55 Pa. Code Chapter 2800, are amended by adding §§ 2800.1—2800.5, 2800.11—2800.30, 2800.41—2800.44, 2800.51—2800.69, 2800.81—2800.109, 2800.121—2800.133, 2800.141—2800.144, 2800.161—2800.164, 2800.171, 2800.181—2800.191, 2800.201—2800.203, 2800.220—2800.229, 2800.231—2800.239, 2800.251—2800.254 and 2800.261—2800.270 to read as set forth in Annex A.

(b) The Secretary of the Department shall submit this order and Annex A to the Offices of General Counsel and Attorney General for approval as to legality and form as required by law.

(c) The Secretary of the Department shall certify and deposit this order and Annex A with the Legislative Reference Bureau as required by law.

(d) This order shall take effect January 18, 2011.

HARRIET DICHTER,
Secretary

(*Editor's Note*: For the text of the order of the Independent Regulatory Review Commission relating to this document, see 40 Pa.B. 3471 (June 19, 2010).)

Fiscal Note: 14-514. (1) General Fund; (2) Implementing Year 2009-10 is $0; (3) 1st Succeeding Year 2010-11 is $437,000; 2nd Succeeding Year 2011-12 is $0; 3rd Succeeding Year 2012-13 is $0; 4th Succeeding Year 2013-14 is $0; 5th Succeeding Year 2014-15 is $0; (4) 2009-10 Program—$38,115,000; 2008-09 Program—$34,843,000; 2007-08 Program—$30,968,000; (7) County Administration Statewide; (8) recommends adoption. Funds have been included in the budget to cover the increase in 2010-11. We expect projected fee revenue will cover any costs in the remaining years.

Annex A

TITLE 55. PUBLIC WELFARE

PART IV. ADULT SERVICES MANUAL

Subpart E. RESIDENTIAL AGENCIES/FACILITIES SERVICES

CHAPTER 2800. ASSISTED LIVING RESIDENCES

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GENERAL PROVISIONS

§ 2800.1. Purpose.

(a) The purpose of this chapter is to protect the health, safety and well-being of assisted living residents.

(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, exercise decision-making and personal choice.

§ 2800.2. Scope.

(a) This chapter applies to assisted living residences as defined in this chapter, and contains the minimum requirements that shall be met to obtain a license to operate an assisted living residence.

(b) This chapter does not apply to personal care homes, domiciliary care homes, independent living communities or commercial boarding homes.

§ 2800.3. Inspections and licenses.

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

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

(c) A license will be issued to the legal entity by the Department if, after an investigation by an authorized agent of the Department, the requirements for a license are met.

(d) The assisted living residence shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the assisted living residence.

§ 2800.4. Definitions.

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

ADL—Activities of daily living—The term includes eating, drinking, ambulating, transferring in and out of a bed or chair, toileting, bladder and bowel management, personal hygiene, securing health care, managing health care, self-administering medication and proper turning and positioning in a bed or chair.

Abuse—The occurrence of one or more of the following acts:

(i) The infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish.

(ii) The willful deprivation by the assisted living residence or its staff persons of goods or services which are necessary to maintain physical or mental health.

(iii) Sexual harassment, rape or abuse, as defined in 23 Pa.C.S. Chapter 61 (relating to protection from abuse).

(iv) Exploitation by an act or a course of conduct, including misrepresentation or failure to obtain informed consent which results in monetary, personal or other benefit, gain or profit for the perpetrator, or monetary or personal loss to the resident.

(v) Neglect of the resident, which results in physical harm, pain or mental anguish.

(vi) Abandonment or desertion by the assisted living residence or its staff persons.

Adult—An individual who is 18 years of age or older.

Age in place or *aging in place*—Receiving care and services at a licensed assisted living residence to accommodate changing needs and preferences in order to remain in the assisted living residence.

Agent—An individual authorized by the Department to enter, visit, inspect or conduct an investigation of an assisted living residence.

Ancillary staff person—An individual who provides services for the residents other than direct assistance with activities of daily living. Ancillary staff may include staff who do not provide direct care but who conduct assessment, care planning or care management activities, and who meet the direct care staff qualifications and training requirements. Ancillary staff may also include RNs, LPNs, dieticians, or skilled professionals who meet the requirements of their professional licensure and the direct care staff requirements, if they also provide direct assistance with activities of daily living. Other ancillary staff may include activities planners, housekeepers, cooking staff or facilities staff.

Appropriate assessment agency—An organization serving adults who are older or adults with disabilities, such as a county mental health/mental retardation agency, a drug and alcohol agency, an area agency on aging or another human service agency or an individual in an occupation maintaining contact with adults who are older and adults with disabilities, such as medicine, nursing or rehabilitative therapies.

Area agency on aging—The local agency designated by the Department of Aging as defined in section 2202-A of The Administrative Code of 1929 (71 P. S. § 581-2).

Assessment—An instrument that includes screening of a resident or potential resident to determine whether the resident or potential resident requires the services of an assisted living residence.

Assisted living residence or *residence*—Any premises in which food, shelter, assisted living services, assistance or supervision and supplemental health care services are

provided for a period exceeding 24-hours for four or more adults who are not relatives of the operator, who require assistance or supervision in matters such as dressing, bathing, diet, financial management, evacuation from the residence in the event of an emergency or medication prescribed for self-administration.

Assisted living residence administrator—An individual who is charged with the general administration of an assisted living residence, whether or not the individual has an ownership interest in the residence or his function and duties are shared with other individuals.

Assisted living services—Services as defined in § 2800.220(b) (relating to service provision).

Basic cognitive support services—These services include the following:

(i) Intermittent cueing.

(ii) Redirecting.

(iii) Environmental cues.

(iv) Measures to address wandering.

(v) Dementia-specific activity programming.

(vi) Specialized communication techniques.

CAM—Complementary and alternative medications—Practices, substances and ideas used to prevent or treat illness or promote health and well-being outside the realm of modern conventional medicine. Alternative medicine is used alone or instead of conventional medicine. Complementary medicine is used along with or in addition to conventional medicine.

CPB—Cognitive, physical, behavioral.

CPR—Cardiopulmonary resuscitation.

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.

(ii) The term includes assessment, health support services and a full range of dementia-capable activity programming and crisis management.

Commercial boarding home—A type of residential living facility providing only food and shelter, or other services normally provided by a hotel, for payment, for individuals who require no services beyond food, shelter and other services usually found in hotel or apartment rental.

Common living area—Includes any of the following:

(i) Dining room.

(ii) Indoor activity space.

(iii) Recreational space.

(iv) Swimming area, if located in the residence.

Complaint—A written or oral criticism, dispute or objection presented by or on behalf of a resident to the Department regarding the care, operations or management of an assisted living residence.

Day—Calendar day.

Dementia—A clinical syndrome characterized by a decline of long duration in mental function in an alert individual. Symptoms of dementia may include memory loss, personality change, chronic wandering and the loss or diminishing of other cognitive abilities, such as learning ability, judgment, comprehension, attention and orientation to time and place and to oneself.

Department—The Department of Public Welfare of the Commonwealth.

Designated person—An individual who may be chosen by the resident and documented in the resident's record, to be notified in case of an emergency, termination of service, assisted living residence closure or other situations as indicated by the resident or as required by this chapter. A designated person may be the resident's legal representative or an advocate.

Designee—A staff person authorized in writing to act in the administrator's absence.

Direct care staff person—A staff person who directly assists residents with activities of daily living, and instrumental activities of daily living and provides services or is otherwise responsible for the health, safety and well-being of the residents.

Discharge—Termination of an individual's residency in an assisted living residence.

Distinct part—A portion of a building that is visually separated such as a wing or floor, or sections or parts of floors.

Emergency medical plan—A plan that ensures immediate and direct access to medical care and treatment for serious injury or illness, or both.

Financial management—

(i) An assisted living service requested or required by the resident in accordance with his support plan, which includes taking responsibility for or assisting with paying bills, budgeting, maintaining accurate records of income and disbursements, safekeeping funds and making funds available to the resident upon request.

(ii) The term does not include solely storing funds in a safe place as a convenience for a resident.

Fire safety expert—A member of a local fire department, fire protection engineer, Commonwealth-certified fire protection instructor, college instructor in fire science, county or Commonwealth fire school, volunteer trained and certified by a county or Commonwealth fire school, an insurance company loss control representative, Department of Labor and Industry building code inspector or construction code official.

Health care or human services field—Includes the following:

(i) Child welfare services.

(ii) Adult services.

(iii) Older adult services.

(iv) Mental health/mental retardation services.

(v) Drug and alcohol services.

(vi) Services for individuals with disabilities.

(vii) Medicine.

(viii) Nursing.

(ix) Rehabilitative services.

(x) Any other human service or occupation that maintains contact with adults who are older or adults and children with disabilities.

Housekeeping—The cleaning of the living unit and common living areas. Cleaning of the living unit includes

at least weekly dusting, sweeping, vacuuming, mopping, emptying trash, and cleaning of bathroom, counters, refrigerator and microwave oven, if these appliances are in the resident's living area. Housekeeping for common living areas means keeping them in clean sanitary condition.

IADL—Instrumental activities of daily living—The term includes the following activities when done on behalf of a resident:

(i) Doing laundry.

(ii) Shopping.

(iii) Securing and using transportation.

(iv) Financial management.

(v) Using a telephone.

(vi) Making and keeping appointments.

(vii) Caring for personal possessions.

(viii) Writing correspondence.

(ix) Engaging in social and leisure activities.

(x) Using a prosthetic device.

(xi) Obtaining and keeping clean, seasonal clothing.

INRBI—Intense neurobehavioral rehabilitation after brain injury.

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.

LPN—Licensed practical nurse.

Legal entity—A person, society, corporation, governing authority or partnership legally responsible for the administration and operation of an assisted living residence.

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

License—A certificate of compliance issued by the Department permitting the operation of an assisted living residence, at a given location, for a specific period of time, for a specified capacity, according to Chapter 20 (relating to licensure or approval of facilities and agencies).

Licensee—A person legally responsible for the operations of an assisted living residence licensed in accordance with this chapter.

Long-term care ombudsman—A representative of the Office of the State Long-Term Care Ombudsman in the Department of Aging who investigates and seeks to resolve complaints made by or on behalf of individuals who are 60 years of age or older who are consumers of long-term care services. These complaints may relate to action, inaction or decisions of providers of long-term care services, of public agencies, of social service agencies or their representatives, which may adversely affect the health, safety, well-being or rights of these consumers.

Mobile resident—

(i) A resident who is physically and mentally capable of vacating the assisted living residence on the resident's own power or with limited physical or oral assistance in the case of an emergency, including the capability to ascend or descend stairs if present on the exit path.

(A) Physical assistance means assistance in getting to one's feet or into a wheelchair, walker or prosthetic device.

(B) Oral assistance means giving instructions to assist the resident in vacating the assisted living residence.

(ii) The term includes an individual who is able to effectively operate an ambulation device required for moving from one place to another, and able to understand and carry out instructions for vacating the assisted living residence.

Neglect—The failure of an assisted living residence or its staff persons to provide goods or services essential to avoid a clear and serious threat to the physical or mental health of a resident. The failure or omission to provide the care, supervision and services that the assisted living residence has voluntarily, or by contract, agreed to provide and that are necessary to maintain the resident's health, safety and well-being, including assisted living services, food, clothing, medicine, shelter, supervision and medical services. Neglect may be repeated conduct or a single incident.

OTC—Over-the-counter or nonprescription.

Premises—The grounds and buildings on the same grounds, used for providing services required by residents.

Protective services unit—The local area agency on aging unit designated by the Department of Aging to investigate allegations of abuse of adults who are 60 years of age or older and assess the need for protective interventions.

RN—Registered nurse.

Referral agent—An agency or individual who arranges for or assists, or both, with placement of a resident into an assisted living residence.

Relative—A spouse, parent, child, stepparent, stepchild, grandparent, grandchild, brother, sister, half-brother, half-sister, aunt, uncle, niece or nephew.

Resident—An adult, unrelated to the legal entity, who resides in an assisted living residence, and who may require assisted living services or supplemental health care services, or both.

Resident with mobility needs—An adult who is unable to move from one location to another, has difficulty in understanding and carrying out instructions without the continued full assistance of other individuals or is incapable of independently operating an ambulation device, such as a wheelchair, prosthesis, walker or cane to exit a building.

Restraint—A manual, chemical or mechanical device used to limit or restrict the movement or normal function of an individual or a portion of the individual's body.

SSI—Supplemental Security Income.

Secretary—The Secretary of the Department.

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.

Specialized cognitive support services—These services include the following:

(i) Nonpharmacological interventions.

(ii) Dining with dignity.

(iii) Routines and roles.

(iv) Close of day programming.

(v) Pain management and person-centered care planning.

(vi) Implementation and management.

Staff person—An individual who works for the assisted living residence for compensation either on payroll or under contract.

Supplemental health care services—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 under the Health Care Facilities Act (35 P. S. §§ 448.101—448.901).

Support plan—A written document that describes for each resident the resident's care, service or treatment needs based on the assessment of the resident, and when the care, service or treatment will be provided, and by whom.

Third-party provider—Any contractor, subcontractor, agents or designated providers under contract with the resident or residence to provide services to any resident.

Transfer—Movement of a resident within the assisted living residence or to a temporary placement outside the assisted living residence.

Volunteer—

(i) An individual who, of his own free will, and without monetary compensation, provides direct care services for residents in the assisted living residence.

(ii) The term does not include visitors or individuals who provide nondirect services or entertainment on an occasional basis.

§ 2800.5. Access.

(a) The administrator, administrator designee or staff person designated under § 2800.56(c) (relating to administrator staffing) shall provide, upon request, immediate access to the residence, the residents and records to:

(1) Agents of the Department.

(2) Representatives of the area agency on aging.

(3) Representatives of the Long-Term Care Ombudsman Program.

(4) Representatives of the protection and advocacy system for individuals with disabilities designated under the Protection and Advocacy for Individual Rights Program of the Vocational Rehabilitation and Rehabilitation Services Act (29 U.S.C.A. § 794e), the Protection and Advocacy for Individuals with Mental Illness Act (42 U.S.C.A. §§ 10801—10851) and the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C.A. §§ 15041—15043).

(5) The resident's designated person, if so requested by the resident. The access to records under this paragraph is limited to the records of the resident.

(b) The administrator, administrator designee or staff person designated under § 2800.56(c) shall permit community service organizations and representatives of legal services programs to have access to the residence during visitation hours or by appointment for the purpose of assisting or informing the residents of the availability of services and assistance. A resident or a resident's designated person if so authorized may decline the services of the community service organization or the legal service program.

GENERAL REQUIREMENTS

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

(a) Except for § 20.32 (relating to announced inspections), the requirements in Chapter 20 (relating to licensure or approval of facilities and agencies) apply to assisted living residences.

(b) Before a residence is initially licensed and permitted to open, operate or admit residents, it will be inspected by the Department and found to be in compliance with applicable laws and regulations including this chapter. The Department will reinspect newly licensed residences within 3 months of the date of initial licensure.

(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 $300 license application or renewal fee.

(2) A $75 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.

(d) A person, organization or program may not use the term "assisted living" in any name or written material, except as a licensee in accordance with this chapter. Corporate entities which own subsidiaries that are licensed as assisted living residences may not use the term "assisted living" in any written material to market programs that are not licensed in accordance with this chapter.

(e) Multiple buildings located on the same premises may apply for a single assisted living residence license.

(f) A licensed assisted living residence may submit an application and a $150 application fee to the Department requesting special care designation. If the Department determines that the residence meets the requirements for special care designation, the residence will be issued a license indicating special care designation.

(g) A licensed personal care home may submit an application to the Department requesting dual licensure if the licensed personal care home and the assisted living residence are collocated in the same building and are each located in a distinct part of the building. If the Department determines that the licensed facility meets all of the requirements of this chapter, the facility will be issued a dual license.

(1) A facility that is dually licensed may not segregate residents or transfer residents from one licensed facility to another based on payment source.

(2) A facility that is dually licensed may request approval from the Department to share the administrator for the two licensed facilities by requesting a waiver of the administrator hourly staffing requirements contained

in § 2800.56 (relating to administrator staffing). The qualifications for a shared administrator must be as set forth in this chapter.

§ 2800.12. Appeals.

(a) Appeals related to the licensure or approval of the assisted living residence shall be made in accordance with 1 Pa. Code Part II (relating to General Rules of Administrative Practice and Procedure (GRAPP)).

(b) Appeals related to the licensure or approval of the assisted living residence shall be made by filing a petition within 30 days after service of notice of the action.

(c) Subsection (b) supersedes the appeal period of 1 Pa. Code § 35.20 (relating to appeals from actions of the staff).

§ 2800.13. Maximum capacity.

(a) The maximum capacity is the total number of residents who are permitted to reside in the residence at any time. A request to increase the capacity shall be submitted to the Department and other applicable authorities and approved prior to the admission of additional residents. The maximum capacity is limited by physical plant space and other applicable laws and regulations.

(b) The maximum capacity specified on the license may not be exceeded.

§ 2800.14. Fire safety approval.

(a) Prior to issuance of a license under this chapter, a written fire safety approval from the Department of Labor and Industry, the Department of Health or the appropriate local building authority under the Pennsylvania Construction Code Act (35 P. S. §§ 7210.101—7210.1103) is required.

(b) If the fire safety approval is withdrawn or restricted, the residence shall notify the Department orally immediately, and in writing, within 48 hours of the withdrawal or restriction.

(c) If a building is structurally renovated or altered after the initial fire safety approval is issued, the residence shall submit the new fire safety approval, or written certification that a new fire safety approval is not required, from the appropriate fire safety authority. This documentation shall be submitted to the Department within 15 days of the completion of the renovation or alteration.

(d) The Department will request additional fire safety inspections by the appropriate agency if possible fire safety violations are observed during an inspection by the Department.

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

§ 2800.15. Abuse reporting covered by law.

(a) The residence shall immediately report suspected abuse of a resident served in the residence in accordance with the Older Adult Protective Services Act (35 P. S. §§ 10225.701—10225.707) and 6 Pa. Code §§ 15.21—15.27 (relating to reporting suspected abuse, neglect, abandonment or exploitation) and comply with the requirements regarding restrictions on staff persons.

(b) If there is an allegation of abuse of a resident involving a residence's staff person, the residence shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

(c) The residence shall immediately submit to the Department's assisted living residence office a plan of supervision or notice of suspension of the affected staff person.

(d) The residence shall immediately notify the resident and the resident's designated person of a report of suspected abuse or neglect involving the resident.

§ 2800.16. Reportable incidents and conditions.

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

(1) The death of a resident.

(2) A physical act by a resident to commit suicide.

(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.

(4) A violation of a resident's rights in §§ 2800.41—2800.44 (relating to resident rights).

(5) An unexplained absence of a resident for 24 hours or more, or when the support plan so provides, a period of less than 24 hours, or an absence of a resident from a special care unit.

(6) Misuse of a resident's funds by the residence's staff persons or legal entity.

(7) An outbreak of a serious communicable disease as defined in 28 Pa. Code § 27.2 (relating to specific identified reportable diseases, infections and conditions).

(8) Food poisoning of residents.

(9) A physical or sexual assault by or against a resident.

(10) Fire or structural damage to the residence.

(11) An incident requiring the services of an emergency management agency, fire department or law enforcement agency, except for false alarms.

(12) A complaint of resident abuse, suspected resident abuse or referral of a complaint of resident abuse to a local authority.

(13) A prescription medication error as defined in § 2800.188 (relating to medication errors).

(14) An emergency in which the procedures under § 2800.107 (relating to emergency preparedness) are implemented.

(15) An unscheduled closure of the residence or the relocation of the residents.

(16) Bankruptcy filed by the legal entity.

(17) A criminal conviction against the legal entity, administrator or staff that is subsequent to the reporting on the criminal history checks under § 2800.51 (relating to criminal history checks).

(18) A termination notice from a utility.

(19) A violation of the health and safety laws under § 2800.18 (relating to applicable laws).

(20) An absence of staff so that residents receive inadequate care as defined by the respective resident's support plan.

(b) The residence shall develop and implement written policies and procedures on the prevention, reporting, notification, investigation and management of reportable incidents and conditions.

(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. The residence shall immediately report the incident or condition to the resident's family and the resident's designated person. 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.

(e) If the residence's final report validates the occurrence of the alleged incident or condition, the affected resident and other residents who could potentially be harmed or his designated person shall also be informed immediately following the conclusion of the investigation.

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

§ 2800.17. Confidentiality of records.

Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

§ 2800.18. Applicable laws.

A residence shall comply with applicable Federal, State and local laws, ordinances and regulations.

§ 2800.19. Waivers.

(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:

(1) There is no jeopardy to the residents.

(2) There is an alternative for providing an equivalent level of health, safety and well-being protection of the residents.

(3) Residents will benefit from the waiver of the requirement.

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

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

(d) At least 30 days prior to the submission of the completed written waiver request to the Department, the residence shall provide a copy of the completed written waiver request to the affected resident and designated person to provide the opportunity to submit comments to the Department. The residence shall provide the affected resident and designated person with the name, address and telephone number of the Department staff person to submit comments.

(e) The residence shall discuss the waiver request with the affected resident and designated person upon the request of the resident or designated person.

(f) The residence shall notify the affected resident and designated person of the approval or denial of the waiver. A copy of the waiver request and the Department's written decision shall be posted in a conspicuous and public place within the residence.

(g) The Department will review waivers annually to determine compliance with the conditions required by the waiver. The Department may revoke the waiver if the conditions required by the waiver are not met. When the Department revokes a standing waiver from a residence that residence may appeal the revocation consistent with § 2800.12 (relating to appeals).

§ 2800.20. Financial management.

(a) A resident may manage his personal finances unless the resident has a guardian of his estate.

(b) If the residence provides assistance with financial management or holds resident funds, the following requirements apply:

(1) The residence shall keep a record of financial transactions with the resident, including the dates, amounts of deposits, amounts of withdrawals and the current balance.

(2) Resident funds shall be disbursed during normal business hours within 24 hours of the resident's request.

(3) The residence shall obtain a written receipt from the resident for cash disbursements at the time of disbursement.

(4) Resident funds and property shall only be used for the resident's benefit.

(5) Commingling of resident funds and residence funds is prohibited.

(6) If a residence is holding more than $200 for a resident for more than 2 consecutive months, the administrator shall notify the resident and offer assistance in establishing an interest-bearing account in the resident's name at a local Federally-insured financial institution. This does not include security deposits.

(7) The legal entity, administrator and staff persons of the residence are prohibited from being assigned power of attorney or guardianship of a resident or a resident's estate.

(8) The residence shall give the resident and the resident's designated person, an itemized account of financial transactions made on the resident's behalf on a quarterly basis.

(9) A copy of the itemized account shall be kept in the resident's record.

(10) The residence shall provide the resident the opportunity to review his own financial record upon request during normal business hours.

§ 2800.21. Offsite services.

If services or activities are provided by the residence at a location other than the premises, the residence shall ensure that the residents' support plans are followed and that the health and safety needs of the residents are met.

§ 2800.22. Application and admission.

(a) *Documentation*. The following admission documents shall be completed for each resident:

(1) Medical evaluation completed within 60 days prior to admission on a form specified by the Department. The medical evaluation may be completed within 15 days after admission if one of the following conditions applies:

(i) The resident is being admitted directly to the residence from an acute care hospital.

(ii) The resident is being admitted to escape from an abusive situation.

(iii) The resident has no alternative living arrangement.

(2) Assisted living resident initial assessment completed within 30 days prior to admission on a form specified by the Department. The initial assessment may be completed within 15 days after admission subject to § 2800.224 (relating to initial assessment and preliminary support plan).

(3) Preliminary support plan developed within 30 days prior to admission. The preliminary support plan may be completed within 15 days after admission if one of the following conditions applies:

(i) The resident is being admitted directly to the residence from an acute care hospital.

(ii) The resident is being admitted to escape from an abusive situation.

(iii) The resident has no alternative living arrangement.

(4) Final support plan is developed and implemented within 30 days after admission.

(5) Resident-residence contract is completed prior to admission or within 24 hours after admission.

(6) Medical evaluations, resident assessments and support plans may be subsequently updated as needed, but no less frequently than required in §§ 2800.225 and 2800.227 (relating to additional assessments; and development of the final support plan).

(b) *Certification.*

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

(2) The certification shall be made by one of the following persons:

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

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

(iii) The medical director of the residence.

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

(c) *Supplemental health care.* A potential resident who requires assisted living services but does not currently require assistance in obtaining supplemental health care services may be admitted to the residence, provided the resident is only provided supplemental health care services required or requested by the resident. When supplemental health care services are required, the residence shall develop a preliminary support plan as required in § 2800.224. This subsection applies to residents under any of the following circumstances:

(1) A resident who currently does not require assistance in obtaining supplemental health care services, but who may require supplemental health care services in the future.

(2) A resident who wishes to obtain assistance in obtaining supplemental health care services.

(3) A resident who resides in a residence in which supplemental health care services are available.

(d) *Adults requiring services of a long-term care nursing facility.* Adults requiring the services of a licensed long-term care nursing facility, including those with mobility needs, may reside in a residence, provided that appropriate supplemental health care services are provided those residents and the design, construction, staffing and operation of the residence allows for their safe emergency evacuation.

(e) *Written disclosure.* 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:

(1) A list of the nonwaivable resident rights.

(2) A copy of the contract the resident will be asked to sign.

(3) A copy of residence rules and resident handbook. The resident handbook shall be approved by the Department.

(4) Specific information about the following:

(i) The services and the core packages that are offered by the residence.

(ii) The cost of those services and of the core packages to the potential resident.

(iii) When a potential resident may require the services offered in a different core package.

(iv) The contact information for the Department.

(v) The licensing status of the most recent inspection reports and instructions for access to the Department's public website for information on the residence's most recent inspection reports.

(vi) The number of living units in the residence that comply with the Americans with Disabilities Act (42 U.S.C.A. §§ 12101—12213).

(vii) Disclosure of any waivers that have been approved for the residence and are still in effect.

§ 2800.23. Activities.

(a) A residence shall provide each resident with assistance with ADLs and appropriate cueing for ADLs as indicated in the resident's assessment and support plan.

(b) A residence shall provide each resident with assistance with IADLs and appropriate cueing for IADLs as indicated in the resident's assessment and support plan.

§ 2800.24. Personal hygiene.

A residence shall provide the resident with assistance with personal hygiene and appropriate cueing to encour-

age personal hygiene as indicated in the resident's assessment and support plan. Personal hygiene includes one or more of the following:

(1) Bathing.

(2) Oral hygiene.

(3) Hair grooming and shampooing.

(4) Dressing, undressing and care of clothes.

(5) Shaving.

(6) Nail care.

(7) Foot care.

(8) Skin care.

§ 2800.25. Resident-residence contract.

(a) Prior to admission, or within 24 hours after admission, a written resident-residence contract between the resident and the residence must be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

(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).

(c) At a minimum, the contract must specify the following:

(1) Each resident shall retain, at a minimum, the current personal needs allowance as the resident's own funds for personal expenditure. A contract to the contrary is not valid. A personal needs allowance is the amount that a resident shall be permitted to keep for his personal use.

(2) A fee schedule that lists the actual amount of charges for each of the assisted living services that are included in the resident's core service package in accordance with § 2800.220 (relating to service provision).

(3) An explanation of the annual assessment, medical evaluation and support plan requirements and procedures, which shall be followed if either the assessment or the medical evaluation indicates the need for another and more appropriate level of care.

(4) The party responsible for payment.

(5) The method for payment of charges for long distance telephone calls.

(6) The conditions under which refunds will be made, including the refund of admission fees and refunds upon a resident's death.

(7) The financial arrangements if assistance with financial management is to be provided.

(8) The residence's rules related to residence services, including whether the residence permits smoking.

(9) The conditions under which the resident-residence contract may be terminated including residence closure as specified in § 2800.228.

(10) A statement that the resident is entitled to at least 30 days advance notice, in writing, of the residence's request to change the contract.

(11) A list of assisted living services or supplemental health care services, or both, to be provided to the resident based on the outcome of the resident's support plan, a list of the actual rates that the resident will be periodically charged for food, shelter and services and how, when and by whom payment is to be made.

(12) Charges to the resident for holding a bed during hospitalization or other extended absence from the residence.

(13) Written information on the resident's rights and complaint procedures as specified in § 2800.41 (relating to notification of rights and complaint procedures).

(d) A residence may not seek or accept payments from an SSI resident in excess of one-half of any funds received by the resident under the Senior Citizens Rebate and Assistance Act (72 P. S. §§ 4751-1—4751-12). If the residence will be assisting the resident to manage a portion of the rent rebate, the requirements of § 2800.20 (relating to financial management) may apply. There may be no charge for filling out this paperwork.

(e) The resident-residence contract must include whether the residence collects a portion of a resident's rent rebate under subsection (d).

(f) If the residence collects a resident's rent rebate under subsection (e), the resident-residence contract must include the following:

(1) The dollar amount or percentage of the rent rebate to be collected.

(2) The residence's intended use of the revenue collected from the rent rebate.

(g) A statement signed by the resident, and the resident's designated person if applicable, at the time of admission, informing the resident that the information required in subsections (e) and (f) is to be kept in the resident's record.

(h) 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. The resident shall pay only for the services received. Rescission of the contract must be in writing addressed to the residence.

(i) The residence may not require or permit a resident to assign assets to the residence in return for a life care contract/guarantee. A life care contract/guarantee is an agreement between the legal entity and the resident that the legal entity will provide care to the resident for the duration of the resident's life. Continuing care communities that have obtained a Certificate of Authority from the Insurance Department and have provided a copy of the certificate to the Department are exempt from this requirement.

(j) A copy of the signed resident-residence contract shall be given to the resident and a copy shall be filed in the resident's record.

(k) The service needs addressed in the resident's support plan shall be available to the resident every day of the year.

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

§ 2800.26. Quality management.

(a) The residence shall establish and implement a quality management plan.

(b) The quality management plan must address the periodic review and evaluation of the following, to assure compliance with law and with the relevant standard of care:

(1) The reportable incident and condition reporting procedures.

(2) Complaint procedures.

(3) Staff person training.

(4) Licensing violations and plans of correction, if applicable.

(5) Resident or family councils, or both, if applicable.

(c) The quality management plan must include the development and implementation of measures to address the areas needing improvement that are identified during the periodic review and evaluation.

§ 2800.27. SSI recipients.

(a) If a residence agrees to admit a resident eligible for SSI benefits, the residence's charges for actual rent and other services may not exceed the SSI resident's actual current monthly income reduced by the current personal needs allowance.

(b) The administrator or staff persons may not include funds received as lump sum awards, gifts or inheritances, gains from the sale of property or retroactive government benefits when calculating payment of rent for an SSI recipient or for a resident eligible for SSI benefits.

(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.

(d) The administrator shall provide each resident who is a recipient of SSI, at no charge beyond the amount determined in subsection (a), the following items or services as needed:

(1) Necessary personal hygiene items, such as a comb, toothbrush, toothpaste, soap and shampoo. Cosmetic items are not included.

(2) Laundry services for personal laundry, bed linens and towels, but not including dry cleaning or other specialized services.

(3) Assistance or supervision in ADL or IADL, or both.

(e) Third-party payments made on behalf of an SSI recipient and paid directly to the residence are permitted. These payments may not be used for food, clothing or shelter because to do so would reduce SSI payments. See 20 CFR 416.1100 and 416.1102 (relating to income and SSI eligibility; and what is income). These payments may be used to purchase items or services for the resident that are not food, clothing or shelter.

§ 2800.28. Refunds.

(a) If, after the residence gives notice of transfer or discharge in accordance with § 2800.228(b) (relating to transfer and discharge), and the resident moves out of the residence before the 30 days are over, the residence shall give the resident a refund equal to the previously paid charges for rent, assisted living services and supplemental health care services, if applicable, for the remainder of the 30-day time period. The refund shall be issued within 30-days of transfer or discharge. The resident's personal needs allowance shall be refunded within 2 business days of transfer or discharge.

(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 assisted living 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.

(c) If no notice is required, as set forth in subsection (d), the resident shall be required to pay only for the nights spent in the residence.

(d) If the residence does not require a written notice prior to a resident's departure, the administrator shall refund the remainder of previously paid charges to the resident within 30 days of the date the resident moved from the residence.

(e) In the event of the death of a resident under 60 years of age, the administrator shall refund the remainder of previously paid charges to the resident's estate within 30 days from the date the living unit is cleared of the resident's personal property. In the event of the death of a resident 60 years of age and older, the residence shall provide a refund in accordance with the Elder Care Payment Restitution Act (35 P. S. §§ 10226.101—10226.107). The residence shall keep documentation of the refund in the resident's record.

(f) Within 30 days of either the termination of service by the residence or the resident's leaving the residence, the resident shall receive an itemized written account of the resident's funds, including notification of funds still owed the residence by the resident or a refund owed the resident by the residence. Refunds shall be made within 30 days of discharge.

(g) Upon discharge of the resident or transfer of the resident, the administrator shall return the resident's funds being managed or stored by the residence to the resident within 2 business days from the date the living unit is cleared of the resident's personal property.

§ 2800.29. Hospice care and services.

Hospice care and services that are licensed by the Department of Health as a hospice may be provided in an assisted living residence.

§ 2800.30. Informed consent process.

(a) *Initiation of process.*

(1) When a licensee determines that a competent resident's decision, behavior or action creates a dangerous situation and places the competent resident, other residents or staff members at risk of harm by the competent resident's wish to exercise independence in directing the manner in which the competent resident receives 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 competent 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 competent resident wishes to exercise independence in directing the manner in which the competent resident receives care, the competent 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.

(3) An incompetent 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 competent resident and, if applicable, the resident's designated person in writing and orally. The notification must include the contact information for the ombudsman. For incompetent 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 competent resident chooses to initiate an informed consent negotiation, the competent resident shall do so by notifying the licensee in writing and orally. Notification shall be documented in the competent resident's file by the licensee. When a legal representative for an incompetent resident chooses to initiate an informed consent negotiation, the legal representative shall do so by notifying the licensee in writing or orally. Notification shall be documented in the incompetent resident's file by the licensee.

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

(d) *Informed consent meeting.*

(1) In a manner the competent resident can understand, the licensee shall discuss the competent 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 competent resident, other residents or staff members at risk of 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 an incompetent resident, the incompetent resident's legal representative shall participate in the discussion.

(2) A resident may not have the right to place other residents or staff members 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 competent 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 competent 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 competent 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 contact information on the local ombudsman or the appropriate advocacy organization 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 other residents or staff members at risk of 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, other residents or staff members at risk of 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, tort, products defect, breach of fiduciary duty, contract violation, or any other claim or cause of action. An informed consent agreement does not relieve a licensee of liability for violation of statutory or regulatory requirements promulgated under this chapter nor does it affect the 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, other residents or staff members.

(k) Either party has a right to rescind the informed consent agreement within 30 days of execution of the agreement.

RESIDENT RIGHTS

§ 2800.41. Notification of rights and complaint procedures.

(a) Upon admission, each resident and, if applicable, the resident's designated person, shall be informed of resident rights and the right to lodge complaints without intimidation, retaliation or threats of retaliation by the residence or its staff persons against the reporter. Retaliation includes transfer or discharge from the residence.

(b) Notification of rights and complaint procedures shall be communicated in an easily understood manner and in a language understood by or mode of communication used by the resident and, if applicable, the resident's designated person.

(c) The Department's poster of the list of resident's rights shall be posted in a conspicuous and public place in the residence.

(d) A copy of the resident's rights and complaint procedures shall be given to the resident and, if applicable, the resident's designated person, upon admission.

(e) A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

§ 2800.42. Specific rights.

(a) A resident may not be discriminated against because of race, color, religious creed, disability, ancestry, sexual orientation, national origin, age or sex.

(b) A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way. A resident must be free from mental, physical, and sexual abuse and exploitation, neglect, financial exploitation and involuntary seclusion.

(c) A resident shall be treated with dignity and respect.

(d) A resident shall be informed of the rules of the residence and given 30 days' written notice prior to the effective date of a new residence rule.

(e) A resident shall have access to a telephone in the residence to make calls in privacy. Nontoll calls must be without charge to the resident.

(f) A resident has the right to receive and send mail.

(1) Outgoing mail may not be opened or read by staff persons unless the resident requests.

(2) Incoming mail may not be opened or read by staff persons unless upon the request of the resident or the resident's designated person.

(g) A resident has the right to communicate privately with and access the local ombudsman.

(h) A resident has the right to practice the religion or faith of the resident's choice, or not to practice any religion or faith.

(i) A resident shall receive assistance in accessing health care services, including supplemental health care services.

(j) A resident shall receive assistance in obtaining and keeping clean, seasonal clothing. A resident's clothing may not be shared with other residents.

(k) A resident and the resident's designated person, and other individuals upon the resident's written approval shall have the right to access, review and request corrections to the resident's record.

(l) A resident has the right to furnish his living unit and purchase, receive, use and retain personal clothing and possessions.

(m) A resident has the right to leave and return to the residence at times consistent with the residence rules and the resident's support plan.

(n) A resident has the right to relocate and to request and receive assistance, from the residence, in relocating to another facility. The assistance must include helping the resident get information about living arrangements, making telephone calls and transferring records.

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

(p) A resident shall be free from restraints.

(q) A resident shall be compensated in accordance with State and Federal labor laws for labor performed on behalf of the residence. Residents may voluntarily and without coercion perform tasks related directly to the resident's personal space or common areas of the residence.

(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 residence.

(s) A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

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

(u) A resident has the right to remain in the residence, as long as it is operating with a license, except as specified in § 2800.228 (relating to transfer and discharge).

(v) A resident has the right to receive services contracted for in the resident-residence contract.

(w) A resident has the right to use both the residence's procedures and external procedures to appeal involuntary discharge.

(x) A resident has the right to a system to safeguard a resident's money and property.

(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 medical care and supplemental health care services). When the residence does not designate, 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 may not conflict with Federal laws governing residents.

(z) The resident has the right to choose his primary care physician.

§ 2800.43. Prohibition against deprivation of rights.

(a) A resident may not be deprived of his rights.

(b) A resident's rights may not be used as a reward or sanction.

(c) Waiver of any resident right shall be void.

§ 2800.44. Complaint procedures.

(a) Prior to admission, the residence shall inform the resident and the resident's designated person of the right to file and the procedure for filing a complaint with the Department's Assisted Living Residence Licensing Office,

local ombudsman or protective services unit in the area agency on aging, the Disability Rights Network or law enforcement agency.

(b) The residence shall permit and respond to oral and written complaints from any source regarding an alleged violation of resident rights, quality of care or other matter without retaliation or the threat of retaliation.

(c) If a resident indicates that he wishes to make a written complaint, but needs assistance in reducing the complaint to writing, the residence shall assist the resident in writing the complaint.

(d) The residence shall ensure investigation and resolution of complaints. The residence shall designate the staff person responsible for receiving complaints and determining the outcome of the complaint. The residence shall keep a log of all complaints and the outcomes of the complaints.

(e) Within 2 business days after the submission of a written complaint, a status report shall be provided by the residence to the complainant. If the resident is not the complainant, the resident and the resident's designated person shall receive the status report unless contraindicated by the support plan. The status report must indicate the steps that the residence is taking to investigate and address the complaint.

(f) Within 7 days after the submission of a written complaint, the residence shall give the complainant and, if applicable, the designated person, a written decision explaining the residence's investigation findings and the action the residence plans to take to resolve the complaint. If the resident is not the complainant, the affected resident shall receive a copy of the decision unless contraindicated by the support plan. If the residence's investigation validates the complaint allegations, a resident who could potentially be harmed or his designated person shall receive a copy of the decision, with the name of the affected resident removed, unless contraindicated by the support plan.

(g) The telephone number of the Department's Assisted Living Residence Licensing Office, the local ombudsman or protective services unit in the area agency on aging, the Disability Rights Network, the local law enforcement agency, the Commonwealth Information Center and the assisted living residence complaint hotline shall be posted in large print in a conspicuous and public place in the residence.

(h) Nothing in this section may affect in any way the right of the resident to file suit or claim for damages.

STAFFING

§ 2800.51. Criminal history checks.

(a) Criminal history checks shall be in accordance with the Older Adult Protective Services Act (35 P. S. §§ 10225.101—10225.5102), and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

(b) The hiring policies shall be in accordance with the Department of Aging's Older Adult Protective Services Act policy as posted on the Department of Aging's web site.

§ 2800.52. Staff hiring, retention and utilization.

Hiring, retention and utilization of staff persons shall be in accordance with the Older Adult Protective Services Act (35 P. S. §§ 10225.101—10225.5102), 6 Pa. Code Chapter 15 (relating to protective services for older adults) and other applicable regulations.

§ 2800.53. Qualifications and responsibilities of administrators.

(a) The administrator shall have one of the following qualifications:

(1) A license as an RN from the Department of State and 1 year, in the prior 10 years, of direct care or administrative experience in a health care or human services field.

(2) An associate's degree or 60 credit hours from an accredited college or university in a human services field and 1 year, in the prior 10 years, of direct care or administrative experience in a health care or human services field.

(3) An associate's degree or 60 credit hours from an accredited college or university in a field that is not related to human services and 2 years, in the prior 10 years, of direct care or administrative experience in a health care or human services field.

(4) A license as an LPN from the Department of State and 1 year, in the prior 10 years, of direct care or administrative experience in a health care or human services field.

(5) A license as a nursing home administrator from the Department of State and 1 year, in the prior 10 years, of direct care or administrative experience in a health care or human services field.

(6) With the exception of administrators qualified under § 2600.53(a)(5) (relating to qualifications and responsibilities of administrators), experience as a personal care home administrator, if the following requirements are met:

(i) Employed as a personal care home administrator for 2 years prior to January 18, 2011.

(ii) Completed the administrator training requirements and pass the Department-approved competency-based training test in § 2800.64 (relating to administrator training and orientation) by January 18, 2012.

(b) The administrator shall be 21 years of age or older.

(c) The administrator shall be responsible for the administration and management of the residence, including the health, safety and well-being of the residents, implementation of policies and procedures and compliance with this chapter.

(d) The administrator shall have the ability to provide assisted living services or to supervise or direct the work to provide assisted living services.

(e) The administrator shall have knowledge of this chapter.

(f) The administrator shall have the ability to comply with applicable laws, rules and regulations, including this chapter.

(g) The administrator shall have the ability to maintain or supervise the maintenance of financial and other records.

(h) At all times the administrator shall be free from a medical condition, including drug or alcohol addiction that would limit the administrator from performing duties with reasonable skill and safety.

§ 2800.54. Qualifications for direct care staff persons.

(a) Direct care staff persons shall have the following qualifications:

(1) Be 18 years of age or older, except as permitted in subsection (d).

(2) Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

(3) Be free from a medical condition, including drug or alcohol addiction, that would limit direct care staff persons from providing necessary assisted living services with reasonable skill and safety.

(4) Be able to communicate in a mode or manner understood by the resident. Strategies that promote interactive communication on the part of direct care staff and individual residents shall be developed in accordance with the resident's final support plan under § 2800.227(e) (relating to development of the final support plan).

(b) A volunteer who performs or provides ADLs shall meet the direct staff person qualifications and training requirements specified in this chapter.

(c) A resident receiving assisted living services who voluntarily performs tasks in the residence will not be considered a volunteer under this chapter.

(d) Food services or housekeeping staff may be 16 or 17 years of age.

§ 2800.55. Portability of staff training.

A staff person who transfers to another licensed residence, or from a licensed personal care home shall be given credit for any completed hours of training that are required on an annual basis, provided however, that the staff person shall complete any additional training required by this chapter for assisted living residence direct care staff.

§ 2800.56. Administrator staffing.

(a) Except for temporary absences under subsection (b), the administrator shall be present in the residence an average of 36 hours or more per week, in each calendar month. At least 30 hours per week must be during normal business hours.

(b) If the administrator is unavailable to meet the hourly requirements in subsection (a) due to a temporary absence, the administrator shall assign an administrator designee in writing to supervise the residence during the administrator's temporary absence. The administrator designee shall meet the following requirements:

(1) Have 3,000 hours of direct operational responsibility for a senior housing facility, health care facility, residential care facility, adult daily living facility or other group home licensed or approved by the Commonwealth.

(2) Pass the Department-approved competency-based administrator training test under § 2800.64(a)(3) (relating to administrator training and orientation.)

(3) Meet the qualification and training requirements of a direct care staff person under §§ 2800.54 and 2800.65 (relating to qualifications for direct care staff persons; and staff orientation and direct care staff person training and orientation).

(c) The administrator shall assign a staff person in writing to supervise the residence during the administrator's or administrator designee's absence. The staff person shall meet the qualification and training requirements of a direct care staff person under §§ 2800.54 and 2800.65.

(d) During the administrator's and administrator designee's absence, the administrator or administrator designee shall be on-call.

§ 2800.57. Direct care staffing.

(a) At all times one or more residents are present in the residence, a direct care staff person who is 21 years of age or older shall be present in the residence. The direct care staff person may be the administrator if the administrator provides direct care services.

(b) Direct care staff persons shall be available to provide at least 1 hour per day of assisted living services to each mobile resident.

(c) Direct care staff persons shall be available to provide at least 2 hours per day of assisted living services to each resident who has mobility needs.

(d) At least 75% of the assisted living service hours specified in subsections (b) and (c) shall be available during waking hours.

§ 2800.58. Awake staff persons.

Direct care staff persons on duty in the residence shall be awake at all times.

§ 2800.59. Multiple buildings.

For a residence with multiple buildings on the same premises regardless of the distance between buildings, the direct care staffing requirements in § 2800.57 (relating to direct care staffing) apply at all times residents are present in the residence.

§ 2800.60. Additional staffing based on the needs of the residents.

(a) Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan. Residence staff or service providers who provide services to the residents in the residence shall meet the applicable professional licensure requirements.

(b) The staffing level in this chapter is minimum only. The Department may require additional staffing as necessary to protect the health, safety and well-being of the residents. Requirements for additional staffing will be based on the resident's assessment and support plan, the design and construction of the residence and the operation and management of the residence.

(c) Additional staff hours, or contractual hours, shall be provided as necessary to meet the transportation, laundry, food service, housekeeping and maintenance needs of the residents.

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

(e) The residence shall have a dietician on staff or under contract to provide for any special dietary needs of a resident as indicated in his support plan.

§ 2800.61. Substitute personnel.

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

§ 2800.62. List of staff persons.

The administrator shall maintain a current list of the names, addresses and telephone numbers of staff persons including substitute personnel and volunteers.

§ 2800.63. First aid, CPR and obstructed airway training.

(a) For every 35 residents, there shall be at least one staff person trained in first aid and certified in obstructed airway techniques and CPR present in the residence at all times to meet the needs of the residents.

(b) Current training in first aid and certification in obstructed airway techniques and CPR shall be provided by an individual certified as a trainer by a hospital or other recognized health care organization.

(c) Licensed, certified and registered medical personnel meet the qualifications in subsection (a) and are exempt from the training requirements in subsections (a) and (b).

(d) A staff person who is trained in first aid or certified in obstructed airway techniques or CPR shall provide those services in accordance with his training, unless the resident has a do not resuscitate order.

§ 2800.64. Administrator training and orientation.

(a) Prior to initial employment as an administrator, a candidate shall successfully complete the following:

(1) An orientation program approved and administered by the Department.

(2) A 100-hour standardized Department-approved administrator training course. The training provided for in § 2800.69 (relating to additional dementia-specific training) shall be in addition to the 100-hour training course.

(3) A Department-approved competency-based training test with a passing score.

(b) The standardized Department-approved administrator training course specified in subsection (a)(2) must include the following:

(1) Fire prevention and emergency preparedness.

(2) Medication procedures, medication effects and side effects, universal precautions and personal hygiene.

(3) Certification in CPR and obstructed airway techniques and training in first aid.

(4) Assisted living services.

(5) Local, State and Federal laws and regulations pertaining to the operation of a residence.

(6) Nutrition, food handling and sanitation.

(7) Recreation.

(8) Care for residents with mental illness.

(9) Resident rights.

(10) Care for residents with cognitive and neurological impairments and other special needs.

(11) Care for residents with mental retardation.

(12) Community resources, social services and activities in the community.

(13) Staff supervision and staff person training including developing orientation and training guidelines for staff.

(14) Budgeting, financial recordkeeping and resident records including:

(i) Writing, completing and implementing initial assessments, annual assessments and support plans.

(ii) Resident-residence contracts.

(15) Gerontology.

(16) Abuse and neglect prevention and reporting.

(17) Cultural competency.

(18) Infection control.

(19) Training specific to the resident composition.

(20) Training on person-centered care, informed consent, aging in place and the availability of services to support aging in place.

(21) Incident management and incident reporting.

(22) The requirements of this chapter.

(c) An administrator shall have at least 24 hours of annual training relating to the job duties. The Department-approved administrator training course specified in subsection (a) fulfills the annual training requirement for the first year.

(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, courses approved for credit by National Continuing Education Review Service/National Association of Boards of Examiners of Long-Term Care Administrators or the Bureau of Professional and Occupational Affairs in the Department of State.

(e) An administrator who has successfully completed the training in subsections (a)—(d) shall provide written verification of successful completion to the Department's Assisted Living Residence Licensing Office.

(f) A record of training including the individual trained, date, source, content, length of each course and copies of certificates received shall be kept.

(g) A licensed nursing home administrator who is employed as an administrator prior to January 18, 2011, is exempt from the qualification and training requirements under §§ 2800.53 and 2800.64 (relating to qualifications and responsibilities of administrators; and administrator training and orientation) if the administrator continues to meet the applicable licensing requirements. A licensed nursing home administrator hired as an administrator after January 18, 2011, shall complete and pass the Department-approved assisted living administrator competency-based test.

§ 2800.65. Staff orientation and direct care staff person training and orientation.

(a) Prior to or during the first work day, direct care staff persons and other staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

(1) Evacuation procedures.

(2) Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location, if applicable.

(3) The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.

(4) Smoking safety procedures, the residence's smoking policy and location of smoking areas, if applicable.

(5) The location and use of fire extinguishers.

(6) Smoke detectors and fire alarms.

(7) Telephone use and notification of emergency services.

(b) Direct care staff persons shall complete an initial orientation approved by the Department before providing direct care to residents.

(c) Direct care staff persons shall be certified in first aid and CPR before providing direct care to residents.

(d) A sufficient number of direct care staff persons shall be certified in obstructed airway techniques to meet the staff to resident ratios under § 2800.63(a) (relating to first aid, CPR and obstructed airway training) before providing direct care to residents.

(e) Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation training that includes the following:

(1) Resident rights.

(2) Emergency medical plan.

(3) Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P. S. §§ 10225.101—10225.5102).

(4) Reporting of reportable incidents and conditions.

(5) Safe management techniques.

(6) Core competency training that includes the following:

(i) Person-centered care.

(ii) Communication, problem solving and relationship skills.

(iii) Nutritional support according to resident preference.

(f) Ancillary staff persons shall have a general orientation to their specific job functions as it relates to their position prior to working in that capacity.

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

(1) Training that includes a demonstration of job duties, followed by supervised practice.

(2) Successful completion and passing the Department-approved direct care training course and passing of the competency test.

(3) Initial direct care staff person training to include the following:

(i) Safe management techniques.

(ii) Assisting with ADLs and IADLs.

(iii) Personal hygiene.

(iv) Care of residents with mental illness, neurological impairments, mental retardation and other mental disabilities.

(v) The normal aging-cognitive, psychological and functional abilities of individuals who are older.

(vi) Implementation of the initial assessment, annual assessment and support plan.

(vii) Nutrition, food handling and sanitation.

(viii) Recreation, socialization, community resources, social services and activities in the community.

(ix) Gerontology.

(x) Staff person supervision, if applicable.

(xi) Care and needs of residents with special emphasis on the residents being served in the residence.

(xii) Safety management and hazard prevention.

(xiii) Universal precautions.

(xiv) The requirements of this chapter.

(xv) The signs and symptoms of infections and infection control.

(xvi) Care for individuals with mobility needs, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, if applicable to the residents served in the residence.

(xvii) Behavioral management techniques.

(xviii) Understanding of the resident's assessment and how to implement the resident's support plan.

(xix) Person-centered care and aging in place.

(h) Direct care staff persons shall have at least 16 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 16 hour annual training.

(i) Training topics for the annual training for direct care staff persons must include the following:

(1) Medication self-administration training.

(2) Instruction on meeting the needs of the residents as described in the assessment tool, medical evaluation and support plan.

(3) Care for residents with dementia, cognitive and neurological impairments.

(4) Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.

(5) Assisted living service needs of the resident.

(6) Safe management techniques.

(7) Care for residents with mental illness or mental retardation, or both, if the population is served in the residence.

(j) Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

(1) Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.

(2) Emergency preparedness procedures and recognition and response to crises and emergency situations.

(3) Resident rights.

(4) The Older Adult Protective Services Act (35 P. S. §§ 10225.101—10225.708).

(5) Falls and accident prevention.

(6) New population groups that are being served at the residence that were not previously served, if applicable.

(k) If a staff person has completed the required initial direct care staff person training within the past year as a direct care staff person at another residence, the requirement for initial direct care staff person training in this section does not apply if the staff person provides written verification of completion of the training.

(l) A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

§ 2800.66. Staff training plan.

(a) A staff training plan shall be developed annually.

(b) The plan must include training aimed at improving the knowledge and skills of the residence's direct care staff persons in carrying out their job responsibilities. The staff training plan must include the following:

(1) The name, position and duties of each direct care staff person.

(2) The required training courses for each staff person.

(3) The dates, times and locations of the scheduled training for each staff person for the upcoming year.

(c) Documentation of compliance with the staff training plan shall be kept.

§ 2800.67. Training institution registration.

(a) An institution and the course of study offered by an educational institution, association, professional society or organization for the purpose of educating and qualifying applicants for certification as assisted living residence administrators shall be registered and approved by the Department prior to offering the course of study.

(b) An application for registration of an institution and approval of a course of study shall be submitted to the Department on a form provided by the Department and include the following information:

(1) The full name, address, telephone number, facsimile number and electronic mail address of the prospective training provider, each instructor and the program coordinator.

(2) The training objectives, instructional materials, content and teaching methods to be used and the number of clock hours.

(3) The recommended class size.

(4) The attendance certification method.

(5) Proof that each course instructor is certified by the Department to conduct administrator training.

(6) The subject that each instructor will teach and documentation of the instructor's academic credentials, instructional experience and work experience to teach the subject.

(7) The location of the training site, which shall accommodate the number of anticipated participants.

(c) A request to amend a Department-approved course of study shall be submitted for the Department's review and approval prior to implementation of a change in the course of study.

(d) The training institution shall issue a training certificate to each participant who successfully completes the Department-approved course and passes the competency test. Each training certificate must indicate the participant's name, the name of the training institution, the date and location of the training and the number of clock hours completed for each training topic.

§ 2800.68. Instructor approval.

(a) Training for assisted living residence administrators provided by an individual who is not certified as an instructor by the Department will not be considered valid training.

(b) To receive the Department's certification as an approved instructor for assisted living residence administrators, an instructor shall successfully complete the Department's train-the-trainer course. The train-the-trainer course is designed to provide and reinforce basic training skills, including the roles and responsibilities of the trainer, training methodology, the use of instructional aids and recordkeeping.

(c) An instructor shall demonstrate competent instructional skills and knowledge of the applicable topic and meet the Department's qualifications for the topic being taught.

(d) An instructor is subject to unannounced monitoring by the Department while conducting training.

(e) The Department will establish approval standards that include the following:

(1) The mechanism to measure the quality of the training being offered.

(2) The criteria for selecting and evaluating instructors, subject matter and instructional materials.

(3) The criteria for evaluating requests to amend a course.

(4) The criteria for evaluating the effectiveness of each course.

(5) The instructor qualifications for each subject being taught.

(f) The Department may withdraw approval under the following conditions:

(1) Failure to follow the approved curriculum.

(2) Lack of trainer competency.

(3) A pattern of violations of this chapter by a residence conducting the training.

§ 2800.69. Additional dementia-specific training.

Administrative staff, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall receive at least 4 hours of dementia-specific training within 30 days of hire and at least 2 hours of dementia-specific training annually thereafter in addition to the training requirements of this chapter.

PHYSICAL SITE

§ 2800.81. Physical accommodations and equipment.

(a) The residence shall provide or arrange for physical site accommodations and equipment necessary to meet the health and safety needs of a resident with a disability and to allow safe movement within the residence and exiting from the residence.

(b) Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

§ 2800.82. Poisons.

(a) Poisonous materials shall be stored in their original, labeled containers.

(b) Poisonous materials shall be stored separately from food, food preparation surfaces and dining surfaces.

(c) Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the residence are able to safely use or avoid poisonous materials.

§ 2800.83. Temperature.

(a) The indoor temperature, in areas used by the residents, must be at least 70° F when residents are present in the residence.

(b) A residence in existence prior to January 18, 2011, shall provide central air conditioning. If central air conditioning is not feasible or is cost prohibitive, window air conditioning units shall be provided. The residence shall submit justification to the Department for the use of window air conditioning units.

(c) For new construction after January 18, 2011, the residence shall provide central air conditioning.

§ 2800.84. Heat sources.

Heat sources, such as steam and hot heating pipes, water pipes, fixed space heaters, hot water heaters and radiators exceeding 120° F that are accessible to the resident must be equipped with protective guards or insulation to prevent the resident from coming in contact with the heat source.

§ 2800.85. Sanitation.

(a) Sanitary conditions shall be maintained.

(b) There may be no evidence of infestation of insects or rodents in the residence.

(c) Trash shall be removed from the premises at least once a week.

(d) Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

(e) Trash outside the residence shall be kept in covered receptacles that prevent the penetration of insects and rodents.

(f) For a residence serving 9 or more residents that is not connected to a public sewer system, there shall be a written sanitation approval for its sewage system by the sewage enforcement official of the municipality in which the residence is located.

§ 2800.86. Ventilation.

(a) All areas of the residence that are used by the resident shall be ventilated. Ventilation includes an operable window, air conditioner, fan or mechanical ventilation that ensures airflow.

(b) A bathroom that does not have an operable, outside window must be equipped with an exhaust fan for ventilation.

§ 2800.87. Lighting.

The residence's rooms, hallways, interior stairs, outside steps, outside doorways, porches, ramps, evacuation routes, outside walkways and fire escapes must be lighted and marked to ensure that residents, including those with vision impairments, can safely move through the residence and safely evacuate.

§ 2800.88. Surfaces.

(a) Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

(b) The residence may not use asbestos products for renovations or new construction.

(c) If asbestos is found in a residence or contained in any part of the residence, the residence shall have a certification from an asbestos remediation company that the residence is safe for residents and that the asbestos does not pose a risk.

§ 2800.89. Water.

(a) The residence must have hot and cold water under pressure in each bathroom, kitchen and laundry area to accommodate the needs of the residents in the residence.

(b) Hot water temperature in areas accessible to the resident may not exceed 120° F.

(c) A residence that is not connected to a public water system shall have a coliform water test at least every 3 months, by a Department of Environmental Protection-certified laboratory, stating that the water is below maximum contaminant levels. A public water system is a system that provides water to the public for human consumption, which has at least 15 service connections or regularly serves an average of at least 25 individuals daily at least 60 days out of the year.

(d) If the water is found to be above maximum contaminant levels, the residence shall conduct remediation activity to reduce the level of contaminants to below the maximum contaminant level. During remediation activity, an alternate source of drinking water shall be provided to the residents.

(e) The residence shall keep documentation of the laboratory certification, in addition to the results and corrections made to ensure safe water for drinking.

§ 2800.90. Communication system.

(a) The residence shall have a working, noncoin operated, landline telephone that is accessible in emergencies and accessible to individuals with disabilities.

(b) For a residence serving nine or more residents, there shall be a system or method of communication such as an intercom, public address, pager or cell phone system that enables staff persons to immediately contact other staff persons in the residence for assistance in an emergency.

§ 2800.91. Emergency telephone numbers.

Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and assisted living residence complaint hotline shall be posted on or by each telephone with an outside line.

§ 2800.92. Windows and screens.

Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

§ 2800.93. Handrails and railings.

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

(b) Each porch must have a well-secured railing.

§ 2800.94. Landings and stairs.

(a) Interior and exterior doors that open directly into a stairway and are used for exit doors, resident areas and fire exits must have a landing, which is a minimum of 3 feet by 3 feet.

(b) Interior stairs, exterior steps and ramps must have nonskid surfaces.

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

§ 2800.95. Furniture and equipment.

Furniture and equipment must be in good repair, clean and free of hazards.

§ 2800.96. First aid kit.

(a) The residence shall have a first aid kit in each building on the premises that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield,

eye coverings and tweezers. The residence shall have an automatic external defibrillation device located in each building on the premises.

(b) Staff persons shall know the location of the first aid kit.

(c) The first aid kit must be in a location that is easily accessible to staff persons.

§ 2800.97. Elevators and stair glides.

Each elevator and stair glide must have a certificate of operation from the Department of Labor and Industry or the appropriate local building authority in accordance with 34 Pa. Code Chapter 405 (relating to elevators and other lifting devices).

§ 2800.98. Indoor activity space.

(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.

(b) The residence shall have at least one furnished living room or lounge area for residents, their families and visitors. The combined living room or lounge areas must accommodate all residents at one time. There must be at least 15 square feet per living unit for up to 50 living units. There must be a total of 750 square feet if there are more than 50 living units. These rooms or areas must contain tables, chairs and lighting to accommodate the residents, their families and visitors.

(c) The residence shall have a working television and radio available to residents in a living room or lounge area.

§ 2800.99. Recreation space.

The residence shall provide regular access to outdoor and indoor recreation space and recreational items, such as books, newspapers, magazines, puzzles, games, cards and crafts.

§ 2800.100. Exterior conditions.

(a) The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

(b) The residence shall ensure that ice, snow and obstructions are removed from outside walkways, ramps, steps, recreational areas and exterior fire escapes.

§ 2800.101. Resident living units.

(a) A residence shall provide a resident with the resident's own living unit unless the conditions of subsection (c) are met.

(b) The following conditions apply to a residence:

(1) For new construction of residences after January 18, 2011, each living unit for a single resident must have at least 225 square feet of floor space measured wall-to-wall, excluding bathrooms and closet space. If two residents share a living unit, there must be a total of 300 square feet in the living unit. Exceptions to the size of the living unit may be made at the Department's discretion.

(2) For facilities in existence prior to January 18, 2011, each living unit must have at least 160 square feet measured wall to wall, excluding bathrooms and closet space. If two residents share a living unit, there must be a total of 210 square feet in the living unit. Exceptions to the size of the living unit may be made at the Department's discretion.

(3) Each living unit must have a telephone jack and individually controlled thermostats for heating and cooling.

(4) The doors in living units, including entrance doors, must be accessible or adaptable for wheelchair use.

(c) Two residents may voluntarily agree to share one living unit provided that the agreement is in writing and contained in each of the resident-residence contract of those residents. A licensee may not require residents to share a living unit. The maximum number of residents in any living unit shall be two residents.

(d) Kitchen capacity requirements are as follows:

(1) *New construction.* For new construction of residences after January 18, 2011, the kitchen capacity, at a minimum, must contain a cabinet for food storage, a small bar-type sink with hot and cold running water and space with electrical outlets suitable for small appliances such as a microwave oven and a small refrigerator.

(i) Upon entering the assisted living residence, the resident or his designated person shall be asked if the resident wishes to have a cooking appliance or small refrigerator, or both. The cooking appliance or small refrigerator, or both, shall be provided by the residence if desired by the resident or his designated person. If the resident or the designated person wishes to provide his own cooking appliance or small refrigerator, or both, it shall meet the residence's safety standards.

(ii) An appliance shall be designed so it can be disconnected and removed for resident safety or if the resident chooses not to have the appliance within his living unit.

(2) *Existing facilities.* Facilities that convert to residences after January 18, 2011, must meet the following requirements related to kitchen capacity:

(i) The residence shall provide space with electrical outlets suitable for small appliances, such as a microwave oven and small refrigerator.

(A) Upon entering the assisted living residence, the resident or his designated person shall be asked if the resident wishes to have a cooking appliance or small refrigerator, or both. The cooking appliance or small refrigerator, or both, shall be provided by the residence if desired by the resident or his designated person. If the resident or his designated person wishes to provide his own cooking appliance or small refrigerator, or both, it must meet the residence's safety standards.

(B) An appliance shall be designed so it can be disconnected and removed for resident safety or if the resident chooses not to have the appliance within his living unit.

(ii) 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.

(e) Ceiling height in each living unit must be an average of at least 7 feet.

(f) Each living unit must have at least one window with direct exposure to natural light.

(g) A resident's bedroom in the living unit shall be used only by the occupying resident unless two consenting adult residents agree to share a bedroom and the requirements of subsection (c) are met.

(h) Each living unit must have a door with a lock, except where a lock in a unit under a special care designation would pose a risk or be unsafe. The administrator shall maintain a master key that can open all locks in the event of an emergency.

(i) A resident shall have access to his living unit at all times.

(j) Each resident shall have the following in the living unit:

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

(2) A chair for each resident that meets the resident's needs.

(3) Pillows, bed linens and blankets that are clean and in good repair.

(4) A storage area for clothing that includes a chest of drawers and a closet or wardrobe space with clothing racks or shelves accessible to the resident.

(5) A bedside table or a shelf.

(6) A mirror.

(7) An operable lamp or other source of lighting that can be turned on at bedside.

(8) If a resident shares a bedroom with another resident, the items specified in paragraphs (4)—(7) may be shared with one other resident.

(k) Cots and portable beds are prohibited.

(l) Bunk beds or other raised beds that require residents to climb steps or ladders to get into or out of bed are prohibited.

(m) A living unit may not be used as an exit from or used as a passageway to another part of the residence unless in an emergency situation.

(n) The living unit must have walls, floors and ceilings, which are finished, clean and in good repair.

(o) In living units with a separate bedroom, there must be a door on the bedroom.

(p) Space for storage of personal property shall be provided in a dry, protected area.

(q) There must be drapes, shades, curtains, blinds or shutters on the living unit windows. Window coverings must be clean, in good repair, provide privacy and cover the entire window when drawn.

(r) Each living unit must be equipped with an emergency notification system to notify staff in the event of an emergency.

§ 2800.102. Bathrooms.

(a) There must be one functioning flush toilet in the bathroom in the living unit.

(b) There must be at least one sink and wall mirror in the bathroom of the living unit.

(c) There must be at least one bathtub or shower in the bathroom of the living unit.

(d) Toilet and bath areas in the living unit must have grab bars, hand rails or assist bars. Bathtubs and showers must have slip-resistant surfaces.

(e) Privacy in the living unit must be provided for toilets, showers and bathtubs by partitions or doors. Bathroom doors in a double occupancy living unit must be lockable by the resident, unless contraindicated by the support plan.

(f) An individual towel, washcloth and soap shall be provided for each resident unless the resident provides his own supplies of these items.

(g) Individual toiletry items including toothpaste, toothbrush, shampoo, deodorant, comb and hairbrush shall be made available to residents who are not recipients of SSI. If the residence charges for these items, the charges shall be indicated in the resident-residence contract. Availability of toiletry items for residents who are recipients of SSI is specified in § 2800.27(d)(1) (relating to SSI recipients).

(h) Toilet paper shall be provided for every toilet.

(i) Bar soap or a dispenser with soap shall be provided within reach of each bathroom sink. Bar soap, however, is not permitted when a living unit is shared unless there is a separate bar clearly labeled for each resident sharing the living unit.

(j) Towels and washcloths shall be in the possession of the resident in the resident's living unit unless the resident has access to the residence's linen supply.

(k) Use of a common towel is prohibited.

(l) Shelves or hooks for the resident's towel and clothing shall be provided.

(m) A residence shall have at least one public restroom that is convenient to common areas and wheelchair accessible.

(n) Each bathroom must be equipped with an emergency notification system to notify staff in the event of an emergency.

§ 2800.103. Food service.

(a) A residence shall have access on the grounds to an operable kitchen with a refrigerator, sink, stove, oven, cooking equipment and cabinets or shelves for storage. If the kitchen is not in the residence, the residence shall have a kitchen area with a refrigerator, cooking equipment, a sink and food storage space.

(b) Kitchen surfaces must be of a nonporous material and cleaned and sanitized after each meal.

(c) Food shall be protected from contamination while being stored, prepared, transported and served.

(d) Food shall be stored off the floor.

(e) Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

(f) Food requiring refrigeration shall be stored at or below 40° F. Frozen food shall be kept at or below 0° F. Thermometers are required in refrigerators and freezers.

(g) Food shall be stored in closed or sealed containers.

(h) Food shall be thawed either in the refrigerator, microwave oven, under cool water or as part of the cooking process.

(i) Outdated or spoiled food or dented cans may not be used.

(j) Eating, drinking and cooking utensils shall be washed, rinsed and sanitized after each use by a method specified in 7 Pa. Code Chapter 46, Subchapter D (relating to equipment, utensils and linens).

§ 2800.104. Dining room.

(a) An assisted living residence shall have an accessible common dining space outside the resident living units. A dining room area must be equipped with tables and chairs and able to accommodate the maximum number of residents scheduled for meals at any one time. There must be at least 15 square feet per person for residents scheduled for meals at any one time.

(b) Dishes, glassware and utensils shall be provided for eating, drinking, preparing and serving food. These utensils must be clean, and free of chips and cracks. Plastic and paper plates, utensils and cups for meals may not be used on a regular basis.

(c) Condiments shall be available at the dining table.

(d) Adaptive eating equipment or utensils shall be available, if needed, to assist residents in eating at the table.

(e) Breakfast, midday and evening meals shall be served to residents in a dining room except in the following situations:

(1) Service in the resident's living unit shall be available at no additional charge when the resident is unable to come to the dining room due to illness.

(2) When room service is available in a residence, a resident may choose to have a meal served in the resident's living unit. This service shall be provided at the resident's request and may not replace daily meals in a dining room.

§ 2800.105. Laundry.

(a) Laundry service for bed linens, towels and personal clothing shall be provided by the residence, at no additional charge, to residents who are recipients of or eligible applicants for SSI benefits. Laundry service does not include dry cleaning.

(b) Laundry service for bed linens, towels and personal clothing for the residents who are not recipients of SSI shall be provided by the residence unless otherwise indicated in the resident-residence contract. If a residence provides laundry facilities, there may not be a prohibition against residents doing their own laundry.

(c) The supply of bed linens and towels must be sufficient to ensure a complete change of bed linen and towels at least once per week.

(d) Bed linens and towels shall be changed at least once every week and more often as needed to maintain sanitary conditions.

(e) Clean linens and towels shall be stored in an area separate from soiled linen and clothing.

(f) Measures shall be implemented to ensure that residents' clothing are not lost or misplaced during laundering or cleaning. The resident's clean clothing shall be returned to the resident within 24 hours after laundering.

(g) To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

§ 2800.106. Swimming areas.

If a residence operates a swimming area, the following requirements apply:

(1) Swimming areas shall be operated in accordance with applicable laws and regulations.

(2) Written policy and procedures to protect the health, safety and well-being of the residents shall be developed and implemented.

§ 2800.107. Emergency preparedness.

(a) The administrator shall have a copy and be familiar with the emergency preparedness plan for the municipality in which the residence is located.

(b) The residence shall have written emergency procedures that include the following:

(1) Contact information for each resident's designated person.

(2) The residence's plan to provide the emergency medical information for each resident that ensures confidentiality.

(3) Contact telephone numbers of local and State emergency management agencies and local resources for housing and emergency care of residents.

(4) Means of transportation in the event that relocation is required.

(5) Duties and responsibilities of staff persons during evacuation, transportation and at the emergency location. These duties and responsibilities shall be specific to each resident's emergency needs.

(6) Alternate means of meeting resident needs in the event of a utility outage.

(c) The residence shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

(d) The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

§ 2800.108. Firearms and weapons.

(a) A residence shall have a written policy regarding firearms, weapons and ammunition where these items are on the premises or in possession of any resident or staff member. A residence is not required to permit firearms, weapons and ammunition.

(b) The policy must include, at a minimum, procedures regarding the safety, access and use of firearms, weapons and ammunition.

(c) Firearms, weapons and ammunition shall be permitted on the licensed premises of a residence only when the following conditions are met:

(1) Firearms and weapons shall be contained in a locked cabinet located in a place other than the residents' living unit or in a common living area.

(2) Ammunition shall be contained in a locked area separate from firearms and weapons, and located in a place other than the residents' living unit or in a common living area.

(3) The key to the locked cabinet containing the firearms, weapons and ammunition shall be in the possession of the administrator or a designee.

(4) The administrator or designee shall be the only individual permitted to open the locked cabinet containing the firearms and weapons and the locked area containing the ammunition.

(d) If a firearm, weapon or ammunition is the property of a resident, there shall be a written policy and procedures regarding the safety, access and use of firearms, weapons and ammunition. A resident may not take a firearm, weapon or ammunition out of the locked cabinet into the common living area.

§ 2800.109. Pets.

(a) The residence rules must specify whether the residence permits pets on the premises.

(b) Cats and dogs present at the residence shall have a current rabies vaccination. A current certificate of rabies vaccination from a licensed veterinarian shall be kept.

(c) Pets that are accessible to the residents shall be in good health and nonaggressive to the residents.

(d) If a residence has additional charges for pets, the charges shall be included in the resident-residence contract.

(e) A residence shall disclose to applicants whether pets are permitted and present in the residence.

FIRE SAFETY

§ 2800.121. Unobstructed egress.

(a) Stairways, hallways, doorways, passageways and egress routes from living units and from the building must be unlocked and unobstructed.

(b) Except as provided in § 2800.101 (relating to resident living units), doors used for egress routes from living units and from the building may not be equipped with key-locking devices, electronic card operated systems or other devices which prevent immediate egress of residents from the building, unless the residence has written approval or a variance from the Department of Labor and Industry, the Department of Health or the appropriate local building authority.

§ 2800.122. Exits.

Unless otherwise regulated by the Department of Labor and Industry, the Department of Health or the appropriate local building authority, all buildings must have at least two independent and accessible exits from every floor, arranged to reduce the possibility that both will be blocked in an emergency situation.

§ 2800.123. Emergency evacuation.

(a) Exit doors must be equipped so that they can be easily opened by residents from the inside without the use of a key or other manual device that can be removed, misplaced or lost.

(b) Copies of the emergency procedures as specified in § 2800.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the residence and a copy shall be kept.

(c) For a residence serving nine or more residents, an emergency evacuation diagram of each floor showing corridors, line of travel to exit doors and location of the fire extinguishers and pull signals shall be posted in a conspicuous and public place on each floor.

(d) If the residence serves one or more residents with mobility needs above or below grade level of the residence, there shall be a fire-safe area, as specified in writing within the past year by a fire safety expert, on the same floor as each resident with mobility needs.

§ 2800.124. Notification of local fire officials.

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.

§ 2800.125. Flammable and combustible materials.

(a) Combustible and flammable materials may not be located near heat sources or hot water heaters.

(b) Combustible materials shall be inaccessible to residents.

§ 2800.126. Furnaces.

(a) A professional furnace cleaning company or trained maintenance staff person shall inspect furnaces at least annually. Documentation of the inspection shall be kept.

(b) Furnaces shall be cleaned according to the manufacturer's instructions. Documentation of the cleaning shall be kept.

§ 2800.127. Space heaters.

(a) Portable space heaters are prohibited.

(b) Nonportable space heaters must be well vented and installed with permanent connections and protectors.

§ 2800.128. Supplemental heating sources.

(a) The use of kerosene burning heaters is prohibited.

(b) Wood and coal burning stoves shall be used only if a local fire department or other municipal fire safety authority, professional cleaning company or trained maintenance staff person inspects and approves them annually. Wood and coal burning stoves that are used as a regular heating source shall be cleaned every year according to the manufacturer's instructions. Documentation of wood and coal burning stove inspections and cleanings shall be kept.

(c) Wood and coal burning stoves must be securely screened or equipped with protective guards while in use.

§ 2800.129. Fireplaces.

(a) A fireplace must be securely screened or equipped with protective guards while in use.

(b) A fireplace chimney and flue shall be cleaned when there is an accumulation of creosote. Written documentation of the cleaning shall be kept.

(c) A fireplace chimney and flue that is used must be serviced annually and written documentation of the servicing shall be kept.

§ 2800.130. Smoke detectors and fire alarms.

(a) There shall be an operable automatic smoke detector located in each living unit.

(b) Smoke detectors and fire alarms must be of a type approved by the Department of Labor and Industry, the appropriate local building authority or local fire safety expert, or listed by Underwriters Laboratories.

(c) If the residence serves nine or more residents, there shall be at least one smoke detector on each floor interconnected and audible throughout the residence or an automatic fire alarm system that is interconnected and audible throughout the residence.

(d) If one or more residents or staff persons are not able to hear the smoke detector or fire alarm system, a signaling device approved by a fire safety expert shall be used and tested so that each resident and staff person with a hearing impairment will be alerted in the event of a fire.

(e) Smoke detectors and fire alarms shall be tested for operability at least once per month. A written record of the monthly testing shall be kept.

(f) If a smoke detector or fire alarm becomes inoperative, repair shall be completed within 48 hours of the time the detector or alarm was found to be inoperative.

(g) The residence's emergency procedures must indicate the procedures that will be immediately implemented until the smoke detector or fire alarms are operable.

(h) In residences housing five or more residents with mobility needs, the fire alarm system shall be directly connected to the local fire department or 24-hour monitoring service approved by the local fire department, if this service is available in the community.

§ 2800.131. Fire extinguishers.

(a) There shall be at least one operable fire extinguisher with a minimum 2-A rating for each floor, including public walkways and common living areas every 3,000 square feet, the basement and attic.

(b) If the indoor floor area on a floor including the basement or attic is more than 3,000 square feet, there shall be an additional fire extinguisher with a minimum 2-A rating for each additional 3,000 square feet of indoor floor space.

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

(d) Fire extinguishers must be listed by Underwriters Laboratories or approved by Factory Mutual Systems.

(e) Fire extinguishers shall be accessible to staff persons. Fire extinguishers shall be kept locked if access to the extinguisher by a resident could cause a safety risk to the resident. If fire extinguishers are kept locked, each staff person shall be able to immediately unlock the fire extinguisher in the event of a fire emergency.

(f) Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

§ 2800.132. Fire drills.

(a) An unannounced fire drill shall be held at least once a month.

(b) A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

(c) A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the residence at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

(d) Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the residence.

(e) A fire drill shall be held during sleeping hours once every 6 months.

(f) Alternate exit routes shall be used during fire drills.

(g) Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

(h) Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

(i) A fire alarm or smoke detector shall be set off during each fire drill.

(j) Elevators may not be used during a fire drill or a fire.

§ 2800.133. Exit signs.

The following requirements apply for a residence serving nine or more residents:

(1) Signs bearing the word "EXIT" in plain legible letters shall be placed at all exits.

(2) Access to exits shall be marked with readily visible signs indicating the direction to travel.

(3) Exit sign letters must be at least 6 inches in height with the principal strokes of letters at least 3/4 inch wide.

RESIDENT HEALTH

§ 2800.141. Resident medical evaluation and health care.

(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, subject to the provisions of § 2800.22 (relating to application and admission). The evaluation must include the following:

(1) A general physical examination by a physician, physician's assistant or nurse practitioner.

(2) Medical diagnosis including physical or mental disabilities of the resident, if any.

(3) Medical information pertinent to diagnosis and treatment in case of an emergency.

(4) Special health or dietary needs of the resident.

(5) Allergies.

(6) Immunization history.

(7) Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.

(8) Body positioning and movement stimulation for residents, if appropriate.

(9) Health status.

(10) Mobility assessment, updated annually or at the Department's request.

(11) An indication that a tuberculin skin test has been administered with negative results within 2 years; or if the tuberculin skin test is positive, the result of a chest X-ray. In the event a tuberculin skin test has not been administered, the test shall be administered within 15 days after admission.

(12) Information about a resident's day-to-day assisted living service needs.

(b) A resident shall have a medical evaluation:

(1) At least annually.

(2) If the medical condition of the resident changes prior to the annual medical evaluation.

§ 2800.142. Assistance with medical care and supplemental health care services.

(a) Each residence shall demonstrate the ability to provide or arrange for the provision of supplemental health care services in a manner protective of the health,

safety and well-being of its residents utilizing employees, independent contractors or contractual arrangements with other health care facilities or practitioners licensed, registered or certified to the extent required by law to provide the service.

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

(1) The residence shall permit a resident to select or retain his primary care physician.

(2) 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.

(3) The residence shall document the resident's need for the medical care, including updating the resident's assessment and support plan.

(c) If a resident refuses routine medical or dental examination or treatment, the refusal and the continued attempts to educate and inform the resident about the need for medical care shall be documented in the resident's record.

(d) If a resident has a serious medical or dental condition, reasonable efforts shall be made to obtain consent for treatment from the resident or the resident's designated person.

(e) The residence shall assist the resident to secure preventative medical, dental, vision and behavioral health care as requested by a physician, physician's assistant or certified registered nurse practitioner.

§ 2800.143. Emergency medical plan.

(a) The residence shall have a written emergency medical plan that includes the following:

(1) The hospital or source of health care that will be used in an emergency. This shall be the resident's choice, if possible.

(2) Emergency transportation to be used.

(3) An emergency staffing plan.

(b) The following current emergency medical and health information shall be available at all times for each resident and shall accompany the resident when the resident needs emergency medical attention:

(1) The resident's name and birth date.

(2) The resident's Social Security number.

(3) The resident's medical diagnosis.

(4) The resident's physician's name and telephone number.

(5) Current medication, including the dosage and frequency.

(6) A list of allergies.

(7) Other relevant medical conditions.

(8) Insurance or third party payer and identification number.

(9) A power of attorney for health care or health care proxy, if applicable.

(10) The resident's designated person with current address and telephone number.

(11) Personal information and related instructions regarding advance directives, do not resuscitate orders or organ donation, if applicable.

(12) A speech, hearing or vision need which requires accommodation or awareness, such as written communication or American sign language.

(13) A language need which requires accommodation or awareness, such as an interpreter of translation.

§ 2800.144. Use of tobacco.

(a) A residence may permit smoking tobacco in a designated smoking room of the residence.

(b) The residence rules must specify whether the residence is designated as smoking or nonsmoking.

(c) A residence that permits smoking inside or outside of the residence shall develop and implement written fire safety policy and procedures that include the following:

(1) Proper safeguards inside and outside of the residence to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the residence, extinguishing procedures, fire resistant furniture both inside and outside the residence and fire extinguishers in the smoking rooms.

(2) Location of a smoking room or outside smoking area a safe distance from heat sources, hot water heaters, combustible or flammable materials and away from common walkways and exits.

(3) Prohibition of the use of tobacco during transportation by the residence.

(d) Smoking outside of the smoking room is prohibited.

NUTRITION

§ 2800.161. Nutritional adequacy.

(a) Meals shall be offered that meet the recommended dietary allowances established by the United States Department of Agriculture.

(b) At least three nutritionally well-balanced meals shall be offered daily to the resident. Each meal shall include an alternative food and drink item from which the resident may choose.

(c) Additional portions of meals and beverages at mealtimes shall be available for the resident.

(d) A resident's special dietary needs as prescribed by a physician, physician's assistant, certified registered nurse practitioner or dietitian shall be met. Documentation of the resident's special dietary needs shall be kept in the resident's record.

(e) Dietary alternatives shall be available for a resident who has special health needs or religious beliefs regarding dietary restrictions.

(f) Drinking water shall be available to the resident at all times.

(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.

(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 service provision) in their living units unless it would be unsafe for them to do so consistent with their support plan.

§ 2800.162. Meals.

(a) There may not be more than 15 hours between the evening meal and the first meal of the next day. There

may not be more than 6 hours between breakfast and lunch, and between lunch and supper. This requirement does not apply if a resident's physician has prescribed otherwise.

(b) When a resident misses a meal, food adequate to meet daily nutritional requirements shall be available and offered to the resident.

(c) Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the residence.

(d) Past menus of meals that were served, including changes, shall be kept for at least 1 month.

(e) A change to a menu shall be posted in a conspicuous and public place in the residence and shall be accessible to a resident in advance of the meal. Meal substitutions shall be made in accordance with § 2800.161 (relating to nutritional adequacy).

(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.

(g) Appropriate cueing shall be used to encourage and remind residents to eat and drink, as indicated in the resident's support plan.

§ 2800.163. Personal hygiene for food service workers.

(a) Staff persons, volunteers and residents involved in the storage, preparation, serving and distributing of food shall wash their hands with hot water and soap prior to working in the kitchen areas and after using the bathroom.

(b) Staff persons, volunteers and residents shall follow sanitary practices while working in the kitchen areas.

(c) Staff persons, volunteers and residents involved with the storage, preparation, serving and distributing of food shall be in good health.

(d) Staff persons, volunteers and residents who have a discharging or infected wound, sore, lesion on hands, arms or any exposed portion of their body may not work in the kitchen areas in any capacity.

§ 2800.164. Withholding or forcing of food prohibited.

(a) A residence may not withhold meals, beverages, snacks or desserts as punishment. Food and beverages may be withheld in accordance with prescribed medical or dental procedures.

(b) A resident may not be forced to eat food.

(c) If a resident refuses to eat or drink continuously during a 24-hour period, the resident's primary care physician and the resident's designated person shall be immediately notified.

(d) If a resident has a cognitive impairment that affects the resident's ability to consume adequate amounts of food and water, a staff person shall encourage and remind the resident to eat and drink.

TRANSPORTATION

§ 2800.171. Transportation.

(a) A residence shall be required to provide or arrange for transportation on a regular weekly basis that permits residents to schedule medical and social appointments within a reasonable local area.

(b) The following requirements apply whenever staff persons or volunteers of the residence provide transportation for the resident:

(1) The occupants of the vehicle shall be in an appropriate safety restraint at all times the vehicle is in motion.

(2) The driver of a vehicle shall be 18 years of age or older and possess a valid driver's license.

(3) The driver of the residence vehicle cannot be a resident.

(4) At least one staff member transporting or accompanying the residents shall have completed the initial new hire direct care staff person training as specified in § 2800.65 (relating to staff orientation and direct care staff person training and orientation).

(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 external defibrillation device in a vehicle is optional.

(6) During vehicle operations, the driver may only use a hands-free cellular telephone.

(7) Transportation must include, when necessary, an assistant to the driver who assists the driver to escort residents in and out of the residence and provides assistance during the trip.

(c) The residence shall maintain current copies of the following documentation for each of the residence's vehicles used to transport residents:

(1) Vehicle registration.

(2) Valid driver's license for vehicle operator.

(3) Vehicle insurance.

(4) Current inspection.

(5) Commercial driver's license for vehicle operator if applicable.

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

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

(2) The resident may not be dropped off at the medical or social appointment more that 1 hour prior to the time of the appointment.

(3) The residence shall make every reasonable effort to pick-up a resident from a medical appointment no later than 1 hour after the medical appointment.

(4) The residence shall make every reasonable effort to pick-up a resident from a social appointment no later than 1 hour after the end of the social appointment.

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

(1) The residence shall schedule a pick-up time for the resident to be transported to the medical or social appointment. The residence shall make every reasonable

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

(2) The residence shall make every reasonable effort for a resident to not be dropped off at the medical or social appointment more that 1 hour prior to the time of the appointment.

(3) The residence shall make every reasonable effort for a resident to be picked-up from the medical appointment no later than 1 hour after the medical appointment.

(4) The residence shall make every reasonable effort for a resident to be picked-up from the social appointment no later than 1 hour after the end of the social appointment.

MEDICATIONS

§ 2800.181. Self-administration.

(a) A residence shall provide residents with assistance, as needed, with medication prescribed for the resident's self-administration. This assistance includes helping the resident to remember the schedule for taking the medication, storing the medication in a secure place and offering the resident the medication at the prescribed times.

(b) If assistance includes helping the resident to remember the schedule for taking the medication, the resident shall be reminded of the prescribed schedule. Appropriate cueing shall be used to remind residents to take their medication.

(c) The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2800.227(e) (relating to development of the final support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

(d) If the resident does not need assistance with medication, medication may be stored in a resident's living unit for self-administration. Medications stored in the resident's living unit shall be kept in a safe and secure location to protect against contamination, spillage and theft. The residence shall provide a lockable storage unit for this purpose.

(e) To be considered capable to self-administer medications, a resident shall:

(1) Be able to recognize and distinguish his medication.

(2) Know how much medication is to be taken.

(3) Know when medication is to be taken.

(f) The resident's record shall include a current list of prescription, CAM and OTC medications for each resident who is self-administering his medication.

§ 2800.182. Medication administration.

(a) A residence shall provide medication administration services for a resident who is assessed to need medication administration services in accordance with § 2800.181 (relating to self-administration) and for a resident who chooses not to self-administer medications.

(b) Prescription medication that is not self-administered by a resident shall be administered by one of the following:

(1) A physician, licensed dentist, licensed physician's assistant, RN, certified registered nurse practitioner, LPN or licensed paramedic.

(2) A graduate of an approved nursing program functioning under the direct supervision of a professional nurse who is present in the residence.

(3) A student nurse of an approved nursing program functioning under the direct supervision of a member of the nursing school faculty who is present in the residence.

(4) A staff person who has completed the medication administration training as specified in § 2800.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

(c) Medication administration includes the following activities, based on the needs of the resident:

(1) Identify the correct resident.

(2) If indicated by the prescriber's orders, measure vital signs and administer medications accordingly.

(3) Remove the medication from the original container.

(4) Crush or split the medication as ordered by the prescriber.

(5) Place the medication in a medication cup or other appropriate container, or in the resident's hand.

(6) Place the medication in the resident's hand, mouth or other route as ordered by the prescriber, in accordance with the limitations specified in subsection (b)(4).

(7) Complete documentation in accordance with § 2800.187 (relating to medication records).

§ 2800.183. Storage and disposal of medications and medical supplies.

(a) Prescription medications, OTC medications and CAM shall be kept in their original labeled containers and may not be removed more than 2 hours in advance of the scheduled administration. Assistance with insulin and epinephrine injections and sterile liquids shall be provided immediately upon removal of the medication from its container.

(b) Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes unless kept in the resident's living unit.

(c) Prescription medications, OTC medications and CAM stored in a refrigerator shall be kept in an area or container that is locked unless the resident has the capacity to store the medications in the resident's own refrigerator in the resident's living unit.

(d) Only current prescription, OTC medications, sample and CAM for individuals living in the residence may be kept in the residence.

(e) Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

(f) Prescription medications, OTC medications and CAM that are discontinued, expired or for residents who are no longer served at the residence shall be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations. When a resident permanently leaves the residence, the resident's medications shall be given to the resident, the designated person, if any, or the person or entity taking responsibility for the new placement on the day of departure from the residence.

(g) Subsections (a) and (e) do not apply to a resident who self-administers medication and stores the medication in his living unit.

§ 2800.184. Labeling of medications.

(a) The original container for prescription medications must be labeled with a pharmacy label that includes the following:

(1) The resident's name.

(2) The name of the medication.

(3) The date the prescription was issued.

(4) The prescribed dosage and instructions for administration.

(5) The name and title of the prescriber.

(b) If the OTC medications and CAM belong to the resident, they must be identified with the resident's name.

(c) Sample prescription medications must have written instructions from the prescriber that include the components specified in subsection (a).

§ 2800.185. Accountability of medication and controlled substances.

(a) The residence shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

(b) At a minimum, the procedures must include:

(1) Documentation of the receipt of controlled substances and prescription medications.

(2) A process to investigate and account for missing medications and medication errors.

(3) Limited access to medication storage areas.

(4) Documentation of the administration of prescription medications, OTC medications and CAM for residents who receive medication administration services or assistance with self-administration. This requirement does not apply to a resident who self-administers medication without the assistance of a staff person and stores the medication in his living unit.

(5) To the extent indicated in the resident's support plan, the residence shall obtain prescribed medication for residents and keep an adequate supply of resident medication on hand at all times.

§ 2800.186. Prescription medications.

(a) Each prescription medication must be prescribed in writing by an authorized prescriber. Prescription orders shall be kept current.

(b) Prescription medications shall be used only by the resident for whom the prescription was prescribed.

(c) Changes in medication may only be made in writing by the prescriber, or in the case of an emergency, an alternate prescriber, except for circumstances in which oral orders may be accepted by nurses in accordance with regulations of the Department of State. The resident's medication record shall be updated as soon as the residence receives written notice of the change.

§ 2800.187. Medication records.

(a) A medication record shall be kept to include the following for each resident for whom medications are administered:

(1) Resident's name.

(2) Drug allergies.

(3) Name of medication.

(4) Strength.

(5) Dosage form.

(6) Dose.

(7) Route of administration.

(8) Frequency of administration.

(9) Administration times.

(10) Duration of therapy, if applicable.

(11) Special precautions, if applicable.

(12) Diagnosis or purpose for the medication, including pro re nata (PRN).

(13) Date and time of medication administration.

(14) Name and initials of the staff person administering the medication.

(b) The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

(c) If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

(d) The residence shall follow the directions of the prescriber.

§ 2800.188. Medication errors.

(a) Medication errors include the following:

(1) Failure to administer a medication.

(2) Administration of the wrong medication.

(3) Administration of the wrong amount of medication.

(4) Failure to administer a medication at the prescribed time.

(5) Administration to the wrong resident.

(6) Administration through the wrong route.

(b) A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

(c) Documentation of medication errors and the prescriber's response shall be kept in the resident's record.

(d) There shall be a system in place to identify and document medication errors and the residence's pattern of error.

(e) There shall be documentation of the follow-up action that was taken to prevent future medication errors.

§ 2800.189. Adverse reaction.

(a) If a resident has a suspected adverse reaction to a medication, the residence shall immediately consult a physician or seek emergency medical treatment. The resident's designated person shall be notified, if applicable.

(b) The residence shall document adverse reactions, the prescriber's response and any action taken in the resident's record.

§ 2800.190. Medication administration training.

(a) A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

(b) A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

(c) A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

§ 2800.191. Resident education.

The residence shall educate 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.

SAFE MANAGEMENT TECHNIQUES

§ 2800.201. Safe management techniques.

The residence shall use positive interventions to modify or eliminate a behavior that endangers the resident himself or others. Positive interventions include improving communications, reinforcing appropriate behavior, redirection, conflict resolution, violence prevention, praise, deescalation techniques and alternative techniques or methods to identify and defuse potential emergency situations.

§ 2800.202. Prohibitions.

The following procedures are prohibited:

(1) Seclusion, defined as involuntary confinement of a resident in a room or living unit from which the resident is physically prevented from leaving, is prohibited. This does not include the admission of a resident in a secured dementia care unit in accordance with § 2800.231 (relating to admission).

(2) Aversive conditioning, defined as the application of startling, painful or noxious stimuli, is prohibited.

(3) Pressure point techniques, defined as the application of pain for the purpose of achieving compliance, is prohibited.

(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.

(5) A mechanical restraint, defined as a device that restricts the movement or function of a resident or portion of a resident's body, is prohibited. Mechanical restraints include geriatric chairs, handcuffs, anklets, wristlets, camisoles, helmet with fasteners, muffs and mitts with fasteners, poseys, waist straps, head straps, papoose boards, restraining sheets, chest restraints and other types of locked restraints. A mechanical restraint does not include a device used to provide support for the achievement of functional body position or proper balance that has been prescribed by a medical professional as long as the resident can easily remove the device or the resident or his designee understands the need for the device and consents to its use.

(6) A manual restraint, defined as a hands-on physical means that restricts, immobilizes or reduces a resident's ability to move his arms, legs, head or other body parts freely, is prohibited. A manual restraint does not include prompting, escorting or guiding a resident to assist in the ADLs or IADLs.

§ 2800.203. Bedside rails.

(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.

SERVICES

§ 2800.220. Service provision.

(a) *Services.* The residence shall provide assisted living services as specified in subsection (b). The residence shall offer and provide the core service packages specified in subsection (c). The residence shall provide or arrange for the provision of supplemental health care services as specified in subsection (e). 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 assisted living services provided by the residence and do not supplant them.

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

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

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

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

(4) Assistance with performing ADLs and IADLs 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) Housekeeping services essential for the health, safety and comfort of the resident based upon the resident's needs and preferences.

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

(8) Financial management in accordance with § 2800.20 (relating to financial management).

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

(10) Activities and socialization.

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

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

(1) *Independent Core Package.* This core package shall be provided to residents who do not require assistance with ADLs. The services must include the following:

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

(ii) Nutritious meals and snacks in accordance with §§ 2800.161 and 2800.162.

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

(iv) Laundry services in accordance with § 2800.105.

(v) Assistance with unanticipated ADLs for a defined recovery period.

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

(vii) Basic cognitive support services as defined in § 2800.4.

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

(i) The services provided in the basic core package under paragraph (c)(1)(i)—(vii).

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

(iii) Transportation in accordance with § 2800.171.

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

(d) *Opt-out.* If a resident wishes not to have the residence provide a service under subsection (c)(1)(ii)—(iv), the resident-residence contract must state the following:

(1) The service not being provided.

(2) The corresponding fee schedule charge adjustment that takes into account the reduction in service.

(e) *Supplemental health care services.* The residence shall provide or arrange for the provision of supplemental health care services, including, but not limited to, the following:

(1) Hospice services.

(2) Occupational therapy.

(3) Skilled nursing services.

(4) Physical therapy.

(5) Behavioral health services.

(6) Home health services.

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

(8) Specialized cognitive support services as defined in § 2800.4.

§ 2800.221. Activities program.

(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 and provide the necessary space and equipment for the activities in accordance with §§ 2800.98 and 2800.99 (relating to indoor activity space; and recreation space). The residence shall offer the opportunity for the residents' active participation in the development of the daily activities calendar.

(b) The program must be based upon individual and group interests and provide social, physical, intellectual and recreational activities in a planned, coordinated and structured manner and shall encourage active participation in the community at large.

(c) The week's daily activity calendar shall be posted in advance in a conspicuous and public place in the residence. The residence shall provide verbal cueing and reminders of activities, their start times and locations within the residence.

§ 2800.222. Community social services.

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.

§ 2800.223. Description of services.

(a) The residence shall have a current written description of services and activities that the residence provides including the following:

(1) The scope and general description of the services and activities that the residence provides.

(2) The criteria for admission and discharge.

(3) Specific services that the residence does not provide, but will arrange or coordinate.

(b) The residence shall develop written procedures for the delivery and management of services from admission to discharge.

§ 2800.224. Initial assessment and preliminary support plan.

(a) *Initial assessment.*

(1) The administrator, administrator designee, or LPN, under the supervision of an RN, or an RN shall complete the initial assessment.

(2) An individual shall have a written initial assessment that is documented on the Department's assessment form within 30 days prior to admission unless one of the conditions contained in paragraph (3) apply.

(3) A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days after admission if one of the following conditions applies:

(i) The resident is being admitted directly to the residence from an acute care hospital.

(ii) The resident is being admitted to escape from an abusive situation.

(iii) The resident has no alternative living arrangement.

(4) A residence may use its own assessment form if it includes the same information as the Department's assessment form.

(5) The written initial assessment must, at a minimum include the following:

(i) The individual's need for assistance with ADLs and IADLs.

(ii) The mobility needs of the individual.

(iii) The ability of the individual to self-administer medication.

(iv) The individual's medical history, medical conditions, and current medical status and how they impact or interact with the individual's service needs.

(v) The individual's need for supplemental health care services.

(vi) The individual's need for special diet or meal requirements.

(vii) The individual's ability to safely operate key-locking devices.

(viii) The individual's ability to evacuate from the residence.

(b) An initial assessment will not be required to commence supplemental health care services to a resident of a residence under any of the following circumstances:

(1) If the resident was not receiving the services at the time of the resident's admission.

(2) To transfer a resident from a portion of a residence that does not provide supplemental health care services to a portion of the residence that provides such service.

(3) To transfer a resident from a personal care home to a residence licensed by the same operator.

(c) *Preliminary support plan.*

(1) An individual requiring services shall have a written preliminary support plan developed within 30 days prior to admission to the residence unless one of the conditions contained in paragraph (2) applies.

(2) A resident requiring services shall have a written preliminary support plan developed within 15 days after admission if one of the following conditions applies:

(i) The resident is being admitted directly to the residence from an acute care hospital.

(ii) The resident is being admitted to escape from an abusive situation.

(iii) Any other situation where the resident has no alternative living arrangement.

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

(4) The preliminary support plan shall be documented on the Department's support plan form.

(5) A residence may use its own support plan form it if includes the same information as the Department's support plan form. An LPN, under the supervision of an RN, or an RN shall review and approve the preliminary support plan.

(6) An individual's preliminary support plan must document the ability of the individual to self-administer medications or the need for medication reminders or medication administration and the ability of the resident to safely operate key-locking devices.

(7) An individual shall be encouraged to participate in the development of the preliminary support plan. An individual may include a designated person or family member in making decisions about services.

(8) Individuals who participate in the development of the preliminary support plan shall sign and date the preliminary support plan.

(9) If an individual or designated person is unable or chooses not to sign the preliminary support plan, a notation of inability or refusal to sign shall be documented.

(10) The residence shall give a copy of the preliminary support plan to the resident and the resident's designated person.

§ 2800.225. Additional assessments.

(a) The administrator or administrator designee, or an LPN, under the supervision of an RN, or an RN shall complete additional written assessments for each resident. A residence may use its own assessment form if it includes the same information as the Department's assessment form. Additional written assessments shall be completed as follows:

(1) Annually.

(2) If the condition of the resident significantly changes prior to the annual assessment.

(3) At the request of the Department upon cause to believe that an update is required.

(b) The assessment must, at a minimum include the following:

(1) The resident's need for assistance with ADLs and IADLs.

(2) The mobility needs of the resident.

(3) The ability of the resident to self-administer medication.

(4) The resident's medical history, medical conditions, and current medical status and how these impact or interact with the individual's service needs.

(5) The resident's need for supplemental health care services.

(6) The resident's need for special diet or meal requirements.

(7) The resident's ability to safely operate key-locking devices.

§ 2800.226. Mobility criteria.

(a) The resident shall be assessed for mobility needs as part of the resident's assessment.

(b) If a resident is determined to have mobility needs as part of the resident's initial or annual assessment, specific requirements relating to the care, health and safety of the resident shall be met immediately.

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

§ 2800.227. Development of the final support plan.

(a) Each resident requiring services shall have a written final support plan developed and implemented within 30 days after admission to the residence. The final support plan shall be documented on the Department's support plan form.

(b) A residence may use its own support plan form if it includes the same information as the Department's support plan form. An LPN, under the supervision of an RN, shall review and approve the final support plan.

(c) The final 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 final support plan on a quarterly basis and modify as necessary to meet the resident's needs.

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

(e) The resident's final support plan must document the ability of the resident to self-administer medications or the need for medication reminders or medication administration and the ability of the resident to safely operate key-locking devices. Strategies that promote interactive communication on the part of and between direct care staff and individual residents shall also be included in the final support plan.

(f) A resident shall be encouraged to participate in the development and implementation of the final support plan. A resident may include a designated person or family member in making decisions about services.

(g) Individuals who participate in the development of the final support plan shall sign and date the support plan.

(h) If a resident or designated person is unable or chooses not to sign the final support plan, a notation of inability or refusal to sign shall be documented.

(i) The final support plan shall be accessible by direct care staff persons at all times.

(j) A resident or a designated person has a right to request the review and modification of his support plan.

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

§ 2800.228. Transfer and discharge.

(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.

(v) The resident's transfer or discharge rights, as applicable.

(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. 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 well-being 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 and the resident's designated person. The residence shall provide justification for the residence's determination that the needs of the resident cannot be met. 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.

(i) If grounds for transfer or discharge is based upon subsection (h)(1) or (3), a certification from one of the following individuals shall be required to certify in writing that the resident can no longer be retained in the residence:

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

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

(3) The medical director of the residence.

§ 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. 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 with an excludable condition 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.

(10) For purposes of paragraphs (1), (4), (7) and (8), a "qualified individual" means an individual who has been determined by a certification provider listed under subsection (d) to be capable of care or administration under paragraphs (1), (4), (7) and (8).

(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.

SPECIAL CARE UNITS

§ 2800.231. Admission.

(a) *Special care units.* 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 one or both of the following:

(1) Specialized care and services for residents with Alzheimer's disease or 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.

(i) Admission of a resident shall be in consultation with the resident's family or designated person.

(ii) Prior to admission other service options that may be available to a resident shall be considered.

(2) Intense neurobehavioral rehabilitation for residents with severely disruptive and potentially dangerous behaviors as a result of brain injury in the least restrictive manner consistent with the resident's rehabilitation and support plan to ensure the safety of the resident and others in the residence.

(i) Each resident of a special care unit for INRBI shall have a rehabilitation and support plan that supports independence and promotes recovery and thereby discharge to a less restrictive setting.

(ii) Special care units for INRBI shall provide for each resident to age in place.

(iii) Admission of a resident shall be in consultation with the resident or potential resident and, when appropriate, the resident's designated person or the resident's family, or both.

(iv) Prior to admission other less restrictive service options that may be available to a resident or potential resident shall be considered.

(b) *Medical evaluation.* A resident or potential resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission.

(1) Documentation for a special care unit for residents with Alzheimer's disease or dementia must include the resident's diagnosis of Alzheimer's disease or dementia and the need for the resident to be served in a special care unit.

(2) Documentation for a special care unit for INRBI must include the resident's or potential resident's diagnosis of brain injury and need for residential services to be provided in a special care unit for INRBI. The evaluation must include visual function, hearing, swallowing, mobility and hand function.

(c) *Preadmission screening.*

(1) *Special care unit for residents with Alzheimer's disease or dementia.*

(i) A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's cognitive preadmission screening form shall be completed for each resident within 72 hours prior to admission to a special care unit.

(ii) A geriatric assessment team is a group of multidisciplinary specialists in the care of adults who are older that conducts a multidimensional evaluation of a resident and assists in developing a support plan by working with the resident's physician, designated person and the resident's family to coordinate the resident's care.

(2) *Special care unit for INRBI.*

(i) A written CPB preadmission screening completed in collaboration with a physician, neuropsychologist or cognitive, physical, behavioral assessment team and documented on the Department's CPB preadmission screening form shall be completed for each resident or potential resident within 72 hours prior to admission to a special care unit for INRBI.

(ii) A cognitive, physical, behavioral specialist with brain injury experience shall assist in developing a rehabilitation and support plan by working with the resident's physician, neuropsychologist and, when appropriate, the resident's designated person or the resident's family, or both to develop the resident's rehabilitation and support plan. This plan must include a high level of nursing and behavioral supervision, medication management, occupational therapy, cognitive therapy, behavioral therapy, vocational services, support for social reentry, and a personalized treatment plan.

(d) *Resident admission to special care unit.* Each resident record must have documentation that the resident or potential resident and, when appropriate, the resident's designated person or the resident's family have agreed to the resident's admission or transfer to the special care unit.

(e) *Additional assessments.*

(1) In addition to the requirements in § 2800.225 (relating to additional assessments), residents of a special care unit for Alzheimer's disease or dementia shall also be assessed quarterly for the continuing need for the special care unit for Alzheimer's disease or dementia.

(2) In addition to the requirements in § 2800.225, residents of a special care unit for INRBI shall also be assessed at least semiannually or more frequently as necessary to assure the continuing need for residence in the special care unit for INRBI.

(f) *Additional resident in special care unit.* A spouse, friend or family member who does not have a primary diagnosis of Alzheimer's disease or dementia or brain injury may reside in the special care unit if desired by the resident or his designated person.

(1) The spouse, friend or family member shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department within 60 days prior to admission to the residence or 15 days after admission to the residence.

(2) The spouse, friend or family member shall have access to and be able to follow directions for the operation of the key pads or other lock-releasing devices to exit the special care unit.

(g) *Disclosure of services.* The resident-residence contract specified in § 2800.25 (relating to resident-residence contract) must also include a disclosure of services, admission and discharge criteria, change in condition policies, special programming and costs and fees.

(h) *Alzheimer's disease or dementia.* When the residence holds itself out to the public as providing services or housing for individuals with Alzheimer's disease or dementia, the residence shall disclose to individuals and provide materials that include the following:

(1) The residence's written statement of its philosophy and mission which reflects the needs of individuals with Alzheimer's disease or dementia.

(2) A description of the residence's physical environment and design features to support the functioning of individuals with Alzheimer's disease or dementia.

(3) A description of the frequency and types of individual and group activities designed specifically to meet the needs of individuals with Alzheimer's disease or dementia.

(4) A description of the security measures provided by the residence.

(5) A description of the training provided to staff regarding provision of care to individuals with Alzheimer's disease or dementia.

(6) A description of availability of family support programs and family involvement.

(7) The process used for assessment and establishment of a plan of services for the individual, including methods by which the plan of services will remain responsive to changes in the individual's condition.

(i) *Special care unit for INRBI.* When an assisted living residence holds itself out to the public as a special care unit for INRBI, the residence shall disclose and provide materials to individuals and, when appropriate, the individual's designated person or the individual's family, or both, that include the following information:

(1) The residence's written statement of its philosophy and mission which reflects the needs of individuals with brain injury for intense neurobehavioral rehabilitation and support.

(2) A description of the residence's physical environment and design features that support and promote the functioning and rehabilitation of individuals who need INRBI.

(3) A description of the types of individual and group activities that have been designed specifically to meet the requirements of the rehabilitation and support plans of specific residents with brain injury.

(4) A description of the security measures provided by the residence.

(5) A description of the credentials and experience required and the training provided to staff regarding the provision of rehabilitation and support for individuals who require INRBI.

(6) A description of availability of family support programs, family education programs, and family involvement.

(7) The process used for assessment and establishment of a plan of services for the resident, including methods by which the plan of services will remain responsive to progress in the resident's recovery.

(j) *Residents who wander.* The residence shall identify measures to address individuals with Alzheimer's disease or dementia or with INRBI who have tendencies to wander.

(k) *Individuals with INRBI.* The residence with a special care unit for INRBI shall identify measures to address individuals who require INRBI who have problems that may actually impede rehabilitation such as:

(1) Anger.

(2) Self-control.

(3) Aggression toward others.

(4) Self-injury.

(5) Deficient judgment and problem solving due to cognitive deficits.

(6) Frequent agitation.

(7) Prolonged confusional state.

(8) Seizure disorders and related behavioral problems.

(9) Significant memory and learning problems.

(10) Disruption of sleep and wake cycles.

(11) Problems with attention.

(12) Filtering and focusing.

(13) Emergence of mental health problems or exacerbation of preexisting mental health issues.

(14) Emergence of substance abuse problems or exacerbation of preexisting substance abuse issues.

(15) Other cognitive and behavioral problems which have or would prevent successful completion of traditional rehabilitation programs.

(l) *Professionals caring for individuals requiring INRBI.* The residence with a special care unit for INRBI shall identify at a minimum the following professionals with expertise in providing care for individuals requiring INRBI.

(1) Onsite behavioral specialist.

(2) Onsite cognitive rehabilitation therapist.

(3) A consulting physiatrist; a consulting neuropsychologist.

(4) A consulting neuropsychiatrist or psychiatrist for prescribing and monitoring the psychiatric medications that may be needed for residents with behavioral health issues.

§ 2800.232. Environmental protection.

(a) The residence shall provide exercise space, both indoor and outdoor.

(b) No more than two residents may occupy a living unit regardless of its size. A living unit must meet the requirement in § 2800.101 (relating to resident living units), as applicable. Kitchen facilities may not be included in a living unit located in a special care unit for INRBI.

(c) The residence shall provide space for dining, group and individual activities and visits.

(d) The residence shall provide a full description of the measures implemented to enhance environmental awareness, minimize environmental stimulation and maximize independence of the residents in public and private spaces based on the needs of the individuals being served.

(e) The residence with a special care unit for INRBI shall identify the process used to assure conformity of the individual resident's living unit to the ongoing rehabilitation recommendations of the neuropsychologist and the cognitive physical, emotional behavioral assessment team as expressed in the current rehabilitation and support plan.

§ 2800.233. Doors, locks and alarms.

(a) Doors equipped with key-locking devices, electronic card operated systems or other devices that prevent immediate egress are permitted only if there is written approval from the Department of Labor and Industry, Department of Health or appropriate local building authority permitting the use of the specific locking system.

(b) A residence shall have a statement from the manufacturer, specific to that residence, verifying that the electronic or magnetic locking system will shut down, and that all doors will open easily and immediately when one or more of the following occurs:

(1) Upon a signal from an activated fire alarm system, heat or smoke detector.

(2) Power failure to the residence.

(3) Overriding the electronic or magnetic locking system by use of a key pad or other lock-releasing device.

(c) If key-locking devices, electronic card systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

(d) Doors that open onto areas such as parking lots, or other potentially unsafe areas, shall be locked by an electronic or magnetic system.

(e) Fire alarm systems must be interconnected to the local fire department, when available, or a 24-hour monitoring service approved by the local fire department.

§ 2800.234. Resident care.

(a) *Support or rehabilitation plan.*

(1) Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the special care unit, a support plan shall be developed, implemented and documented in each resident's record.

(2) For individuals being admitted into a special care unit for INRBI, a rehabilitation plan shall be developed, implemented and documented in the resident record. This rehabilitation plan and the individual's support plan shall be based on the CPB preadmission assessment and other available records and information.

(b) *Plan requirements.*

(1) The support plan and if applicable, the rehabilitation plan must identify the resident's physical, medical, social, cognitive and safety needs.

(2) The rehabilitation and support plan for residents of a special care unit for INRBI must identify the residents' emotional and behavioral needs.

(c) *Responsible individual.* The support plan and if applicable, the rehabilitation plan must identify the individual responsible to address the resident's needs.

(d) *Review of plans.*

(1) The support plan for a resident of a special care unit for residents with Alzheimer's disease or dementia shall be reviewed, and if necessary, revised at least quarterly and as the resident's condition changes.

(2) The support plan and rehabilitation plan for a resident of a special care unit for INRBI shall be reviewed, and if necessary, revised at least monthly and as the resident's condition changes.

(e) *Resident involvement in development of plan.* The resident, the resident's designated person or the resident's family shall be involved in the development and the revisions of the support plan and if applicable, the rehabilitation plan.

§ 2800.235. Discharge.

(a) If the residence initiates a discharge or transfer of a resident, or the legal entity chooses to close the residence, the administrator shall give a 30-day advance written notice to the resident, the resident's designated person and the referral agent citing the reasons for the discharge or transfer. This requirement shall be stipulated in the resident-residence contract signed prior to admission to the special care unit.

(b) If a resident of a special care unit for INRBI, or when appropriate, the resident's designated person or the resident's family, request discharge to another facility, another assisted living residence or an independent living arrangement, transition services shall be provided by the special care unit.

§ 2800.236. Training.

(a) Each direct care staff person working in a special care unit for residents with Alzheimer's disease or dementia shall have 8 hours of initial training within the first 30 days of the date of hire and a minimum of 8 hours of annual training related to dementia care and services, in addition to the 16 hours of annual training specified in § 2800.65 (relating to staff orientation and direct care staff person training and orientation).

(b) The training for each direct care staff person working in a special care unit for residents with Alzheimer's disease or dementia at a minimum must include the following topics:

(1) An overview of Alzheimer's disease and related dementias.

(2) Managing challenging behaviors.

(3) Effective communications.

(4) Assistance with ADLs.

(5) Creating a safe environment.

(c) Each direct care staff person working in a special care unit for INRBI shall have 8 hours of initial training within the first 30 days of the date of hire and a minimum of 8 hours of annual training related to brain injury, in addition to the 16 hours of annual training specified in § 2800.65 and any continuing education required for professional licensing.

(d) The training for each direct care staff person working in a special care unit for INRBI in addition to subsection (b)(3), (4) and (5), must at a minimum include the following topics:

(1) An overview of brain injury including the common cognitive, physical and behavioral effects.

(2) Understanding and managing challenging behaviors which follow from the cognitive, physical and behavioral effects of brain injury.

(3) Tailoring activities and interactions to provide individualized rehabilitation and support in accordance with the resident's rehabilitation and support plan.

(4) Coaching and cueing, interactive problem solving, promoting the initiation of self-soothing activities, and timing the fading of supports.

§ 2800.237. Program.

(a) The following types of activities shall be offered at least weekly to residents of a special care unit for residents with Alzheimer's disease or dementia:

(1) Gross motor activities, such as dancing, stretching and other exercise.

(2) Self-care activities, such as personal hygiene.

(3) Social activities, such as games, music and holiday and seasonal celebrations.

(4) Crafts, such as sewing, decorations and pictures.

(5) Sensory and memory enhancement activities, such as review of current events, movies, story telling, picture albums, cooking, pet therapy and reminiscing.

(6) Outdoor activities, as weather permits, such as walking, gardening and field trips.

(b) Resident participation for residents of a special care unit for residents with Alzheimer's disease or dementia in general activity programming shall:

(1) Be voluntary.

(2) Respect the resident's age and cognitive abilities.

(3) Support the retention of the resident's abilities.

(c) The rehabilitation and support plans of the residents in a special care unit for INRBI will determine the types and frequency of the individual and group activities to be offered.

§ 2800.238. Staffing.

Each resident in a special care unit shall be considered to be a resident with mobility needs under § 2800.57(c) (relating to direct care staffing).

§ 2800.239. Application to Department.

(a) The legal entity shall submit an application to the Department at least 60 days prior to the following:

(1) Opening a special care unit.

(2) Adding a special care unit to an existing residence.

(3) Increasing the maximum capacity in an existing unit.

(4) Changing the locking system, exit doors or floor plan of an existing unit.

(b) The Department will inspect and approve the special care unit prior to operation or change. The requirements of this chapter shall be met prior to operation.

(c) The following documents shall be included in the application specified in subsection (a):

(1) The name, address and legal entity of the residence.

(2) The name of the administrator of the residence.

(3) The maximum capacity of the residence.

(4) The requested resident population of the special care unit.

(5) A building description.

(6) A unit description.

(7) The type of locking system.

(8) Policy and procedures to be implemented for emergency egress and resident elopement.

(9) A sample of a 2-week staffing schedule.

(10) Verification of completion of additional training requirements.

(11) The operational description of the special care unit locking system of the doors.

(12) The manufacturer's statement regarding the special care unit locking system.

(13) A written approval or a variance permitting locked exit doors from the Department of Labor and Industry, the Department of Health or the appropriate local building authority.

(14) The name of the municipality or 24-hour monitoring service maintaining the interconnection with the residence's fire alarm system.

(15) A sample plan of care and service for the resident addressing the resident's physical, medical, social, cognitive and safety needs for the residents.

(16) The activity standards.

(17) The complete medical and cognitive preadmission assessment that is completed upon admission and reviewed and updated annually.

(18) A consent form agreeing to the resident's placement in the special care unit, to be signed by the resident or the resident's designated person.

(19) A written agreement containing full disclosure of services, admission and discharge criteria, change in condition policies, services, special programming, costs and fees.

(20) A description of environmental cues being utilized.

(21) A general floor plan of the entire residence.

(22) A specific floor plan of the special care unit, outside enclosed area and exercise space.

RESIDENT RECORDS

§ 2800.251. Resident records.

(a) A separate record shall be kept for each resident.

(b) The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

(c) The residence shall use standardized forms to record information in the resident's record.

(d) Separate resident records shall be kept on the premises where the resident lives.

(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 resident's designated person.

§ 2800.252. Content of resident records.

Each resident's record must include the following information:

(1) Name, gender, admission date, birth date and Social Security number.

(2) Race, height, weight at time of admission, color of hair, color of eyes, religious affiliation, if any, and identifying marks.

(3) A photograph of the resident that is no more than 2 years old.

(4) A language, speech, hearing or vision need which requires accommodation or awareness of during oral or written communication.

(5) The name, address, telephone number and relationship of a designated person to be contacted in case of an emergency.

(6) The name, address and telephone number of the resident's physician or source of health care.

(7) The current and previous 2 years' physician's examination reports, including copies of the medical evaluation forms.

(8) A list of prescribed medications, OTC medications and CAM.

(9) Dietary restrictions.

(10) A record of incident reports for the individual resident.

(11) A list of allergies.

(12) Documentation of health care services and orders, including orders for the services of visiting nurse or home health agencies.

(13) The initial assessment, the preliminary support plan and the most current version of the annual assessment.

(14) A final support plan.

(15) Applicable court order, if any.

(16) The resident's medical insurance information.

(17) The date of entrance into the residence, relocations and discharges, including the transfer of the resident to other residences owned by the same legal entity.

(18) An inventory of the resident's personal property as voluntarily declared by the resident upon admission and voluntarily updated.

(19) An inventory of the resident's property entrusted to the administrator for safekeeping.

(20) The financial records of residents receiving assistance with financial management.

(21) The reason for termination of services or transfer of the resident, the date of transfer and the destination.

(22) Copies of transfer and discharge summaries from hospitals, if available.

(23) If the resident dies in the residence, a copy of the official death certificate.

(24) Signed notification of rights, grievance procedures and applicable consent to treatment protections specified in § 2800.41 (relating to notification of rights and complaint procedures).

(25) A copy of the resident-residence contract.

(26) A termination notice, if any.

(27) A record relating to any exception request under § 2800.229 (relating to excludable conditions; exceptions).

(28) Ongoing resident progress notes.

§ 2800.253. Record retention and disposal.

(a) The resident's entire record shall be maintained for a minimum of 3 years following the resident's death, discharge from the residence or until any audit or litigation is resolved.

(b) Records shall be destroyed in a manner that protects confidentiality.

(c) The residence shall keep a log of resident records destroyed on or after January 18, 2011. This log must include the resident's name, record number, birth date, admission date and discharge date.

(d) Records required under this chapter that are not part of the resident records shall be kept for a minimum of 3 years or until any audit or litigation is resolved.

§ 2800.254. Record access and security.

(a) Records of active and discharged residents shall be maintained in a confidential manner, which prevents unauthorized access.

(b) Each residence shall develop and implement policy and procedures addressing record accessibility, security, storage, authorized use and release and who is responsible for the records.

(c) Resident records shall be stored in locked containers or a secured, enclosed area used solely for record storage and be accessible at all times to the administrator, the administrator's designee, or the nurse involved in assessment and support plan development and upon request, to the Department or representatives of the area agency on aging.

ENFORCEMENT

§ 2800.261. Classification of violations.

(a) The Department will classify each violation of this chapter into one of three categories as described in paragraphs (1)—(3). A violation identified may be classified as Class I, Class II or Class III, depending upon the severity, duration and the adverse effect on the health and safety of residents.

(1) *Class I.* Class I violations have resulted in or have a substantial probability of resulting in death or serious mental or physical harm to a resident.

(2) *Class II.* Class II violations have a substantial adverse effect upon the health, safety or well-being of a resident.

(3) *Class III.* Class III violations are minor violations, which have an adverse effect upon the health, safety or well-being of a resident.

(b) The Department's guidelines for determining the classification of violations are available from the Department.

§ 2800.262. Penalties and corrective action.

(a) The Department will assess a penalty for each violation of this chapter.

(b) Penalties will be assessed on a daily basis from the date on which the citation was issued until the date the violation is corrected, except in the case of Class II and Class III violations.

(c) In the case of a Class II violation, assessment of the penalty will be suspended for 5 days from the date of citation to permit sufficient time for the residence to correct the violation. If the residence fails to provide proof of correction of the violation to the Department within the 5-day period, the fine will be retroactive to the date of citation. The Department may extend the time period for good cause.

(d) The Department will assess a penalty of $20 per resident per day for each Class I violation. Each Class I violation shall be corrected within 24 hours.

(e) The Department will assess a minimum penalty of $5 per resident per day, up to a maximum penalty of $15 per resident per day, for each Class II violation.

(f) There is no monetary penalty for Class III violations unless the residence fails to correct the violation within 15 days. Failure to correct a Class III violation within the 15-day period may result in a penalty assessment of up to $3 per resident per day for each Class III violation retroactive to the date of the citation.

(g) If a residence is found to be operating without a license, a penalty of $500 will be assessed. After 14 days, if the residence operator cited for operating without a license fails to file an application for a license, the Department will assess an additional $20 for each resident for each day during which the residence operator fails to apply.

(h) A residence charged with a violation of this chapter or Chapter 20 (relating to licensure or approval of facilities and agencies) has 30 days to pay the assessed penalty in full.

§ 2800.263. Appeals of penalty.

(a) If the residence that is fined intends to appeal the amount of the penalty or the fact of the violation, the residence shall forward the assessed penalty, not to exceed $500, to the Secretary for placement in an escrow account with the State Treasurer. A letter appealing the penalty shall be submitted with the assessed penalty. This process constitutes an appeal.

(b) If, through an administrative hearing or judicial review of the proposed penalty, it is determined that no violation occurred or that the amount of the penalty shall be reduced, the Secretary will, within 30 days, remit the appropriate amount to the legal entity together with interest accumulated on these funds in the escrow deposit.

(c) Failure to forward payment of the assessed penalty to the Secretary within 30 days will result in a waiver of the right to contest the fact of the violation or the amount of the penalty.

(d) After an administrative hearing decision that is adverse to the legal entity, or a waiver of the administrative hearing, the assessed penalty amount will be made

payable to the "Commonwealth of Pennsylvania." It will be collectible in a manner provided by law for the collection of debts.

(e) If a residence liable to pay the penalty neglects or refuses to pay the penalty upon demand, the failure to pay will constitute a judgment in favor of the Commonwealth in the amount of the penalty, together with the interest and costs that may accrue on these funds.

§ 2800.264. Use of fines.

(a) Money collected by the Department under this section will be placed in a special restricted receipt account.

(b) Money collected will be used first to defray the expenses incurred by residents relocated under this chapter.

(c) The Department will use money remaining in this account to assist with paying for enforcement of this chapter. Fines collected will not be subject to 42 Pa.C.S. § 3733 (relating to deposits into account).

§ 2800.265. Review of classifications.

Semiannually, the Department will review the standard guidelines for the classification of violations and evaluate the use of these guidelines. This review is to ensure the uniformity and consistency of the classification process.

§ 2800.266. Revocation or nonrenewal of licenses.

(a) The Department will temporarily revoke the license of a residence if, without good cause, one or more Class I violations remain uncorrected 24 hours after the residence has been cited for the violation.

(b) The Department will temporarily revoke the license of a residence if, without good cause, one or more Class II violations remain uncorrected 15 days after the citation.

(c) Upon the revocation of a license in the instances described in subsections (a) and (b), or if the residence continues to operate without applying for a license as described in § 2800.262(h) (relating to penalties and corrective action), residents shall be relocated.

(d) The revocation of a license may terminate upon the Department's determination that its violation is corrected.

(e) If, after 3 months, the Department does not issue a new license for a residence, the prior license is revoked under section 1087 of the Public Welfare Code (62 P. S. § 1087).

(1) Revocation or nonrenewal under this section will be for a minimum of 5 years.

(2) A residence, which has had a license revoked or not renewed under this section, will not be allowed to operate, staff or hold an interest in a residence which applies for a license for 5 years after the revocation or nonrenewal.

(f) If a residence has been found to have Class I violations on two or more separate occasions during a 2-year period without justification, the Department will revoke or refuse to renew the license of the residence.

(g) The power of the Department to revoke or refuse to renew or issue a license under this section is in addition to the powers and duties of the Department under section 1026 of the Public Welfare Code (62 P. S. § 1026).

§ 2800.267. Relocation of residents.

(a) If the relocation of residents is due to the failure of the residence to apply for a license, the Department will offer relocation assistance to the residents. This assistance will include each resident's involvement in planning the relocation, except in the case of an emergency. Each resident shall have the right to choose among the available alternatives after an opportunity to visit the alternative residences. These procedures will occur even if the residents are placed in a temporary living situation.

(b) A resident will not be relocated if the Secretary determines in writing that the relocation is not in the best interest of the resident.

§ 2800.268. Notice of violations.

(a) The administrator shall give each resident and the resident's designated person written notification of a Class I violation within 24 hours of the citation.

(b) The administrator shall give each resident and the resident's designated person oral or written notification of a Class I or Class II violation, as defined in § 2800.261 (relating to classification of violations), which remains uncorrected for 5 days after the date of citation.

(c) If a Class II violation remains uncorrected within 5 days following the citation, the administrator shall give written notice of the violation to each resident and the resident's designated person on the 6th day from the date of the citation.

(d) The Department will provide immediate written notification to the appropriate long-term care ombudsman of Class I violations, and notification of Class II violations which remain uncorrected 5 days after the date of citation.

§ 2800.269. Ban on admissions.

(a) The Department will ban new admissions to a residence:

(1) That has been found to have a Class I violation.

(2) That has been found to have a Class II violation that remains uncorrected without good cause 5 days after being cited for the violation.

(3) Whose license has been revoked or nonrenewed.

(b) The Department may ban new admissions to a residence that has been found to have a repeated Class II violation within the past 2 years.

(c) A ban on admissions will remain in effect until the Department determines that the residence has corrected the violation, and after the correction has been made, has maintained regulatory compliance for a period of time sufficient to permit a conclusion that the compliance will be maintained for a prolonged period.

§ 2800.270. Correction of violations.

The correction of a violation cited under section 1086 of the Public Welfare Code (62 P. S. § 1086) does not preclude the Department from issuing a provisional license based upon the same violation.

Appendix A

Assisted Living Resident Rights: During Residency and During Discharge or Termination of Residency

The following are assisted living resident rights, including the notification of a resident's designated person:

General Requirements

1	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.	§ 2800.25(h) Resident-residence contract
2	Either party has a right to rescind the informed consent agreement within 30 days of execution of the agreement.	§ 2800.30(k) Informed consent process

Resident Rights

3	Upon admission, each resident and, if applicable, the resident's designated person, shall be informed of resident rights and the right to lodge complaints without intimidation, retaliation or threats of retaliation by the residence or its staff persons against the reporter. Retaliation includes transfer or discharge from the residence.	§ 2800.41(a) Notification of rights and complaint procedures
4	Notification of rights and complaint procedures shall be communicated in an easily understood manner and in a language understood by or mode of communication used by the resident, and if applicable, the resident's designated person.	§ 2800.41(b) Notification of rights and complaint procedures
5	The Department's poster of the list of resident's rights shall be posted in a conspicuous and public place in the residence.	§ 2800.41(c) Notification of rights and complaint procedures
6	A copy of the resident's rights and complaint procedures shall be given to the resident and, if applicable, the resident's designated person upon admission.	§ 2800.41(d) Notification of rights and complaint procedures
7	A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.	§ 2800.41(e) Notification of rights and complaint procedures
8	A resident may not be discriminated against because of race, color, religious creed, disability, ancestry, sexual orientation, national origin, age or sex.	§ 2800.42(a) Specific rights
9	A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way. A resident must be free from mental, physical, and sexual abuse and exploitation, neglect, financial exploitation and involuntary seclusion.	§ 2800.42(b) Specific rights
10	A resident shall be treated with dignity and respect.	§ 2800.42(c) Specific rights
11	A resident shall be informed of the rules of the residence and given 30 days written notice prior to the effective date of a new residence rule.	§ 2800.42(d) Specific rights
12	A resident shall have access to a telephone in the residence to make calls in privacy. Nontoll calls must be without charge to the resident.	§ 2800.42(e) Specific rights
13	A resident has the right to receive and send mail. 1. Outgoing mail may not be opened or read by staff persons unless the resident requests. 2. Incoming mail may not be opened or read by staff persons unless the resident requests.	§ 2800.42(f)(1) & (2) Specific rights
14	A resident has the right to communicate privately with and access the local ombudsman.	§ 2800.42(g) Specific rights
15	A resident has the right to practice the religion or faith of the resident's choice, or not to practice any religion or faith.	§ 2800.42(h) Specific rights
16	A resident shall receive assistance in accessing health care services, including supplemental health care services.	§ 2800.42(i) Specific rights

17	A resident shall receive assistance in obtaining and keeping clean, seasonal clothing. A resident's clothing may not be shared with other residents.	§ 2800.42(j) Specific rights
18	A resident and the resident's designated person, and other individuals upon the resident's written approval shall have the right to access, review and request corrections to the resident's record.	§ 2800.42(k) Specific rights
19	A resident has the right to furnish his living unit and purchase, receive, use and retain personal clothing and possessions.	§ 2800.42(l) Specific rights
20	A resident has the right to leave and return to the residence at times consistent with the residence rules and the resident's support plan.	§ 2800.42(m) Specific rights
21	A resident has the right to relocate and to request and receive assistance, from the residence, in relocating to another facility. The assistance must include helping the resident get information about living arrangements, making telephone calls and transferring records.	§ 2800.42(n) Specific rights
22	A resident has the right to freely associate, organize and communicate privately with his friends, family, physician, attorney and other persons.	§ 2800.42(o) Specific rights
23	A resident shall be free from restraints.	§ 2800.42(p) Specific rights
24	A resident shall be compensated in accordance with State and Federal labor laws for labor performed on behalf of the residence. Residents may voluntarily and without coercion perform tasks related directly to the resident's personal space or common areas of the residence.	§ 2800.42(q) Specific rights
25	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 residence.	§ 2800.42(r) Specific rights
26	A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.	§ 2800.42(s) Specific rights
27	A resident has the right to file complaints, grievances or appeals with any individual or agency and recommend changes in policies, residence rules and services of the residence without intimidation, retaliation or threat of discharge.	§ 2800.42(t) Specific rights
28	A resident has the right to remain in the residence, as long as it is operating with a license, except as specified in § 2800.228 (relating to transfer and discharge).	§ 2800.42(u) Specific rights
29	A resident has the right to receive services contracted for in the resident-residence contract.	§ 2800.42(v) Specific rights
30	A resident has the right to use both the residence's procedures and external procedures to appeal involuntary discharge.	§ 2800.42(w) Specific rights
31	A resident has the right to a system to safeguard a resident's money and property.	§ 2800.42(x) Specific rights
32	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 medical care and supplemental health care services). When the residence does not designate, the resident may choose the supplemental health care services 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.	§ 2800.42(y) Specific rights
33	The resident has the right to choose his primary care physician.	§ 2800.42(z) Specific rights
34	A resident may not be deprived of his rights.	§ 2800.43(a) Prohibition against deprivation of rights
35	A resident's rights may not be used as a reward or sanction.	§ 2800.43(b) Prohibition against deprivation of rights

36	Waiver of any resident right shall be void.	§ 2800.43(c) Prohibition against deprivation of rights
37	Prior to admission, the residence shall inform the resident and the resident's designated person of the right to file and the procedure for filing a complaint with the Department's Assisted Living Residence Licensing Office, local ombudsman or protective services unit in the area agency on aging, the Disability Rights Network or law enforcement agency.	§ 2800.44(a) Complaint procedures
38	The residence shall permit and respond to oral and written complaints from any source regarding an alleged violation of resident rights, quality of care or other matter without retaliation or the threat of retaliation.	§ 2800.44(b) Complaint procedures
39	If a resident indicates that he wishes to make a written complaint, but needs assistance in reducing the complaint to writing, the residence shall assist the resident in writing the complaint.	§ 2800.44(c) Complaint procedures
40	The residence shall ensure investigation and resolution of complaints. The residence shall designate the staff person responsible for receiving complaints and determining the outcome of the complaint. The residence shall keep a log of all complaints and the outcomes of the complaints.	§ 2800.44(d) Complaint procedures
41	Within 2 business days after the submission of a written complaint, a status report shall be provided by the residence to the complainant. If the resident is not the complainant, the resident and the resident's designated person shall receive the status report unless contraindicated by the support plan. The status report must indicate the steps that the residence is taking to investigate and address the complaint.	§ 2800.44(e) Complaint procedures
42	Within 7 days after the submission of a written complaint, the residence shall give the complainant and, if applicable, the designated person, a written decision explaining the residence's investigation findings and the action the residence plans to take to resolve the complaint. If the resident is not the complainant, the affected resident shall receive a copy of the decision unless contraindicated by the support plan. If the residence's investigation validates the complaint allegations, a resident who could potentially be harmed or his designated person shall receive a copy of the decision, with the name of the affected resident removed, unless contraindicated by the support plan.	§ 2800.44(f) Complaint procedures
43	The telephone number of the Department's Assisted Living Residence Licensing Office, the local ombudsman or protective services unit in the area agency on aging, the Disability Rights Network, the local law enforcement agency, the Commonwealth Information Center and the assisted living residence complaint hotline shall be posted in large print in a conspicuous and public place in the residence.	§ 2800.44(g) Complaint procedures
44	Nothing in this § 2800.44 (relating to complaint procedures) shall affect in any way the right of the resident to file suit or claim for damages.	§ 2800.44(h) Complaint procedures

Nutrition

45	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 service provision) in their living units unless it would be unsafe for them to do so consistent with their support plan.	§ 2800.161(h) Nutritional adequacy

Medications

46	The residence shall educate 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.	§ 2800.191 Resident Education

Services

47	A resident or a designated person has a right to request the review and modification of his support plan.	§ 2800.227(j) Development of the final support plan
48	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.	§ 2800.228(f) Transfer and discharge

Enforcement

49	If the relocation of residents is due to the failure of the residence to apply for a license, the Department will offer relocation assistance to the residents. This assistance will include each resident's involvement in planning the relocation, except in the case of an emergency. Each resident shall have the right to choose among the available alternatives after an opportunity to visit the alternative residences. These procedures will occur even if the residents are placed in a temporary living situation.	§ 2800.267(a) Relocation of residents

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