

## 5. STATE REGULATORY PROFILES

This section includes the State Regulatory Profiles, which describe the regulatory requirements for the 50 states and the District of Columbia. For each state, information is provided on the licensure and certification framework and requirements including:

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## ALABAMA

### Licensure Terms

Assisted Living Facilities, Specialty Care Assisted Living Facilities

### General Approach

The Department of Public Health, Bureau of Health Provider Standards, licenses three categories of assisted living facilities based on the number of residents. Specialty care assisted living facilities must be separately certified by the Board of Health.

*Adult Foster Care.* The Department of Human Resources, Adult Protective Services Unit, sets policy and standards and oversees adult foster homes that serve one resident. *Regulatory provisions for adult foster homes are not included in this profile but a link to the provisions can found at the end.*

*This profile includes summaries of selected regulatory provisions for assisted living facilities and specialty care assisted living facilities. The complete regulations are online at the links provided at the end.*

### Definitions

**Assisted living facilities** are individuals or entities that provide or offer to provide residence and personal care to two or more individuals who need assistance with activities of daily living (ADLs). Individuals who provide residential and personal care services solely to persons to whom they are personally related are not defined as assisted living.

**Specialty care assisted living facility** means an assisted living facility that is specially licensed and staffed to care for residents with a degree of cognitive impairment that would ordinarily make them ineligible for admission or continued stay in an assisted living facility.

Both assisted living and specialty care assisted living are sub-classified according to the number of residents they serve:

- Family assisted living facilities are authorized to care for 2-3 adults.
- Group assisted living facilities are authorized to care for 4-16 adults.
- Congregate assisted living facilities are authorized to care for 17 or more adults.

## Resident Agreements

**Assisted Living Facilities.** Agreements must be signed prior to or at the time of admission and must include: (1) basic charges for room, board, laundry, personal care, and basic and optional services; refund and discharge policies; (2) bed hold policy; (3) documentation that the resident and sponsor understand that the facility is not authorized or staffed to perform skilled nursing services nor to care for residents with severe cognitive impairment, and that the resident and sponsor agree that if the resident needs skilled nursing services or care for a severe cognitive impairment as a result of a condition expected to last for more than 90 days, the resident will be discharged by the facility after prior written notice; and (4) information about the local ombudsman.

**Specialty care assisted living facilities** require the same agreement except that these facilities may care for residents with severe cognitive impairment.

## Disclosure Provisions

*No provisions identified for either type of facility.*

## Admission and Retention Policy

**Assisted Living Facilities.** To be admitted and retained, residents may not: (1) require restraints or confinement or limitations on egress from the facility; (2) be unable, because of dementia, to understand the facility's unit dose medication system; (3) have chronic health conditions requiring extensive nursing care, or daily professional observation or judgment; and (4) require medical care, skilled nursing care, or care beyond assistance with ADLs. Persons with severe cognitive impairment may not be admitted or retained.

An exception may be made for a resident who requires medical care, administration of oral medications, or skilled nursing care for a period no longer than 90 days, or if a resident has been admitted to a certified and licensed hospice program because of a condition other than dementia. In these cases, care must be delivered by a properly licensed individual and the facility is responsible for the delivery of the appropriate care.

**Specialty Care Assisted Living Facilities.** A facility may not admit nor retain a resident who requires medical or skilled nursing care for an acute condition or exacerbation of a chronic condition that is expected to exceed 90 days unless: (1) the individual is capable of performing and does perform all tasks related to his or her own care; or (2) the individual is incapable of performing self-care tasks but has sufficient cognitive ability to direct his/her own care and is able to direct others to provide needed

assistance. The resident may not have symptoms that infringe on the rights or safety of other residents.

Residents diagnosed with a terminal illness may be admitted to a licensed hospice program and may remain in the facility beyond 90 days. Residents who are combative, violent, suicidal, or homicidal may not be admitted or retained. Residents who are abusive to other residents must be monitored. Whenever a resident requires hospitalization, medical, nursing, or other care beyond the facility's capabilities, the facility must arrange discharge and transfer to an appropriate setting.

## Services

**Assisted Living Facilities.** Facilities must provide general observation and health supervision of each resident to identify changes in health condition and functioning, and the need for medical attention or nursing services; ADL assistance; medication services; laundry; housekeeping; coordination of medical transportation; and social activities.

**Specialty Care Assisted Living Facilities.** Assistance with ADLs, health monitoring and services, and medication services must be provided. Facilities must also have a daily activity program designed to meet residents' individual needs.

### Service Planning

**Assisted Living Facilities.** Each resident must have a medical examination by a physician prior to admission. A plan of care must be developed by the facility in cooperation with the resident and, if appropriate, their representative.

**Specialty Care Assisted Living Facilities.** Residents must be screened and approved for admission. The screening includes a clinical history, a mental status examination to include aphasia screening, a geriatric depression screen, a physical functioning screen, and a behavior screen.

### Third-Party Providers

Residents in both types of facilities may contract with a hospice or home health agency.

## Medication Provisions

**Assisted Living Facilities.** Residents who are aware of their medications may self-administer medications or receive assistance with self-administration of medication by any staff member, including those who are unlicensed. Aware means that the resident can maintain possession and control of his/her medications and self-administer medications without creating an unreasonable risk to health and safety, or that the

resident has a reasonable layperson's understanding of the unit dose packaging system the facility uses and is unlikely to make medication errors.

Medications managed and kept under the custody and control of the facility must be unit dose packaged. Assistance with self-administration means reminding the resident to take a medication, bringing the container to the resident and opening it, and offering liquids. Assistance with self-administration does not include administering injections, drops, inhalers or suppositories, reminders to take PRN medications, or special preparation (e.g., crushing, mixing with liquids, or inserting in feeding tube). If the resident would be capable of administering medications through these routes except for limitations of mobility or dexterity, then unlicensed staff may assist so long as the assistance provided is under the resident's total control and direction.

***Specialty Care Assisted Living Facilities.*** Facilities may allow residents to self-administer or receive assistance with self-administration of medications, or may provide medication administration. Residents who are aware of their own medications may self-administer medications. Aware means that the resident can maintain possession and control of their own medications and self-administer medications without creating an unreasonable risk to health and safety. Medication administration must be provided by a physician, osteopath, physician assistant, registered nurse (RN), or licensed practical nurse (LPN).

## Food Service and Dietary Provisions

*The following provisions are for both types of facilities.*

Facilities must serve daily at least three meals that meet the Dietary Reference Intakes of the Food and Nutrition Board of the National Research Council, National Academy of Sciences. Snacks and beverages must be available throughout the day and after the evening meal. Alternate food selections must be available for residents on medically prescribed diets, including those for hypertension, diabetes, and hyperlipidemia, as well as modified consistency diets.

If residents need therapeutic or other special diets, a dietician must be available to make certain that food is of the quality and quantity required to meet their needs. Facilities with 17 or more residents (congregate, the third category of licensure) must hire a full-time or part-time professionally qualified dietitian, or contract with a consulting dietitian.

## Staffing Requirements

### ***Assisted Living Facilities***

**Type of Staff.** Facilities must employ an *administrator* to operate the facility and *personal care staff* to meet residents' care needs. If residents require medication administration, a licensed health professional such as a *registered nurse* or *licensed practical nurse* must be hired.

Facilities must be staffed at all times by at least one individual who has current cardiopulmonary resuscitation (CPR) certification. Facilities equipped with an automated external defibrillator (AED) must be staffed at all times by at least one individual who has a current certification from the American Heart Association or the American Red Cross in AED utilization.

**Staff Ratios.** *No minimum ratios.* The number of staff must be adequate to meet residents' needs.

### ***Specialty Care Assisted Living Facilities***

*See Provisions for Serving Persons with Dementia below.*

## Training Requirements

**Assisted Living Facilities.** All staff must receive initial and ongoing training on required topics, such as: (1) applicable rules and statutes; (2) identifying and reporting abuse, neglect and exploitation; (3) needs of the elderly, mentally ill, and intellectually disabled; (4) basic first-aid; (5) advance directives; (6) confidentiality; (7) nutritional needs of the elderly; (8) fire and environmental safety; and (9) signs and symptoms of dementia. Administrators must complete 6 hours of continuing education each year; licensed nursing home administrators are exempt.

**Specialty Care Assisted Living Facilities.** *See Provisions for Serving Persons with Dementia below.*

## Provisions for Apartments and Private Units

**Assisted Living Facilities.** Apartment-style units are not required; units may be single-occupancy or double-occupancy. Bathrooms and bathing facilities may be shared, with at least one bathtub or shower for every eight residents, and one sink and toilet for every six residents.

**Specialty Care Assisted Living Facilities.** *See the following section.*

## Provisions for Serving Persons with Dementia

*This section describes the requirements for Specialty Care Assisted Living Facilities only.*

**Dementia Care Staff.** Facilities are required to have an *administrator*, a *medical director*, at least one *registered nurse*, and a *unit coordinator* in addition to *personal care staff*. Facilities must be staffed at all times by at least one individual who has CPR certification. Facilities equipped with an AED must be staffed at all times by at least one individual who has a current certification from the American Heart Association or the American Red Cross in AED utilization.

Minimum staffing levels are required based on facility size and time of day (based on three shifts). At least two staff must be on-duty 24 hours a day, 7 days a week. If necessary, facilities must exceed minimum ratios to meet residents' needs.

**Dementia Staff Training.** The administrator and all staff must complete 6 hours of continuing education each year. Licensed nurses must complete a specified dementia training curriculum before working in the unit.

**Dementia Facility Requirements.** Apartment-style units are not required; units may be single-occupancy or double-occupancy. Bathrooms and bathing facilities may be shared, with at least one bathtub or shower for every eight residents; and one sink and toilet for every six residents.

Facilities must have a secure boundary or perimeter to safely accommodate residents who wander. Locks on exit doors, if installed, must be electrically locked or electrically delayed-egress locking devices. Delayed-egress locks must comply with detailed requirements. In group and congregate facilities (second and third categories of licensure), panic hardware must be installed on all exit doors, except where electrically controlled door hardware is used.

## Background Checks

Both types of facilities may not hire an individual whose name appears on the Alabama Department of Public Health Nurse Aide Abuse Registry.

## Inspection and Monitoring

Both types of facilities are monitored through periodic inspections by the Board of Health. The initial inspection may occur during building construction. Facilities must renew their license annually.

## Public Financing

*The state does not provide public funding for services in either type of facility, through either Medicaid or non-Medicaid programs.*

### **Room and Board Policy**

The state provides an optional supplement to Supplemental Security Income (SSI) recipients and some non-SSI recipients who reside in specified living arrangements, but not assisted living facilities.

## Location of Licensing, Certification, or Other Requirements

*Rules of Alabama State Board of Health, Chapter 420-5-4: Assisted Living Facilities. Alabama Department of Public Health. [October 27, 2008]*

<http://www.adph.org/HEALTHCAREFACILITIES/assets/ALFRules.pdf>

*Rules of Alabama State Board of Health, Chapter 420-5-20: Specialty Care Assisted Living Facilities. Alabama Department of Public Health. [October 27, 2008]*

<http://www.adph.org/HEALTHCAREFACILITIES/assets/SCALFRules.pdf>

Alabama Department of Human Resources website: An Introduction to Adult Foster Care and Adult Foster Care Home Requirements

[http://dhr.alabama.gov/services/Adult\\_Protective\\_Services/Adult\\_Foster\\_Care.aspx](http://dhr.alabama.gov/services/Adult_Protective_Services/Adult_Foster_Care.aspx)

## Information Sources

Kelley Mitchell, RNC, MSN  
Division of Health Care Facilities  
Alabama Department of Public Health

## ALASKA

### Licensure Terms

Assisted Living Homes

### General Approach

The Department of Health and Social Services, Division of Health Care Services, and the Department of Administration each have responsibilities for licensing assisted living homes. Providers may determine the level of care and the services they will offer, but must furnish the state with a list of these services. Assisted living rules apply to all adult foster homes that serve three or more residents.

Assisted living homes may provide care primarily to persons who have a physical disability, who are elderly, or who suffer from dementia, but who are not diagnosed as chronically mentally ill, in which case, they are the responsibility of the Department of Administration; they may also not provide care primarily to persons with a mental or developmental disability; if they do, they are the responsibility of the Department of Health and Social Services.

*Adult Foster Care.* Licensure is not required for adult foster homes that serve one or two persons, but these homes may choose to apply for licensure as an assisted living facility, which allows the home to participate as a Medicaid waiver program service provider.

*This profile includes summaries of selected regulatory provisions for assisted living homes. The complete regulations can be viewed online using the links provided at the end.*

### Definitions

Assisted living home means a facility that provides room and board to three or more residents who are not related to the owner by blood or marriage, or that receives state or federal payment for services regardless of the number of adults served; and that provides, or obtains for its residents, assistance with activities of daily living (ADLs) and other personal assistance. Typical residents include elderly persons and persons with mental health, developmental, or physical disabilities.

## **Resident Agreements**

A contract must be signed prior to move-in and must include information about the following topics: services and accommodations; rates; resident rights, duties, and obligations; policies and procedures for contract termination; amount and purpose of advance payments; and refund policy.

## **Disclosure Provisions**

*No provisions identified.*

## **Admission and Retention Policy**

Residents may not require skilled nursing care for more than 45 consecutive days. Terminally ill residents may remain in the facility if a physician confirms their needs are being met. Some variances that promote aging in place are permitted.

## **Services**

Facilities provide assistance with: (1) ADLs and instrumental activities of daily living; (2) obtaining supportive services (recreational, leisure, transportation, social, and legal); and (3) monitoring. Facilities may provide health-related services, including assistance with self-administration of medications, intermittent nursing services, 24-hour skilled nursing for up to 45 days, and hospice services.

### ***Service Planning***

Within 30 days of admission, each resident must have an assisted living plan that is approved by the resident or their representative. The plan must identify the resident's strengths and weaknesses in performing ADLs; physical disabilities and impairments; preferences for roommates, living environment, food, and recreation; and religious affiliation. The plan must identify how services will be provided by the facility or other agencies, and how health-related needs will be addressed.

Risks must be addressed during the care planning process. The plan must recognize the responsibility and right of the resident or the resident's representative to evaluate and choose, after discussion with all relevant parties, including the facility, the risks associated with each option when making decisions pertaining to the resident's abilities, preferences, and service needs; and must recognize the right of the facility to evaluate and to either consent to or refuse to accept a resident's choice of risks to assume.

The plan must also identify the resident's reasonable wants and how they will be met. If health-related services are provided or arranged, the service plan must be re-evaluated quarterly; if not, an annual re-evaluation is required.

### ***Third-Party Providers***

A resident who needs skilled nursing or hospice care may, with facility consent, arrange for these services to be provided in the assisted living home by a licensed nurse, if that arrangement does not interfere with the services provided to other residents.

## **Medication Provisions**

Aides (assisted living home staff persons) may provide medication reminders, read labels, open containers, observe a resident while taking medication, check a self-administered dosage against the label, reassure the resident that the dosage is correct, and direct/guide the hand of a resident at a resident's request. A registered nurse may delegate medication administration tasks according to the state's nurse delegation statute and rules.

## **Food Service and Dietary Provisions**

Assisted living homes must offer three balanced, nutritious meals and at least one snack daily at consistent times. All food offered must follow the U.S. Department of Agriculture publication, *The Food Guide Pyramid*. Fresh fruits and vegetables should be offered as often as possible. The home must consider each resident's health-related or religious restrictions and cultural or ethnic preferences in food preparation, as well as any preference for smaller portions.

## **Staffing Requirements**

***Type of Staff.*** Facilities must have an *administrator* who is responsible for daily operation and oversight of the home, and *care providers* who meet residents' specific needs.

***Staff Ratios.*** *No minimum ratios.* Facilities must employ the type and number of staff needed to operate the home and develop a staffing plan that is appropriate to provide services required by residents' care plans. A care provider who has cardiopulmonary resuscitation and first-aid training must be on staff.

## Training Requirements

Staff must receive orientation that covers emergency procedures, fire safety, resident rights, universal precautions, resident interaction, house rules, medication management, physical plant layout, and reporting responsibilities. Annually, administrators must receive 18 hours of continuing education, and care providers must receive 12 hours.

## Provisions for Apartments and Private Units

Apartment-style units are not required. Units may be single-occupancy or double-occupancy. Residents must have “reasonable privacy” (*not defined*) when sharing a room. A minimum of one sink, toilet, and shower/bath is required for every six residents.

## Provisions for Serving Persons with Dementia

***Dementia Care Staff and Staff Training.*** *No provisions identified.*

***Dementia Facility Requirements.*** A facility that provides care for adults with dementia or a cognitive impairment, including adults with a history of wandering or attempting to run away, must have a method to alert staff when someone exits the building. The building must install a 15-second delayed exit door with an alarm at each exit, use a wander alarm system, or use another Department-approved method. If the building owner wants to install a delayed exit door, the municipal fire marshal must give approval.

## Background Checks

No person may be employed who has been convicted of certain crimes specified in the State’s administrative rules, including felonies, domestic violence, indecent exposure, and arson. Administrators and staff must provide: (1) a sworn statement regarding any convictions of the listed crimes; (2) the results of an initial and biennial criminal background check ; and (3) the results of a national fingerprint criminal history check conducted by the Alaska Department of Public Safety, initially and every 6 years.

## Inspection and Monitoring

The Department of Health and Social Services is responsible for screening applicants, issuing licenses, and investigating complaints. An annual monitoring visit or a self-monitoring report filed by the facility is required.

## Public Financing

Two Medicaid 1915(c) waiver programs--Alaskans Living Independently and Adults with Physical and Developmental Disabilities--cover a service called residential supported living in assisted living homes.

### **Room and Board Policy**

In 2011, the monthly federal Supplemental Security Income benefit was \$674 and the state provided an optional state supplement (OSS) of \$100 for residents in an assisted living home.<sup>40</sup>

In 2009, room and board rates were not capped for Medicaid participants, the personal needs allowance (PNA) was \$100, and family supplementation was allowed.<sup>41</sup>

In a limited number of cases, the state covers room and board and some services through its "general relief" program.

## Location of Licensing, Certification, or Other Requirements

*Alaska Administrative Code*, Title 7, Chapter 7: Licensing of Assisted Living Homes.  
<http://dhss.alaska.gov/dhcs/Documents/cl/ALHRegulationsandStatutesEffectiveasof3-7-09.pdf>.

## Information Sources

Dennis Murray  
Alaska State Hospital and Nursing Home Association

Eric Wharton  
Senior and Disabilities Services/Senior Grants Unit  
Department of Health and Social Services

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<sup>40</sup> Social Security Administration. *State Assistance Programs for SSI Recipients*, January 2011.  
[http://www.socialsecurity.gov/policy/docs/progdesc/ssi\\_st\\_asst/2011/ak.html](http://www.socialsecurity.gov/policy/docs/progdesc/ssi_st_asst/2011/ak.html). The amount of the OSS in 2015 was not available online or from other sources.

<sup>41</sup> Mollica, R.L. (2009). *State Medicaid Reimbursement Policies and Practices in Assisted Living*, National Center for Assisted Living, American Health Care Association.  
<http://www.ahcancal.org/ncal/resources/Documents/MedicaidAssistedLivingReport.pdf>. Current information about Medicaid room and board policies, the amount of the PNA, and family supplementation policy was not available online or from other sources.

## ARIZONA

### Licensure Terms

Assisted Living Facilities

### General Approach

The Division of Public Health Licensing Services, Bureau of Residential Facilities Licensing, licenses assisted living facilities (ALFs). This licensure category consolidates six previous licensure categories for residential care institutions into one universal license that is sub-classified based on size and the level of services provided. Physical plant requirements vary depending upon facility size and staff training requirements vary depending upon the level of care provided.

Assisted living facilities include adult foster care (AFC) homes where care is provided for up to four people in the home in which the caregiver lives; assisted living homes, which provide care for up to ten people; and assisted living centers, which provide care for 11 or more people. *This profile does not include provisions for AFC homes.*

Facilities may complete a supplemental application that authorizes the facility to provide adult day health care services and/or behavioral health services.

*This profile includes summaries of selected regulatory provisions for assisted living homes and assisted living centers. The complete regulations can be viewed online using the links provided at the end.*

### Definitions

**Assisted living facility** means a residential care institution that provides, or contracts with another entity to provide, on a continuing basis, one of three types of services: supervisory care services, personal care services, or directed care services.

**Supervisory care services** means general supervision and daily monitoring of residents' abilities and needs, the ability to intervene in a crisis, and assistance with resident self-administration of medications.

**Personal care services** means assistance with activities of daily living, and includes the coordination or provision of intermittent nursing services, and the administration of medications and treatments.

*Directed care services* means programs and services provided to persons who are incapable of recognizing danger, summoning assistance, expressing needs, or making basic care decisions.

## **Resident Agreements**

At the time of admission, a resident or the resident's representative must receive a written agreement with information regarding resident and facility responsibilities. The agreement must also include a list of the services to be provided by the facility and services available from the facility for an additional fee or charge. Information about rates and charges for services must be given before services are provided.

For an assisted living home, the agreement must also include information about whether the manager or a caregiver is awake during nighttime hours, the refund policy, residency criteria, and the complaint process.

## **Disclosure Provisions**

*No provisions identified.*

## **Admission and Retention Policy**

An ALF must not accept or retain a resident who is unable to direct self-care and who requires continuous medical services; nursing services; physical or chemical restraints, including bedrails; behavioral health services; or services that the ALF is not licensed or able to provide. A facility may terminate residency without notice if the resident exhibits behavior that is an immediate threat to his or her health and safety or that of other individuals in the facility.

Facilities licensed to provide personal care services or directed care services may not accept or retain residents who are bedbound, have Stage III or IV pressure sores, or require continuous nursing services, unless the resident is under the care of a licensed hospice service agency, or a private duty nurse is providing the nursing services.

## **Services**

Facilities provide supervisory care services, personal care services, directed care services, behavioral health services, and ancillary services. The facility must establish, in writing, the scope of services it will provide.

Facilities licensed to provide directed care services must have policies and procedures to ensure the safety of residents who may wander, and must provide cognitive stimulation and activities to maximize functioning.

### ***Service Planning***

A written service plan is required and must be completed within 14 calendar days after the resident's date of acceptance and must be developed with assistance and review from the resident or resident's representative, the facility manager, and any individual requested by the resident or the resident's representative. The service plan must include the following:

- A description of the resident's medical or health conditions, including physical, behavioral, cognitive, or functional conditions or impairments.
- The level of service the resident is expected to receive.
- The amount, type, and frequency of services that will be provided to the resident, including medication administration or assistance in the self-administration of medication.

For residents who require behavioral care, the service plan must also include planned goals, strategies, and actions for changing the resident's psychosocial interactions or behavior, and must be reviewed by a medical practitioner or behavioral health professional.

If intermittent nursing services or medication administration are provided, a nurse or medical practitioner must review the service plan. Service plans must be updated no later than 14 calendar days after a significant change in the resident's physical, cognitive, or functional condition, and as follows: (1) at least once every 12 months for a resident receiving supervisory care services; (2) at least once every 6 months for a resident receiving personal care services; and (3) at least once every 3 months for a resident receiving directed care services.

### ***Third-Party Providers***

Nursing and health-related services may be delivered by a licensed home health agency, licensed hospice service agency, or a private duty nurse.

## **Medication Provisions**

Facilities may provide medication administration, assistance with self-administration, monitoring of self-administration, and medication procurement. Medication administration means restricting a patient's access to the patient's medication and providing the medication to the patient or applying the medication to the

patient's body, as ordered by a medical practitioner. Licensed nurses may administer medications.

Certified assisted living managers and trained caregivers may provide medication assistance to residents and may provide medication administration with a physician's order and proper training. Assistance with self-administration of medications includes:

- Reminding the resident when it is time to take the medication.
- Opening the medication container or medication organizer for the resident.
- Observing as the resident removes the medication from a container or organizer:
  - For a resident using a medication organizer, verifying that the resident is taking the medication according to the schedule specified on the medical practitioner's order.
  - For a resident not using a medication organizer, confirming that the resident taking the medication is the individual stated on the medication container label, and is taking the dosage of the medication at the time stated on the medication container label or according to an order from a medical practitioner dated later than the date on the medication container label.

The resident service plan must indicate if the resident stores his or her own medication, how the medication will be controlled, and whether the resident uses psychotropic medications. For residents who self-administer medications, a family member may fill their medication organizer with prescribed medications.

Facilities that provide assistance in the self-administration of medication must store residents' medication. The facility must ensure that a resident's medication organizer, if used, is only filled by the resident, the resident's representative or family member, a personnel member of a home health agency or hospice service agency; or the facility manager or a caregiver who has been designated by--and is under the direction of--a medical practitioner.

## **Food Service and Dietary Provisions**

Facilities must provide meals and snacks in accordance with federal dietary guidelines. Residents must receive a diet that meets any nutritional needs or therapeutic diets specified in their service plan. Adaptive eating equipment or utensils must be available to residents who need them to eat.

## Staffing Requirements

**Type of Staff.** ALF staff include *managers, caregivers, and assistant caregivers*. All staff must be capable of providing assisted living services, behavioral health services, behavioral care, and ancillary services needed by residents.

**Staff Ratios.** *No minimum ratios.* Sufficient staff must be present at all times to provide services consistent with the facility's licensure category. At least one manager or caregiver must be present and awake at an assisted living center when a resident is on the premises.

## Training Requirements

The manager must ensure that orientation and in-service education is provided for employees and volunteers. Before providing assisted living services to a resident, a caregiver or an assistant caregiver, must receive orientation that is specific to their duties. All staff must be trained in first-aid and cardiopulmonary resuscitation for adults.

## Provisions for Apartments and Private Units

Apartment-style units are not required. Assisted living centers (11+ residents) may provide either residential units or bedrooms that are single-occupancy or double-occupancy. Residential units must have a keyed entry, bathroom, resident controlled thermostat, and a kitchen area with sink, refrigerator, cooking appliance that may be removed or disconnected, and space for food preparation.

In an assisted living home (up to ten residents), a resident's sleeping area must be on the ground floor of the home unless the resident is able to direct self-care; the resident is ambulatory without assistance; and there are at least two unobstructed, usable exits to the outside from the sleeping area that the resident is able to use. All facilities require at least one toilet, sink, and shower for every eight residents.

## Provisions for Serving Persons with Dementia

**Dementia Care Staff and Staff Training.** *No provisions identified.*

**Dementia Facility Requirements.** Facilities must have egress controls and access to secure outside areas for residents who wander.

## Background Checks

All staff and volunteers must have a valid fingerprint clearance card issued by the Department of Health Services within 20 days of hire. A person who has been denied a clearance card may not be employed by the facility.

## Inspection and Monitoring

The licensing agency conducts a pre-licensure inspection and annual renewal inspections. Facilities that are free of deficiencies may have licenses renewed for 2 years.

## Public Financing<sup>42</sup>

Services are covered through the Arizona Long-Term Care System (ALTCS) program, which operates under a Medicaid 1115 demonstration waiver. The ALTCS managed care program is part of the Arizona Health Care Costs Containment System. Private insurance companies bid through an RFP process to provide services to residents in AFC, assisted living homes, and assisted living centers. Each plan then contracts with individual facilities to pay for services; there are no uniform costs as insurers work with providers and local agencies to establish rates based on the needs of, in some cases, individual residents (e.g., an individual who requires psychiatric services) and the basic facility services.

## Room and Board Policy<sup>43</sup>

The state did not provide an optional supplementation to the federal Supplemental Security Income (SSI) benefit as of 2009. In the same year, the room and board rate was capped for Medicaid-eligible residents who paid a share of cost that was their spend down amount or the amount of the SSI benefit minus a personal needs allowance (PNA) of \$101.10, whichever was greater. Family supplementation was allowed to pay for room upgrades.

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<sup>42</sup> Information in this section is from Mollica, R.L. (2009). *State Medicaid Reimbursement Policies and Practices in Assisted Living*, National Center for Assisted Living, American Health Care Association. <http://www.ahcancal.org/ncal/resources/Documents/MedicaidAssistedLivingReport.pdf>.

<sup>43</sup> Current information about Medicaid room and board policies, the amount of the PNA, and family supplementation policy, was not available online or from other sources.

## Location of Licensing, Certification, or Other Requirements

*Arizona Administrative Code*, Title 9, Chapter 10, Article 8: Assisted Living Facilities. [July 1, 2014]

<http://www.azdhs.gov/als/residential/documents/article-8.pdf>

Arizona Department of Health Services website: Bureau of Residential Facilities Licensing, Provider Information, with links to licensing tools and resources. [January 13, 2015]

<http://www.azdhs.gov/als/residential/providers.htm>

## Information Sources

Sylvia Balistreri  
Arizona Healthcare Association

Diane Eckles  
Residential Facilities Licensing  
Division of Public Health Licensing  
Arizona Department of Health Services

## ARKANSAS

### Licensure Terms

Assisted Living Facilities, Level I and Level II, Residential Long-Term Care Facilities  
(referred to as residential care facilities)

### General Approach

The Arkansas Department of Human Services (DHS), Division of Medical Services, Office of Long Term Care (Office), licenses and regulates assisted living facilities (ALFs) as either a Level I or Level II facility. Both levels provide services in a home-like setting for elderly and disabled persons. The philosophical tenets of individuality, privacy, dignity and independence, and the promotion of resident self-direction and personal decision-making while protecting resident health and safety are emphasized. All living units in ALFs must be independent apartments, including a kitchen that is a visually and functionally distinct area within the apartment or unit. Separate licenses are required for ALFs maintained on separate premises, even if they are operated under the same management.

The Department also licenses residential care facilities (RCFs) to provide services 24 hours a day to individuals age 18 years or older who are not capable of independent living and who require assistance and supervision. Separate licenses are required for RCFs maintained on separate premises, even if they are operated under the same management.<sup>44</sup>

Alzheimer's special care units (ASCUs) are specialized units of long-term care facilities--including both nursing homes and ALFs--that offer services specifically for individuals with Alzheimer's disease and other dementias. Regulations for ASCUs are part of the regulations for each type of facility that can house an ASCU.

Arkansas covers personal care services through the Medicaid State Plan, which may be provided in a person's home "or other setting" such as a residential long-term care facility. The state also covers services in Level II ALFs under a single service Medicaid 1915(c) Waiver program--the Living Choices Assisted Living Waiver program--and covers services in adult family homes through the State's Medicaid 1915(c) Elder Choices Waiver program.

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<sup>44</sup> Facilities owned and operated by the Veteran's Administration, or regulated or licensed by the Department of Human Services' Division of Developmental Disabilities Services or Division of Mental Health Services, or regulated by the Bureau of Alcohol and Drug Abuse Prevention of the Arkansas Department of Health are excluded from licensure.

*Adult Foster Care.* Adult family homes are certified by the DHS Division of Aging and Adult Services (DAAS). An adult family home provides a family living environment for no more than three persons who are not related to the principal care provider and who, owing to the severity of their functional impairments, are considered to be at imminent risk of death or serious bodily harm and, as a consequence, are not capable of fully independent living.<sup>45</sup> *Regulatory provisions for these settings are not included in this profile, but a link to various information can found at the end.*

*This profile includes summaries of selected regulatory provisions for ALFs and RCFs. The complete regulations are online at the links provided at the end.*

## Definitions

**Residential care facility** means a building or structure that provides on a 24-hour basis a place of residence and board for three or more individuals whose functional capabilities may have been impaired, but who do not require hospital or nursing home care on a daily basis but could require other assistance with activities of daily living (ADLs).

**Assisted living facility** means a building or part of a building that undertakes, through its ownership or management, responsibility to provide assisted living services for a period exceeding 24 hours to four or more adult residents of the facility. Assisted living services may be provided either directly or through contractual arrangement. An ALF provides, at a minimum, services to assist residents in performing all ADLs on a 24-hour basis.

**Alzheimer's special care unit** means a separate and distinct unit within an assisted living or other long-term care facility that segregates and provides a special program for residents with a diagnosis of probable Alzheimer's disease or another dementia, and that advertises, markets, or otherwise promotes the facility as providing specialized Alzheimer's or dementia care services.

## Resident Agreements

**Residential Care Facilities.** Residents must receive a copy of the resident agreement at or prior to moving in that covers: (1) services, materials and equipment, and food included in the basic charge; (2) additional services to be provided and their charges; (3) residency rules; (4) conditions and rules for termination; (5) provisions for changes in charges; and (6) refund policies.

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<sup>45</sup> Only four adult family homes were operating in 2013 and all four reported no clients. More information is available from a DHS-commissioned report: *Gap Analysis of the Capacity of Long-Term Care Providers of HCBS in Arkansas*, available online at the link provided at the end of this profile.

**Assisted Living Facilities.** Prior to or on the day of admission, the ALF and the resident, or his or her responsible party, must enter into an occupancy admission agreement. The agreement must provide information about core services (listed below under *Services*). Other required information includes: (1) optional services; (2) health care services available through home health agencies; (3) medication policies; (4) fees, charges, and payment and refund policies; (5) facility rules; (6) provisions for emergency transfers; and (7) discharge criteria.

## Disclosure Provisions

**Residential Care Facilities.** *No provisions identified.*

**Assisted living facilities** must provide each prospective resident, or the prospective resident's representative, with a comprehensive disclosure statement describing the form of care offered, treatment, staffing, the emergency preparedness plan, special services and related costs provided by the facility, and other information as required by law before the prospective resident signs an admission agreement. The facility disclosure statement is reviewed annually.

Facilities that have an ASCU must provide a facility-prepared statement to individuals or their families or responsible parties prior to admission that describes how care, services, and activities are provided; the pre-admission screening and the assessment processes; implementation of the individual support plan; admission, discharge and transfer criteria and procedures; training topics, policies, and procedures; and the minimum number of direct care staff assigned to the ASCU each shift. They must also provide a written copy of the residents' rights.

## Admission and Retention Policy

**Residential Care Facilities.** Facilities may not admit or retain individuals who are not independently mobile (physically and mentally capable of vacating the facility within 3 minutes), able to self-administer medications, or capable of understanding and responding to reminders and guidance from staff.

Additionally, individuals cannot have specific medical conditions or needs, including the following:

- A feeding or intravenous tube.
- Total incontinence of bowel and bladder.
- A communicable disease that poses a threat to the health or safety of others.

- Nursing services exceeding a level that can be provided by a certified home health agency on a temporary or infrequent basis.
- A level of mental illness, intellectual disability, dementia, or addiction to drugs or alcohol that requires a higher level of medical, nursing, or psychiatric care or active treatment than the facility can safely provide.
- Religious, cultural, or dietary regimens that cannot be met without undue burden.
- A need for physical restraints.
- Current violent behavior.

A resident may be discharged only when the resident's medical needs cannot be met by the facility or a certified home health agency on a temporary or infrequent basis; or the resident presents a danger to the health, safety, or welfare of himself or others.

Waivers of the admission/retention policy are not available. Residents who require frequent skilled nursing services from a home health agency must be assessed by the Office to determine if a nursing home placement is needed.

***Assisted Living Facilities.*** A facility must not admit or retain residents whose needs are greater than the facility is licensed to provide.

Level I ALFs cannot serve nursing home-eligible residents or residents who: (1) need 24-hour nursing services, except as certified by a licensed home health agency for a period of 60 days with one 30-day extension; (2) are bedridden; (3) have transfer assistance needs that the facility cannot meet with current staffing, including assistance to evacuate the building in case of an emergency; (4) present a danger to self or others; and (5) require medication administration performed by the facility.

Level II facilities are allowed to serve nursing home-eligible residents but cannot serve residents who are bedridden or have certain conditions or needs, including a need for 24-hour nursing services; a temporary (more than 14 consecutive days) or terminal condition (unless a physician or advance practice nurse certifies that the facility can meet the resident's needs); need transfer assistance, including but not limited to assistance to evacuate the facility in case of emergency, that the facility cannot meet with current staffing; or who present a danger to self or others.

## Services

***Residential Care Facilities.*** Facilities may provide personal care; supportive services (occasional or intermittent guidance, direction, or monitoring for ADLs); activities and socialization; assistance securing professional services; meals; housekeeping; and laundry.

Residents have a choice of providers for receiving personal care services. RCFs may not provide medical or nursing services. Home health services may be provided by a certified home health agency when ordered by a physician.

**Assisted Living Facilities.** Level I facilities provide 24-hour supervision by awake staff; assistance in obtaining emergency care 24 hours a day (this provision may be met by an agreement with an ambulance service or hospital or emergency services through 911); assistance with social, recreational, and other activities; assistance with ADLs; assistance with obtaining transportation; linen service; and medication assistance.

Level II facilities provide 24-hour available staff to respond to residents' needs identified in the direct care services and health care services plan portions of residents' occupancy admission agreements.

Direct care services help residents with certain routines and ADLs, such as assistance with mobility and transfers; hands-on assistance with feeding, grooming, shaving, trimming or shaping fingernails and toenails, bathing, dressing, personal hygiene, bladder and bowel requirements, including incontinence; and assistance with medication only to the extent permitted by the State Nurse Practice Act. A registered nurse (RN) must complete the assessment for residents with health needs.

Health care services are available that assist in achieving and maintaining functional status and well-being (e.g., psychological, social, physical, and spiritual). They may include nursing assessments and the monitoring and delegation of nursing tasks by RNs pursuant to the Nurse Practice Act, care management, and the coordination of basic health care and social services.

### **Service Planning**

**Residential Care Facilities.** The facility must interview prospective residents prior to admission to determine if the facility can meet their needs.

**Assisted Living Facilities.** An initial needs assessment must be completed for each resident to identify all needed services, and a reassessment must be completed at least annually and more often as changes occur. Facilities must develop compliance agreements that address any situation or condition that is or should be known to the facility that involves risk, the probable consequences of taking risks, the resident or his or her responsible party's preference concerning how risks will be handled and the possible consequences of action on that preference, what the facility will and will not do to meet the resident's needs and comply with the resident's preference to the identified course of action, alternatives offered to deal with the risk, and the agreed-upon course of action.

### ***Third-Party Providers***

***Residential Care Facilities.*** If a service required under the licensing regulations is not provided directly by the facility, the facility must have a written agreement/contract with an outside program, resource, or service to furnish the necessary service.

An RCF that admits or retains persons with a diagnosis of mental illness/disorder in need of active treatment must make arrangements with a mental health service provider for the development and provision of an active treatment plan. This provision applies to all facilities regardless of size.

***Assisted Living Facilities.*** In Level I facilities, home health services may be provided by a certified home health agency on a short-term basis. In both Level I and Level II facilities, other individuals or agencies may furnish care directly or under arrangements with the ALF. Such care must be supplemental to the services provided by the ALF and not supplant, nor be substituted for, the requirements of service provisions by the facility.

### **Medication Provisions**

***Residential Care Facilities.*** Residents must be familiar with their medications and the instructions for taking them. Aides may remind residents to take medications, read label instructions, and remove the cap or packaging, but the resident must remove the medication from the package or container. RCF personnel may not administer or attempt to administer medications.

***Assisted Living Facilities.*** Staff of Level I facilities may assist a resident in the self-administration of oral medication by taking the medication in its container from the area where it is stored and handing the container with the medication in it to the resident. In the presence of the resident, facility staff may remove the container cap or loosen the packaging. If the resident is physically impaired but cognitively able (has awareness with perception, reasoning, intuition, and memory), facility staff, upon request by or with the consent of the resident, may assist the resident in removing oral medication from the container and in taking the medication. If the resident is physically unable to place a dose of oral medication in his or her mouth without spilling or dropping it, facility staff may place the dose of medication in another container and place that container to the mouth of the resident. Facility staff cannot administer medications.

In Level II facilities, licensed nursing personnel may administer medications to residents who are assessed as being unable to self-administer medication. Facilities must employ a consulting pharmacist.

## Food Service and Dietary Provisions

**Residential care facilities** and must provide three balanced meals and between meal snacks. Fluids must be available at all times and meals must be served at approximately the same time each day. There must be no more than 5 hours between breakfast and lunch and between lunch and the evening meal, and no more than 14 hours between the evening meal and breakfast.

**Assisted Living Facilities.** Three balanced meals, snacks, and fluids are required.

## Staffing Requirements

### *Residential Care Facility*

**Type of Staff.** Each facility must have a full-time (minimum 40 hours per week) certified (State-approved certification program) *administrator* on the premises during normal business hours who has responsibility for the facility's daily operation. The administrator must not leave the RCF premises during the day without first delegating authority to a qualified individual who will manage the facility temporarily during the administrator's absence. Each facility must hire direct care staff to provide assistance with certain ADLs. RCFs located in a multi-building facility must provide at least one direct care staff person on duty and awake during all hours.

**Staff Ratios.** Ratios for the number of direct care staff vary by the time of day and the number of residents (see table below). Sufficient staff must be present at all times to meet residents' needs. Staffing requirements are based on current census rather than licensed capacity.

Number of Direct Care Staff to Residents Required Per Shift			
Residents	Day Staff	Evening Staff	Night Staff
1-16	1	1	1
17-32	2	1	1
33-49	2	2	2
50-66	3	2	2
67-83	4	2	2
84-above	5	3	2

For small facilities (16 or fewer beds), each staff person on duty may be counted as direct care staff even if they are currently involved in administrative, housekeeping, or dietary activities; and the night staff person may be asleep in the facility.

Additional staff requirements for large facilities (over 16 beds) are as follows: (1) the staffing table shown above applies to direct care staff only and does not include administrative, housekeeping, or dietary staff; (2) the facility administrator must not be scheduled as direct care staff for purposes of meeting minimum staffing requirements

during normal business hours; (3) staff involved in food and dietary services are not permitted to perform non-food or non-dietary services during the same shift; and (4) in a multi-building facility, at least one direct care staff person must be on-duty and awake during all hours. A relief direct care staff person must be available in the facility to relieve direct care staff for meals and breaks and to cover if a direct care staff person must leave the facility in an emergency.

### ***Assisted Living Facility***

***Type of Staff.*** Each facility must have a full-time (minimum 40 hours per week) certified *administrator*. Administrators must be certified as an ALF, RCF, or nursing home administrator through a State-approved certification program. The administrator is responsible for the facility's daily operation and must be on the premises during normal business hours. If the administrator has to leave the facility during the day, he or she must delegate authority to a qualified individual who will manage the facility temporarily during the administrator's absence. A second administrator must be employed either part-time or full-time depending on the number of beds in the facility.

Level II facilities must designate a full-time (40 hour per week) *administrator* who must be on the premises during normal business hours. Sharing of administrators between ALFs and other types of long-term care facilities is permitted. The facility may employ an individual to act both as administrator and as the facility's *registered nurse*. At no time may the duties of administrator take precedence over, interfere with, or diminish the responsibilities and duties associated with the RN position.

Level II facilities must employ or contract with at least one RN and also employ or contract with *licensed practical nurses* (LPNs) to provide nursing or direct care services to residents. The facility must employ *certified nursing assistants* (CNAs) to provide direct care services to residents. CNAs are permitted to perform the nurse aide duties set forth in Part II, Unit VII of the Rules and Regulations governing Long-Term Care Facility Nursing Assistant Training Curriculum. The facility may employ *personal care aides* (PCAs) to provide direct care services.

The RN is responsible for the preparation, coordination, and implementation of the direct care services plan portion of the resident's occupancy admission agreement, and must review and oversee all LPN, CNA, and PCA staff. (An RN employed by DAAS who works with the Assisted Living Medicaid Waiver Program is responsible for Medicaid waiver residents' direct care services plan portions of the occupancy admission agreement.)

The RN does not need to be physically present but must be available to the facility by phone or pager. Level II facilities must employ a consulting *pharmacist*.

***Staff Ratios.*** The facility must have as many personnel/staff/employees awake and on-duty at all times as is needed to properly safeguard the health, safety, and

welfare of the residents. At least one administrator, on-site manager, or a responsible staff person must be on the premises and awake 24 hours per day.

Level I facilities must meet the staffing ratios specified in regulation. The ratios are based on number of residents and are designated for “day,” “evening,” and “night.” (See table under RCF staff ratios above). Each staff person on-duty may be counted as direct care staff even if they are currently involved in housekeeping, laundry, or dietary activities as long as universal precautions are followed. For facilities with more than 16 residents, a relief staff person must be available to relieve staff and to cover if a staff person must leave the facility in an emergency or for any other reason.

Level II facilities must have a minimum of one staff person per 15 residents from 7:00 a.m. to 8:00 p.m. and one staff person per 25 residents from 8:00 p.m. to 7:00 a.m., but at all times, there must be no fewer than two staff persons on-duty, one of whom must be a CNA. Staff persons who live on-site but are sleeping may not be counted for minimum staffing requirements.

## Training Requirements

**Residential Care Facilities.** Each employee must receive orientation to include but not be limited to: job duties, resident rights, abuse/neglect reporting requirements, and fire and tornado drills. Four hours of in-service training or continuing education pertinent to the operation of an RCF must be provided on a quarterly basis for all employees who have direct contact with residents. Training must include but not be limited to: resident rights, evacuation of building, safe operation of fire extinguishers, incident reporting, and medication supervision. In-service training on facility medication policies and procedures must be provided at least annually for all facility employees supervising medications.

**Assisted Living Facilities.** All staff, including contracted personnel who provide services to residents (excluding licensed home health agency staff), must receive orientation and training on the following topics:

- Within 7 calendar days of hire: building safety and emergency measures and appropriate response to emergencies; abuse, neglect, and financial exploitation and reporting requirements; incident reporting; sanitation and food safety; resident health and related problems; general overview of the job’s specific requirements; philosophy and principles of independent living in an ALF; and the Residents’ Bill of Rights.
- Within 30 calendar days of hire: medication assistance and monitoring, communicable diseases, and dementia and cognitive impairment.
- Within 180 calendar days of hire: communication skills, review of the aging process, and disability sensitivity training.

All staff must receive 6 hours per year of ongoing education and training.

## Provisions for Apartments and Private Units

**Residential Care Facilities.** The state does not require private rooms or private bathrooms. Facilities may provide single-occupancy or double-occupancy rooms. A minimum of one toilet/sink is required for every six residents and one tub/shower for every ten residents.

**Assisted Living Facilities.** All units must be apartments of adequate size and configuration to permit residents to carry out, with or without assistance, all the functions necessary for independent living, including sleeping; sitting; dressing; personal hygiene; storing, preparing, serving, and eating food; storing clothing and other personal possessions; doing personal correspondence and paperwork; and entertaining visitors. Each apartment or unit must be accessible to and useable by residents who use a wheelchair or other mobility aids consistent with accessibility standards.

Each apartment must have a lockable door. Separate bathroom and kitchen areas are required. Apartments may not be occupied by more than two persons. Each unit must provide a small refrigerator as well as a microwave oven, except as may otherwise be provided in the regulations, and must have a call system monitored 24-hours a day by staff.

A Level II facility must maintain physically distinct parts or wings to house individuals who receive, or are medically eligible for, a nursing home level of care separate and apart from those individuals who do not receive, or are not medically eligible for, a nursing home level of care.

An apartment or unit must be single-occupancy except in situations where residents are husband and wife or are two consenting adults who have requested and agreed in writing to share an apartment or unit. An apartment or unit may be occupied by no more than two persons.

## Provisions for Serving Persons with Dementia

**Residential care facilities** may not admit or retain individuals with dementia.

Each **assisted living facility** that advertises or otherwise holds itself out as having one or more special care units for residents with a diagnosis of probable Alzheimer's disease or other dementia must provide an organized, continuous 24-hour-per-day program of supervision, care, and services in a separate unit specifically designed to accommodate residents' complex and varied needs and comply with the following requirements.

**Dementia Care Staff.** An ASCU is subject to the same staffing requirements as set forth in the rules and regulations for the licensure of Level I ALFs, but staffing must be determined separately from the ALF based upon the census for the ASCU only. In addition, a *social worker* or other professional staff (e.g., physician, RN, or psychologist) must be utilized to perform several functions, including assisting in the development of an individual service plan. Nursing, direct care, and personal care staff cannot perform the duties of cooks, housekeepers, or laundry staff during their direct care shifts.

**Dementia Staff Training.** Staff must have 30 hours of training on: (1) policies (1 hour); (2) etiology, philosophy, and treatment of dementia (3 hours); (3) stages of Alzheimer's disease (2 hours); (4) behavior management (4 hours); (5) use of physical restraints, wandering, and egress control (2 hours); (6) medication management (2 hours); (7) communication skills (4 hours); (8) prevention of staff burn-out (2 hours); (9) activities (4 hours); (10) ADLs and individual-centered care (3 hours); and (11) assessment and individual service plans (3 hours).

Staff must receive 2 hours of ongoing in-service training each quarter to include such topics as positive therapeutic interventions and activities, developments and new trends in the fields of Alzheimer's disease and other dementias and treatments for same, and environmental modifications to minimize the effects and problems associated with these conditions.

The individual providing the training must have a minimum of 1 year uninterrupted employment in the care of residents with dementia, or training in the care of individuals with dementia, or is designated by the Alzheimer's Association or its local chapter as being qualified to provide training.

**Dementia Facility Requirements.** The regulations specify standards for the physical design of ASCUs and for locking devices. Facilities must also have policies for egress control.

## Background Checks

**Residential Care Facilities.** The administrator must be of good moral character and of sound physical and mental health. "Character" and "health" may be determined by an investigation conducted by the Office that may include such information as criminal records, doctor statements, and any other information as requested by the Office. The administrator must have no prior conviction pursuant to the Arkansas Code or relating to the operation of a long-term care facility and must not have been convicted of abusing, neglecting, or mistreating individuals. No person who has been convicted of abusing, neglecting, or mistreating individuals may be employed in the facility.

**Assisted Living Facilities.** Administrators must successfully complete a criminal background check; must have no conviction pursuant to the Arkansas Code or relating

to the operation of a long-term care facility; and must not have been convicted or have a substantiated report of abusing, neglecting, or mistreating persons, or misappropriation of resident property. The adult abuse register maintained by DHS/DAAS will be checked prior to employment. The operator of the facility and all employees and other applicable individuals utilized by the facility as staff must successfully complete a criminal check.

Verification is also required that an employee has not been convicted or does not have a substantiated report of abusing or neglecting residents or misappropriating resident property. The facility must, at a minimum, prior to employing any individual or for any individuals working in the facility through contract with a third party, make inquiry to the Employment Clearance Registry of the Office of Long Term Care and the Adult Abuse Register maintained by DHS/DAAS, and must conduct re-checks of all employees every 5 years.

## Inspection and Monitoring

***Residential Care Facilities.*** Annual renewal is required for all RCF licenses and, on average, inspections are conducted annually. All areas of the licensed facility and all records related to the care and protection of residents, including resident and employee records, must be open for inspection by the Department for the purpose of enforcing the licensing regulations.

***Assisted Living Facilities.*** Annual renewal is required for all ALF licenses. The Office of Long Term Care conducts a standard comprehensive survey of each facility on average every 18 months. To receive and maintain a license, a facility must submit to regular and unannounced inspection surveys and complaint investigations.

## Public Financing

Arkansas covers personal care services through the Medicaid State Plan, which may be provided in a person's home "or other setting" such as a RCF.

The state covers services in ALFs under a single service 1915(c) Waiver program --the Living Choices Assisted Living Waiver program. Waiver "assisted living services" providers must be licensed as a Level II ALF or a licensed Class A Home Health Agency that has a contract with a licensed Level II ALF to provide waiver services and pharmacy consultant services. Waiver services include personal care and supportive services (e.g., homemaker, chore, attendant care, companion, transportation, and medication oversight).

### ***Room and Board Policy***

The state does not provide a supplement to the federal Supplemental Security Income (SSI) payment, but limits the room and board payment for Medicaid-eligible

residents to the SSI payment less a personal needs allowance (PNA) that is retained by the resident. In 2014, the SSI payment was \$721 and the PNA was \$65, leaving \$656 per month to pay for room and board.

Family supplementation of room and board payments is not allowed, but families can pay for other items that are not included in the room and board rate, such as phone and cable TV service.

## Location of Licensing, Certification, or Other Requirements

*Rules and Regulations for Assisted Living Facilities Level I.* Arkansas Department of Human Services, Division of Medical Services, Office of Long Term Care. [August 1, 2011]  
<http://humanservices.arkansas.gov/dms/oltcDocuments/alfi.PDF>

*Rules and Regulations for Assisted Living Facilities Level II.* Arkansas Department of Human Services, Division of Medical Services, Office of Long Term Care. [August 1, 2011]  
<http://humanservices.arkansas.gov/dms/oltcDocuments/alfii.pdf>

*Rules and Regulations for Residential Long Term Care Facilities.* Arkansas Department of Human Services, Division of Medical Services, Office of Long Term Care. [August 1, 2007]  
<http://humanservices.arkansas.gov/dms/oltcDocuments/rcf.pdf>

Arkansas Department of Human Services website: Links to various information about Adult Family Care, including a report called *Gap Analysis of the Capacity of Long-Term Care Providers of HCBS in Arkansas*. Division of Aging and Adult Services, Department of Human Services. [May 2013]  
<http://humanservices.arkansas.gov/Pages/siteSearch.aspx?q=Adult%20Family%20Home>

## Information Sources

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## CALIFORNIA

### Licensure Terms

Residential Care Facilities for the Elderly

### General Approach

The Department of Social Services, Community Care Licensing Division, licenses residential care facilities (RCFs) for the elderly. There is no separate category of licensure for adult foster care. Between 2012 and 2015, the California legislature enacted several laws that will affect the operation of these facilities. Although the new laws supersede existing regulations, the state has not yet amended existing regulations or issued new regulations to reflect the statutory changes.

*This profile includes summaries of selected regulatory and statutory provisions for RCFs for the elderly. The complete regulations are online at the links provided at the end.*

### Definitions

**Residential care facility for the elderly** means a housing arrangement chosen voluntarily by the resident, or the resident's responsible person, where 75 percent of the residents are 60 years of age or older, and where varying levels of care and supervision are provided, as agreed to at the time of admission, or as determined necessary at subsequent assessments. Residents under age 60 must have needs compatible with the needs of other residents.

The licensing agency determines the maximum number of residents that a facility may admit based on the licensee's skills, whether any of the licensee's family members reside on-site, building features, and staff availability.

Facilities may admit residents who are diagnosed by a physician as having dementia if specified requirements are met, including an annual medical assessment, adequate supervision, enhanced physical plant safety requirements, and an appropriate activity program.

## **Resident Agreements**

Admission agreements must be signed by the resident and his/her responsible party, if any, within 7 days of admission. Agreements must include information about basic and optional services; service rates, payment provisions, and refund policies; facility policies; and eviction and discharge criteria.

## **Disclosure Provisions**

Prior to admission, the prospective resident and his/her responsible person, if any, must be interviewed by the licensee or the employee responsible for facility admissions, and sufficient information about the facility and its services must be provided to enable all persons involved in the placement to make an informed decision regarding admission.

Facilities that market themselves as special care facilities must describe the following in their plan of operation: program philosophy; pre-admission and ongoing assessment process; admission information (areas where special care is provided, services available, and procedures to review the plan of operation); activity programs; staff qualifications and staff training; building design features; resident change in condition policies; and procedures to review the program's effectiveness.

## **Admission and Retention Policy**

Facilities may not admit or retain anyone who requires any of the following services: (1) access to 24-hour skilled nursing or intermediate care; (2) care for Stage III and IV dermal ulcers; (3) care for gastrostomies, nasogastric tubes, or tracheostomies; and (4) treatment for staph or other serious infections. Individuals with the following conditions may also not be admitted or retained: (1) a need for assistance to perform all activities of daily living (ADLs); (2) a communicable disease; (3) unable to get out of bed; (4) mental disorders that result in ongoing behaviors that would upset other residents; and (5) dementia, unless certain requirements for specialized care are met.

Residents with specified health conditions that require incidental medical services may be admitted and retained if either the resident provides self-care or a licensed professional provides care. These services include, for example: (1) administration of oxygen; (2) catheter care; (3) colostomy/ileostomy care; (4) diabetes; (5) enemas, suppositories, and/or fecal impaction removal; (6) care for bowel and/or bladder incontinence; (7) injections; and (8) treatment of Stage I and II dermal ulcers.

Residents who will be bedridden for more than 14 days may be retained if the facility notifies the Department of Social Services that the condition is temporary and the building meets specified fire safety standards.

Facilities may admit or retain individuals: (1) who are capable of administering their own medications; (2) who receive medical care and treatment outside the facility or from a visiting nurse; (3) who because of forgetfulness or physical limitations need only be reminded or assisted to take medication usually prescribed for self-administration; (4) with cognitive impairment; and (5) with mild dementia or a mild temporary emotional disturbance resulting from personal loss or a change in living arrangement.

## Services

Facilities provide two types of services in addition to room and board: (1) *basic services*, which include personal assistance and care; observation and supervision; planned activities; and arrangements for obtaining incidental medical and dental care; and (2) *care and supervision*, including assistance with dressing, grooming, bathing, and other personal hygiene; assistance with self-administered medications; and monitoring food intake or special diets.

### **Service Planning**

A pre-admission appraisal of all applicants is required prior to move-in to evaluate functional capacity (measured by the ability to perform ADLs), mental condition, and social factors, in order to determine their suitability for admission. A physician-conducted medical evaluation is also required before admission and must include: diagnoses; current status; medications and treatments; and prescribed diets. The medical evaluation and resident appraisal must be updated when a significant change occurs in a resident's condition and as needed to maintain an accurate record of the resident's needs.

### **Third-Party Providers**

Residents may contract with home health or hospice agencies to provide treatment of conditions allowed in a licensed RCF for the elderly.

Residents may hire private paid personal assistants or caregivers only to provide services other than those the licensee is required to provide. Examples of private pay services include: companionship and additional baths beyond what the licensee is required to provide.

## Medication Provisions

Only appropriately skilled medical professionals acting within their scope of practice, including employees and/or licensed home health agency personnel, may administer medications to residents.

Unlicensed staff may assist residents with the self-administration of medications, described as: (1) medications usually prescribed for self-administration that have been authorized by the resident's physician; (2) medications during an illness determined by a physician to be temporary and minor; and (3) assistance required because of tremor, failing eyesight, and similar conditions. Assistance with self-administration does not include forcing a resident to take medication, hiding or camouflaging medications in other substances without the resident's knowledge and consent, or otherwise infringing upon a resident's right to refuse a medication.

Staff who assist with self-administration must complete coursework and pass an examination. Sixteen hours of training is required for staff who work in facilities licensed for 16 or more residents, with 8 hours of hands-on shadowing and 8 hours of other training or instruction. Staff in facilities licensed for 15 or fewer residents must complete 6 hours of training, with 2 hours of hands-on shadowing and 4 hours of instruction. The training material and exam must be developed by, or in consultation with, a licensed nurse, pharmacist, or physician. Staff who assist with self-administration of medications must complete 4 hours of annual in-service training on medication-related issues.

## Food Service and Dietary Provisions

Facilities that have responsibility for all food arrangements must provide at least three meals per day and snacks. If the meal service within a facility is elective, the facility must ensure the availability of an adequate daily food intake for all residents who purchase the meal service. Meals must include an appropriate variety of foods, planned in consideration of cultural and religious backgrounds and residents' dietary preferences. Modified diets prescribed by physicians must be provided. The total daily diet must meet the recommended dietary allowances of the National Academy of Science's Food and Nutrition Board.

## Staffing Requirements

**Type of Staff.** All facilities must have a certified *administrator*, who may be the licensee, to manage the facility according to the rules. A designee must be assigned when the administrator is not available. *Direct care staff* provide personal care services and supervision. Appropriately *skilled professionals* (e.g., a licensed nurse) may be hired to provide medication administration and/or incidental medical services.

**Staff Ratios.** Sufficient staff must be employed to deliver services required by residents. Requirements for awake staff vary by facility size: for 16 or fewer residents, staff must be available in the facility; 16-100 residents, at least one awake staff; 101-200 residents, one on call and one awake, with an additional awake staff for each additional 100 residents.

## **Training Requirements**

Administrators must complete 40 hours of continuing education units every 2 years, which must include 8 hours training on Alzheimer's disease and dementia. With prior approval, 20 of the 40 hours may be completed through online training. Licensed nursing home administrators are required to complete only 20 hours of continuing education.

All personnel must be given on-the-job training or have experience in: (1) housekeeping and sanitation procedures; (2) the skills and knowledge required to provide necessary resident care and supervision, including the ability to communicate with residents; (3) knowledge required to safely assist with prescribed medications; (4) how to recognize early signs of illness and the need for professional help; and (5) knowledge of community services and resources.

All staff who assist residents with ADLs must receive at least 10 hours of initial training within the first 4 weeks of employment and at least 4 additional hours annually. Training topics include: first-aid; the aging process; the importance and techniques of personal care services and universal precautions (at least 3 of the 10 hours); residents' rights; medication policies and procedures (at least 2 of the 10 hours); psychosocial aspects of aging; and recognizing signs and symptoms of dementia.

Before admitting a resident with a restricted health condition, the licensee must ensure that relevant direct care staff complete training provided by a licensed professional to meet the resident's needs. Training includes hands-on instruction in both general procedures and resident-specific procedures; recognizing and responding to health problems; and knowing when to contact a physician or appropriately skilled professional.

## **Provisions for Apartments and Private Units**

Private apartments are not required. Residents' rooms may be single-occupancy or double-occupancy. There must be at least one toilet and a sink for each six residents and one bathtub/shower for each ten persons, including residents, family, and facility-dwelling staff (if any).

Requirements for residents served through the Medicaid Assisted Living Waiver program include private occupancy, with shared occupancy only by residents' choice, and units must have a kitchen area equipped with a refrigerator and a cooking appliance.

## Provisions for Serving Persons with Dementia

***Dementia Care Staff.*** Facilities must have an adequate number of direct care staff to support each resident's physical, social, emotional, safety, and health care needs as identified in his/her current assessment. In facilities with fewer than 16 residents, at least one night staff person must be awake and on-duty if any resident with dementia is determined through a pre-admission appraisal, reappraisal, or observation to require awake night supervision. Facilities with 16-100 residents must have at least one employee on-duty and awake, and another employee on call and capable of responding within 10 minutes.

***Dementia Staff Training.*** All staff who care for residents with dementia must receive training in dementia care, including 6 hours of orientation and 8 hours of annual in-service training on the following topics: common problems (wandering, aggression, and inappropriate sexual behavior); positive therapeutic interventions; communication skills; promoting resident dignity, independence, privacy, and choices; and end of life care.

***Dementia Facility Requirements.*** Delayed-egress and locked doors/perimeters require special fire clearances, and are only allowed with prior Department approval. The resident and/or his or her responsible person must consent to the use of delayed-egress devices or locked facility doors.

## Background Checks

The licensing agency conducts a criminal background check of the organization's officers, administrative staff, direct care staff, and employees having frequent contact with residents. A fingerprint clearance must be received by the licensing agency on all persons subject to criminal record review prior to issuing a license. All facility staff must be fingerprint cleared prior to their physical presence in the facility. Private paid personal assistants hired by residents must also have a criminal background clearance.

## Inspection and Monitoring

Before a facility is licensed, the Department conducts an on-site survey of the proposed premises and a review of applicant qualifications. At least 20 percent of all facilities are inspected annually, and each facility must be inspected at least once every 5 years.

## Public Financing

The state's Medicaid 1915(c) Assisted Living Waiver program pays for services in RCFs for the elderly in several counties.

## **Room and Board Policy**

The state provides an optional state supplement (OSS) to Supplemental Security Income (SSI) recipients who reside in a RCF for the elderly and limits room and board charges for Medicaid-eligible residents to the combined federal SSI and OSS payments minus a personal needs allowance (PNA) retained by the resident. In 2014, the average OSS payment was \$361 and the PNA was \$131.

An extra charge to the resident may be allowed for a private room if a double room is made available but the resident prefers a private room, provided the arrangement is documented in the admissions agreement and the charge is limited to 10 percent of the room and board portion of the SSI/OSS payment.

Family supplementation is not permitted.

## **Location of Licensing, Certification, or Other Requirements**

*California Code of Regulations*, Title 22, Division 6, Chapter 8: Manual of Policies and Procedures, Community Care Licensing Division, Residential Care Facilities for the Elderly.  
<http://www.dss.cahwnet.gov/ord/entres/getinfo/pdf/rcfeman1.pdf>

*California Code of Regulations*, Title 22, Division 6, Chapter 4: Manual of Policies and Procedures, Community Care Licensing Division, Small Family Homes.  
<http://www.dss.cahwnet.gov/ord/entres/getinfo/pdf/sfhman.PDF>

## **Information Sources**

Heather Harrison  
Senior Vice President  
Public Policy and Public Affairs  
California Assisted Living Association

## COLORADO

### Licensure Terms

Assisted Living Residence

### General Approach

The Department of Public Health and Environment licenses assisted living residences (ALRs). The state licenses all adult foster homes as assisted living facilities (ALFs); residential treatment facilities for persons with mental illness are also licensed under assisted living rules.<sup>46</sup> Residences that provide services to individuals who might not be safe outside the residence must have a secured environment.

Residences that are certified to receive Medicaid reimbursement, called alternative care facilities, must meet additional requirements. Facilities are eligible for reduced licensing fees if 35 percent or more of the licensed beds are occupied by Medicaid enrollees for at least 9 months in a fiscal year.

*This profile includes summaries of selected regulatory provisions for ALRs and Medicaid requirements for these settings if they differ. The complete regulations can be viewed online using the links provided at the end.*

### Definitions

**Assisted living residence** means a residential facility for three or more adults not related to the owner of such facility that provides room and board and protective oversight, personal services, social care needed because of impaired capacity to live independently, and regular supervision on a 24-hour basis (24-hour medical or nursing care is not required).

A residential treatment facility for the mentally ill is an ALR that has received program approval from the Department of Human Services to serve no more than 16 mentally ill individuals who are not related to the licensee and are provided treatment commensurate with their psychiatric needs.

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<sup>46</sup> The term assisted living does not include a facility licensed by the Department of Human Services as a residential care facility for individuals with developmental disabilities.

## **Resident Agreements**

A copy of the resident agreement must be provided upon move-in. The agreement must provide information about a range of topics, including: charges, refunds, and deposit policies; services included in the rates and charges and optional services that require an additional, specified charge; types of services provided by the facility, services that are not provided, and services that the facility will assist the resident in obtaining; bed hold fees; transportation services; the availability of therapeutic diets; and whether the facility will be responsible for providing bed and linens, furnishings and supplies.

## **Disclosure Provisions**

Facilities must disclose the following information: policies and procedures; method of determining staffing levels; whether the facility has awake staff 24 hours daily; whether certified or licensed health professionals are available on-site; whether an automatic sprinkler system is installed; whether the facility uses restrictive egress alert devices; the on-site availability of first-aid-certified staff; and the facility policy on cardiopulmonary resuscitation and lifting assistance.

Facilities must disclose if they operate a secured environment and provide information about the type of residents they serve (e.g., based on diagnosis or presence of specific behaviors) and for which staff are trained.

## **Admission and Retention Policy**

Facilities may not admit or retain residents who are consistently, uncontrollably incontinent, unless the resident or staff are able to prevent it from becoming a health hazard; are totally bedridden with limited potential for improvement; are in need of 24-hour nursing or medical service; are in need of restraints; have a communicable disease; or have an acute substance abuse problem.

A facility may keep residents who become bedridden if: (1) a physician describes the services needed to meet specified health needs; (2) a licensed home health agency or hospice service ensures that physical, mental, and psychological needs are met; and (3) adequate staff are trained in the needs of bedridden residents.

Residents may be allowed to receive hospice care if they are long-term residents, the facility can continue to meet the needs of the other residents, and staff are trained to provide hospice care that is not outside their scope of practice. Individuals requiring hospice care upon application for residency must not be admitted.

Residents must not be admitted to a secured environment unless legal authority for admitting them has been established. However, a resident may be voluntarily

admitted or may remain in a secured environment if his or her egress is not restricted and his or her needs can be met by the facility as determined by an assessment.

*Alternative care facilities* (facilities with a Medicaid contract). These facilities may not admit, or retain past 30 days, any resident who: (1) needs skilled services on more than an intermittent basis; (2) is incapable of self-administering medication, and the facility does not administer medications; (3) is consistently unwilling to take prescribed medication; (4) is diagnosed with a substance abuse disorder and refuses appropriate treatment; (5) has an acute physical illness that cannot be managed through medications or prescribed therapy; (6) has an uncontrolled seizure disorder; (7) exhibits specified disruptive behaviors; or (8) has physical limitations that require tray food service on a continuous basis.

## **Services**

Facilities must provide protective oversight and a physically safe and sanitary environment; personal services (i.e., assistance with activities of daily living, instrumental activities of daily living, individualized social supervision, and transportation); and social and recreational services, both within the facility and in the local community, based on residents' interests.

### ***Service Planning***

Written care plans, reviewed at least annually, are required for each resident. Plans must be based on a comprehensive assessment of physical, health, behavioral, and social needs; preferences; capacity for self-care; whether medication is self-administered or administered by staff; dietary restrictions; and any physical or mental limitations or activity restrictions.

Residents whose ability to move safely outside the environment is limited, must be assessed by a qualified professional who can evaluate the need for a secured environment. Reassessments must be completed within 10 days of a significant change to determine whether placement is appropriate.

### ***Third-Party Providers***

Personal services and protective oversight services may be provided to a resident by persons who are not employees, contractors, or volunteers of the facility. The term "external services providers" is used to describe home health, hospice, private pay caregivers, and family members.

## Medication Provisions

The rules specify how drugs that are used to affect or modify behavior may be administered and how staff may assist residents who use oxygen. Staff may assist with medications used on an as-needed (PRN) basis if the resident is capable of requesting the medication and a licensed medical professional has documented instructions for appropriate use.

A “qualified medication administration person” (QMAP) is an employee who has passed a Department-approved medication training course given by a licensed nurse, physician, physician's assistant, or pharmacist, and/or has passed an approved competency test for assisting with medications. QMAPs may administer prescribed and non-prescribed medications but may not prepare, draw, or administer medication in a syringe for injection into the blood stream or skin, including insulin pen type devices.

The Department maintains a current list of persons certified as QMAPs. Facility managers must keep a copy of the QMAP certificate in employee records. A QMAP must complete a competency evaluation every 5 years.

ALRs are encouraged to develop and disclose policies and procedures for residents’ use of medical marijuana. *Alternative care facilities* may not have policies for medical marijuana use because they receive federal funds.<sup>47</sup>

## Food Service and Dietary Provisions

Three nutritionally balanced meals, using a variety of foods from the basic food groups, and between meal snacks of nourishing quality must be provided. Therapeutic diets may be provided if prescribed by a physician. Meals cannot be routinely provided in residents’ rooms unless indicated on the care plan. Residents are encouraged to participate in meal planning and to make suggestions regarding menus. Facilities must reasonably respond to residents’ suggestions regarding meals and must provide access to a food preparation area for heating or reheating food or making hot beverages, subject to the facility’s rules.

*Alternative care facilities* must provide access to food at all times.<sup>48</sup>

## Staffing Requirements

**Type of Staff.** Facilities must have a full-time *administrator* and sufficient staff to provide care. A *qualified medication administration person* and at least one staff

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<sup>47</sup> Medical marijuana policies were in effect in Colorado prior to the current recreational use policies.

<sup>48</sup> The terms “access to food” and “at all times” are not defined.

member with current certification in adult first-aid, which meets the standards of the American Red Cross or American Heart Association, must be on site at all times.

**Staff Ratios.** *No minimum ratios.* Facilities must have a method for determining staffing levels, including whether or not the facility has awake staff available 24 hours a day. Sufficient staff must be present at all times to ensure the provision of services necessary to meet residents' needs, including services provided under the care plan and services provided under the resident agreement.

*Alternative care facilities* must maintain a 1:10 staff-to-participant ratio during the day and a 1:16 ratio during the night unless a lower ratio that does not jeopardize the health and safety of residents is documented. Facilities that provide a secured environment must have a 1:6 ratio and at least one staff member must be awake during the night.

## Training Requirements

Administrators must complete a 30-hour training program approved by the Department. Fifteen hours of the training must cover the following topics: residents' rights; environment and fire safety; emergency procedures and first-aid; assessment skills; identifying and addressing difficult situations and behaviors; and nutrition.

An additional 15 hours of training must include the following required topic: meeting the personal, social, and emotional needs of the resident population served (for example, the elderly, persons with dementia, or persons with severe and persistent mental illness); and can include medication management; management of residents' finances; oxygen use; chronic illnesses, such as diabetes, depression, mental illness, and dementia; legal and ethical issues; activity or care planning; confidentiality; end of life care; and use of community resources.

Staff must be given on-the-job training or have related experience in the job assigned to them. Before staff can furnish direct care services, the facility must provide adequate training on residents' rights; first-aid and injury response; procedures for providing care and services for the current residents; the facility's medication administration program; and specific needs of the population served (e.g., frail elderly, diabetics, residents in secured environments, those who are severely and persistently mentally ill, or have AIDS, dementia, or are bedfast).

Within 1 month of hire, the facility must provide adequate training on assessment skills, infection control, identifying and dealing with difficult situations and behaviors, and health emergency response.

## Provisions for Apartments and Private Units

Apartment-style units are not required. No more than two people can share a room in facilities built after July 1, 1986. One full bathroom is required for every six residents. Cooking may be allowed in facilities that provide apartments rather than bedrooms. Cooking is not allowed in bedrooms, and facilities must provide access to a food preparation area for heating or reheating food or making hot beverages, subject to the facility's rules. Only residents who are capable of cooking safely are allowed to do so.

*Alternative care facilities* must accommodate requests regarding roommate choice, within reason.<sup>49</sup>

## Provisions for Serving Persons with Dementia

***Dementia Care Staff.*** Staffing must be appropriate to meet residents' needs.

***Dementia Staff Training.*** Staff and the owner/operator must have appropriate training to address the needs of residents in secured environments. At least 75 percent of staff must have a minimum of 8 hours of annual training about Alzheimer's specific care techniques. The Colorado Alzheimer's Association training program is recognized by the Department.

***Dementia Facility Requirements.*** Facilities must provide a safe and secure outdoor area for residents' use year round. Fencing or other enclosures may be installed around secure areas and residents must be able to access the secure areas. Requirements for the use of restrictive egress alert devices are specified.

## Background Checks

Owners and administrators must undergo a fingerprint background check. Owners are responsible for obtaining a criminal background check of administrators to determine whether they have been convicted of a felony or a misdemeanor that could pose a risk to residents' health, safety, and welfare. A criminal background check is also required for all staff, volunteers, and contract staff. The owner or licensee must obtain any criminal history record information from relevant agencies for all persons responsible for residents' care and welfare.

## Inspection and Monitoring

Inspections, both announced and unannounced, are conducted periodically by the Department. A license is valid for 1 year from the date of issuance. Facilities meeting

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<sup>49</sup> The term "within reason" is not defined.

the following criteria are eligible for an extended survey cycle: licensed for at least 3 years, and, within that prior 3 years, have had no enforcement activity, no pattern of deficient practice, and no significant deficiency cited in response to a complaint that negatively affected the life, health, or safety of residents.

## Public Financing

The state provides services in ALRs--which are called alternative care facilities--under two Medicaid 1915(c) waiver programs that serve older adults, adults with physical disabilities, adults with HIV/AIDS, and people with mental illness: the Home and Community-Based Services Waiver for Community Mental Health Supports and the Elderly, Blind, and Disabled Waiver.

### ***Room and Board Policy***

In 2015, room and board charges for Medicaid beneficiaries residing in alternate care facilities are capped at \$675 a month and residents are permitted to retain a personal needs allowance (PNA) of the difference between the cap and their income. For federal Supplemental Security Income (SSI) beneficiaries, the difference is \$58.

In 2011, the state paid an optional state supplement of \$551 to SSI recipients residing in ALFs.<sup>50</sup>

In 2009, family supplementation was allowed to pay for items not covered by the Medicaid waiver program.<sup>51</sup>

## Location of Licensing, Certification, or Other Requirements

Code of Colorado Regulations, Title 6, Chapter 7: Assisted Living Residences. [various effective dates between November 1, 2008 and July 15, 2014]

<http://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=5803&fileName=6%20CCR%201011-1%20Chap%2007>

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<sup>50</sup> Social Security Administration. *State Assistance Programs for SSI Recipients*, January 2011. [http://www.socialsecurity.gov/policy/docs/progdesc/ssi\\_st\\_asst/2011/co.html](http://www.socialsecurity.gov/policy/docs/progdesc/ssi_st_asst/2011/co.html). (NOTE: In 2007, the term adult foster care as used in this program was changed to ALR.) The amount of the PNA in 2011 was not stated. We received conflicting information regarding Medicaid room and board caps and the amounts and types of state supplements available to SSI recipients and were unable to resolve these conflicts through online or other sources.

<sup>51</sup> Mollica, R.L. (2009). *State Medicaid Reimbursement Policies and Practices in Assisted Living*. National Center for Assisted Living, American Health Care Association. <http://www.ahcancal.org/ncal/resources/Documents/MedicaidAssistedLivingReport.pdf>. Current information regarding family supplementation was not available online or from other sources.

Colorado Department of Health Care Policy and Financing website: Alternative Care Facilities, with links to provider information and regulations.

<https://www.colorado.gov/pacific/hcpf/alternative-care-facilities>

## Information Sources

Ann Kokish  
Colorado Health Care Association

Dee Reda  
Colorado Department of Health

Michele Craig  
Colorado Department of Health Care Policy and Financing

Caitlin Phillips  
Alternative Care Facility Specialist  
Long-Term Services and Supports Division  
Department of Health Care Policy and Financing

## CONNECTICUT

### Licensure Terms

Assisted Living Services Agency, Residential Care Homes

### General Approach

The Department of Public Health, Facility Licensing and Investigations Section, licenses assisted living services agencies that provide assistance to residents of managed residential communities, state-funded congregate housing facilities, and apartments subsidized by the U.S. Department of Housing and Urban Development. Assisted living services agencies are required to be licensed, but managed residential communities are not; instead, they must register with the Department of Public Health. The operator of a managed residential community may also be licensed as an assisted living services agency.

Residential care homes (RCHs), also licensed by the Department of Public Health, are another type of community-based care for adults. Renovated private homes can be used as small RCHs. These homes used to be called boarding homes, homes for the aged, and rest homes--terms that are used in the regulations and policy documents.

Alzheimer's special care units (SCUs)/programs provide specialized care or services for people with Alzheimer's disease or dementia and have separate licensure requirements.

*Adult Foster Care.* Adult family living, regulated by the Department of Social Services, is a program that matches one or two adults who require room, board, and personal care services with approved host families or individuals. In exchange for a monthly allowance, the host family provides 24-hour supervision and assistance with activities of daily living (ADLs), housekeeping, shopping, and meals. *Regulatory provisions for adult family living are not included in this profile but a link to the provisions can found at the end.*

*This profile includes summaries of selected regulatory provisions for assisted living services agencies that provide services in managed residential communities, and RCHs. The complete regulations can be viewed online using the links provided at the end.*

## Definitions

**Assisted living services agency** means an agency that provides, among other things, nursing services and assistance with ADLs to the residents in managed residential communities whose conditions are chronic and stable. A managed residential community means a facility consisting of private residential units primarily for persons age 55 or older who might need assisted living services.

**Residential care home** means a facility that is staffed to furnish food, shelter, and laundry for two or more persons unrelated to the proprietor, and to provide services that do not require the training or skills of a licensed nurse, including personal care, special diets, and medication services.

**Alzheimer's special care unit/program** means a nursing facility, RCH, assisted living facility, adult congregate living facility, adult day care center, hospice, or adult foster home that: (1) locks, secures, segregates, or provides special programs or units for residents diagnosed with probable Alzheimer's disease, dementia, or a similar disorder; and (2) prevents or limits a resident's access outside the designated or separated area.

## Resident Agreements

**Assisted Living Services Agencies.** The agreement, which must be signed by the resident at move-in, must include information about services available; charges and billing policies and processes; admission and discharge criteria; resident rights and responsibilities; the complaint process; and Medicare-covered services.

**Residential Care Homes.** *No provisions identified.*

## Disclosure Provisions

An Alzheimer's SCU or program that advertises or markets itself as providing specialized care or services for people with Alzheimer's disease or dementia must provide a written disclosure, updated annually, which includes at a minimum, information about: (1) the program's philosophy; (2) pre-admission, admission and discharge policies and procedures; (3) assessment; (4) service planning and implementation; (5) staffing patterns and training requirements; (6) physical environment; (7) resident's activities; (8) the family's role in care; and (9) program costs.

## Admission and Retention Policy

**Assisted Living Services Agencies.** The rules do not specify specific admission or discharge criteria; however, each agency must develop written policies for the

discharge of residents. The policies must include change in a resident's condition and definitions of routine, emergency, financial, and premature discharge. Assisted living services may be provided to residents with chronic and stable health, mental health, and cognitive conditions as determined by a physician or health care practitioner. An attending physician must annually provide written certification that a resident's condition is chronic and stable.

**Residential Care Homes.** Individuals are admitted if they are able to evacuate independently in an emergency.

## Services

**Assisted living services agencies** may provide nursing services, assistance with ADLs, and assistance with self-administered medications to residents with chronic and stable conditions as determined by a physician or health care practitioner. Nursing services may include resident teaching; wellness counseling; health promotion and disease prevention; medication administration and delegation of supervision of self-administered medications; and the provision of care and services to residents whose conditions are chronic and stable.

Managed residential communities provide core services, including three meals a day; laundry; scheduled transportation; housekeeping; maintenance services, including chore services for routine domestic tasks that the resident is unable to perform; and social and recreational services.

Managed residential communities may not provide health services unless they have also been licensed as an assisted living services agency. They may contract with one or more assisted living service agencies, home health care agencies, or other appropriately licensed health care providers, to provide health services for residents.

**Residential Care Homes.** Services provided include personal care, medication services, recreational activities, laundry, and housekeeping.

### Service Planning

**Assisted Living Services Agencies.** Within 7 days of admission, a registered nurse (RN) must develop a resident service program in consultation with the resident, family, and others involved in the resident's care. The service program must include information about the resident's problems and needs; types and frequency of services and equipment required; and medications, treatments, and other required nursing services. The program must be reviewed as the resident's condition requires.

**Residential Care Homes.** No provisions identified.

### **Third-Party Providers**

**Assisted living services agencies** may contract with a home health agency or other licensed health care agency.

**Residential Care Homes.** *No provisions identified.*

## **Medication Provisions**

**Assisted Living Services Agencies.** A licensed nurse may administer medications and/or pre-pour medications for residents who are able to self-administer medications. Family members may also assist a relative with self-administration of medications by preparing or pre-pouring medications.

With the approval of the resident or his or her representative, an assisted living services agency aide may supervise a resident's self-administration of medications, including reminding, verifying, and opening medication packages. All medications must be stored in the resident's unit.

**Residential Care Homes.** Residents may self-administer medications, and may request assistance from staff with opening containers or packages and replacing lids. Unlicensed staff may administer medications if they have been trained by a registered pharmacist, physician, physician assistant, RN, or advanced practice RN, in the methods of medication administration and must have successfully completed a written examination and practicum administered by the Connecticut League For Nursing or other Department-approved certifying organization.

If the RCH permits the administration of medication by certified program staff, a program staff member trained and certified to administer medication by the route ordered by the authorized prescriber must be present at all times whenever a resident has to take physician-prescribed medication.

## **Food Service and Dietary Provisions**

**Assisted Living Services Agencies.** Managed residential communities must offer three meals a day.

**Residential Care Homes.** Menus and the time scheduling of regular meals and snacks must meet Connecticut Department of Health requirements for basic nutritional needs.

## Staffing Requirements

### ***Assisted Living Services Agencies***

**Type of Staff.** Agencies must employ a *supervisor* who is a RN and who is responsible for: (1) coordinating and managing all nursing and assisted living aide services provided to residents by *direct service staff*; and (2) communicating with the service coordinator. Direct care staff are either certified nurse aides or home health aides who assist with ADLs, self-administration of medications, and routine household tasks. A *licensed nurse*, in addition to the supervisor, is required to perform nursing services and quarterly assessments, as well as coordination, training, and supervision of aides.

Managed residential communities must have a service coordinator who assists residents and acts as a liaison with the assisted living services agency. Service coordinators must: (1) ensure that all core services are provided to or are made available to residents and assist residents to make arrangements to meet their personal needs; (2) establish collaborative relations with provider agencies, support services, and community resources; (3) establish a resident council; and (4) coordinate a resident information system. In an assisted living services agency serving no more than 30 residents, one individual may serve as both the supervisor of assisted living services and the service coordinator if the services agency and the managed RCH are owned by the same company.

**Staff Ratios.** *No minimum ratios.* A supervisor must be available 20 hours a week for every ten or fewer licensed nurses or assisted living aides and a full-time supervisor must be available for every 20 licensed nurses or aides. A sufficient number of aides must be available to meet residents' needs. Twenty-four hour awake staff are not required since needs vary among residents, but 24-hour staffing could be required if indicated by residents' service plans. An RN must be available on call 24 hours a day.

### ***Residential Care Homes***

**Type of Staff.** The *licensee* is responsible for daily operations. *Certified unlicensed staff* are those who have completed Department-approved training to assist with medication services. *Program staff* are employees who assist with personal care services.

**Staff Ratios.** At least one program staff person must be on-duty at all times for every 25 residents. Facilities that provide medication administration must have at least one certified unlicensed staff person on duty at all times.

## Training Requirements

**Assisted Living Services Agencies.** All staff must complete a 10-hour orientation program that includes the assisted living philosophy; facility policies and procedures; and applicable regulations. Aides must pass a competency exam. Each aide must have at least 6 hours of annual in-service continuing education on service procedures and techniques for the population being served.

**Residential Care Homes.** New staff must receive an orientation that includes information about safety and emergency procedures for staff and residents, facility policies and procedures, and residents' rights. The amount of required continuing education is calculated based on a percentage of total annual hours worked (to a maximum of 12 hours) per year. Continuing education topics include residents' rights; behavioral management; personal care; nutrition and food safety; and general health and safety.

## Provisions for Apartments and Private Units

**Managed residential communities** must provide private units that include a full bathroom and access to facilities and equipment for the preparation and storage of food. Units must be single-occupancy; sharing a unit is permitted upon the request and mutual consent of residents.

**Residential Care Homes.** Apartment-style units are not required. Residents' rooms may be single-occupancy or double-occupancy. Bathrooms must have one separate shower or bathtub for every eight residents. One toilet may serve two resident rooms, but no more than four residents.

## Provisions for Serving Persons with Dementia

**Dementia Care Staff.** Staffing requirements are based on the licensure category of the facility or program.

**Dementia Staff Training.** All licensed and registered direct care staff in Alzheimer's SCUs or programs must receive training annually that includes, but is not limited to: (1) at least 8 hours of dementia-specific training completed within 6 months of hire, and at least 8 hours of training annually; and (2) at least 2 hours annual training in pain recognition and administration of pain management techniques. At least 1 hour of training must be provided to all non-direct care staff within 6 months of hire.

**Dementia Facility Requirements.** *No provisions identified.*

## Background Checks

*No provisions identified for either licensure category.*

## Inspection and Monitoring

**Assisted living services agencies** are inspected every 2 years.

**Residential care homes** are inspected by the Department of Public Health. *No additional provisions identified.*

## Public Financing

The state pays for assisted living services and RCH services through several Medicaid 1915(c) waiver programs and through the non-Medicaid state-funded Connecticut Home Care Program for Elders.

### **Room and Board Policy**

The Department of Social Services provides an optional state supplement (OSS) to help cover the room and board costs for eligible RCH residents. Only licensed facilities can receive payment through the state supplement program, therefore residents of managed residential communities who receive assisted living services are not eligible.

The OSS amount is calculated individually, based on the per diem rate of the licensed facility and the difference between the resident's income and the Supplemental Security Income federal benefit--\$733 in 2015--less a personal needs allowance of \$29.95, which is retained by the resident.

There are no rules prohibiting a family member from supplementing or assisting a resident with paying for their room and board at a facility.

## Location of Licensing, Certification, or Other Requirements

Connecticut Department of Social Services, Medical Assistance Program, Provider Bulletin: Adult Family Living. [December 2013]  
[http://www.swcaa.org/wp-content/uploads/2014/01/pb13\\_50AdultFamilyLiving.pdf](http://www.swcaa.org/wp-content/uploads/2014/01/pb13_50AdultFamilyLiving.pdf)

Connecticut Department of Social Services website: Assisted Living Program. [October 12, 2012]  
<http://www.ct.gov/dss/cwp/view.asp?a=2353&q=391114>

*Public Health Code*, 19-13-D105: Assisted living services agency. [June 1, 2006]  
[http://www.ct.gov/dph/lib/dph/public\\_health\\_code/sections/19-13-d105\\_assisted\\_living\\_agency.pdf](http://www.ct.gov/dph/lib/dph/public_health_code/sections/19-13-d105_assisted_living_agency.pdf)

*Public Health Code*, 19-13-D6: Home for the Aged and Rest Homes. [April 2, 2002]  
[http://www.sots.ct.gov/sots/lib/sots/regulations/title\\_19/013d.pdf](http://www.sots.ct.gov/sots/lib/sots/regulations/title_19/013d.pdf)

*General Statutes of Connecticut*, Title 19A, Chapter 368v, Sec. 19a-562: Alzheimer's Special Care Units or Programs.  
[http://www.cga.ct.gov/current/pub/chap\\_368v.htm#sec\\_19a-562](http://www.cga.ct.gov/current/pub/chap_368v.htm#sec_19a-562)

## Information Sources

Matt Barrett  
Connecticut Association of Health Facilities

Paul Chase  
Public Assistance Consultant  
Connecticut Department of Social Services  
Alternate Care Unit

## DELAWARE

### Licensure Terms

Assisted Living Facility

### General Approach

The Delaware Department of Health and Social Services (DHSS), Division of Long Term Care Residents Protection, licenses assisted living facilities (ALFs) that offer living arrangements to medically stable persons who do not require skilled nursing services and supervision.

*Adult Foster Care.* The state licenses two types of adult foster care (called rest homes)--family care homes and residential care homes (RCHs)--which provide room and board and personal care services for 2-3 residents who can no longer live independently and/or who need supervision and a family living situation. Family care homes can provide a higher level of care than can RCHs, but when admitted, individuals must be able to perform all activities of daily living (ADLs) and self-administer medications. *Regulatory provisions for adult foster care settings are not included in this profile but a link to the provisions can found at the end.*

*This profile includes summaries of selected regulatory provisions for ALFs. The complete regulations can be viewed online using the links provided at the end.*

### Definitions

**Assisted living** is a special combination of housing, supportive services, supervision, personalized assistance, and health care designed to respond to the individual needs of those who need help with ADLs and/or instrumental activities of daily living.

### Resident Agreements

Prior to executing a contract, which includes financial and non-financial components, residents must receive a statement of all charges. Financial components include: service rates and ancillary charges; billing and payment policies; criteria for additional charges as needs change; the process for changing the rates; and the party responsible for handling finances, obtaining equipment/supplies, arranging services not covered by the contract, and disposing of belongings.

Non-financial components include: basic and optional services; optional services provided by third parties; residents' rights and obligations; grievance procedures; occupancy provisions, such as policies concerning modifications to the resident's living area; procedures for changing the resident's accommodations (relocation, roommate, number of occupants in the room); transfer procedures; security; temporary absence policy; interim service arrangement during an emergency; staff members' right to enter a resident's room; discharge policies and procedures; and facility obligations.

## **Disclosure Provisions**

Facilities must make a financial disclosure statement available to the public.

Facilities offering special care for persons with dementia must disclose the philosophy of care; the population served; the admission and discharge process and criteria; the assessment, care planning, and care implementation process; the staffing plan and training policies; physical environment and design features; resident activities; family roles; psychosocial services; nutrition and hydration services; policies on wandering; and costs.

## **Admission and Retention Policy**

Facilities may not admit people with a range of medical conditions, including those who: (1) require more than intermittent or short-term nursing care; (2) require skilled monitoring, testing, and adjustment of medications and treatments; (3) require monitoring of a chronic unstable medical condition; (4) are bedridden more than 14 days; (5) have Stage III or IV pressure sores; (6) require a ventilator; (7) require treatment for a disease or condition that requires more than contact isolation; (8) have an unstable tracheotomy or a stable tracheotomy of less than 6 months' duration; (9) require an intravenous or central line; (10) wander to the extent that facilities cannot provide adequate supervision or security arrangements; or (11) pose a threat to themselves or others.

Resident-specific waivers may be granted to allow facilities to temporarily care for people with excluded conditions for up to 90 days, as long as services are provided by appropriate health professionals. These restrictions do not apply to residents under the care of a licensed hospice program.

## **Services**

Facilities must provide assistance with ADLs; laundry and housekeeping; access to appropriate health care and social services, as described in resident service agreements; opportunities for social interaction and leisure activities that promote the

physical and mental well-being of each resident; and arrangements for emergency transportation.

### ***Service Planning***

A registered nurse (RN) must complete the state's Uniform Assessment Instrument (UAI) prior to admitting an individual and it must be updated within 30 days of admission, annually, and following a change in condition. The UAI collects information about the applicant's/resident's physical condition, medical status, and psychosocial needs. This information determines whether applicants meet criteria for admission/retention, level of care criteria (for Medicaid-eligible applicants), and whether the facility can meet their service needs.

Facilities must develop a service agreement with each resident to describe what services will be provided, who will provide the services, when the services will be provided, how the services will be provided, and, if applicable, the expected outcome. The service agreement includes a risk agreement.

A managed or negotiated risk agreement is a signed document between a resident and the facility--and any other involved party--that describes mutually agreeable actions for balancing the resident's choices and independence with the facility's requirement to oversee residents' health and safety. Only residents who are capable of making choices and decisions and understanding consequences may enter into a managed/negotiated risk agreement.

### ***Third-Party Providers***

Third-party providers are defined as any party, other than the facility, that furnishes services/supplies to a resident. Third-party providers, including family members, must be specified in the resident's service agreement.

## **Medication Provisions**

Facilities must establish and adhere to written medication policies and procedures that specify processes for obtaining, documenting, storing, and administering medications. Residents may self-administer or receive assistance with self-administration of medications, or have medications administered to them.

An RN must review medications within 30 days of admission for residents who self-administer medications to: (1) assess their cognitive and physical ability and need for assistance; (2) ensure that medications have been received and properly labeled and stored; and (3) determine the presence of adverse side effects.

Staff who complete a Board of Nursing-approved medication training program, called Assistance with Self-Administration of Medication, in accordance with the state's

Nurse Practice Act, may provide assistance with self-administration of medications. Assistance includes holding the container, opening the container, and assisting the resident in taking the medication (other than by injection), following the directions of the original container, and documenting in the medication log that each medication has been taken.

An adult family member/support person, as identified in the resident's contract and service agreement, may provide help with prescription or non-prescription medication. The family role in the care of a resident receiving specialized care for memory impairment must be disclosed in the service agreement.

A required quarterly pharmacy review includes a review of residents' medication regimens and writing a report describing any irregularities.

## Food Service and Dietary Provisions

Facilities must ensure that three meals, snacks, and prescribed food supplements are available during each 24-hour period, 7 days per week. A dietician or nutritionist must ensure that menus are nutritionally adequate.

## Staffing Requirements

**Type of Staff.** Every ALF must have a *director*, who has overall responsibility for managing the facility to ensure that all statutory and regulatory requirements are met, and *resident assistants* who provide direct care services. Facilities licensed for 25 or more beds must have a full-time *nursing home administrator*. Facilities licensed for 5-24 beds must have a part-time nursing home administrator on-site and on-duty at least 20 hours a week. Each facility with four beds or fewer must have a full-time, on-site *house manager* who is responsible for daily operations; the director of the facility must be on site at least 8 hours a week.

Every ALF must have a *director of nursing* who is an RN. The director of nursing must be full-time in facilities licensed for 25 or more beds, and on-site and on-duty at least 20 hours a week in facilities licensed for 5-24 beds, and on site at least 8 hours a week in a facility with four beds or fewer.

The ALF must have a staffing plan that specifies supervisory responsibilities, including the person responsible in the director's absence. All direct care staff must be familiar with the service agreement for each resident for whom they provide care. At least one staff person must be on site 24 hours per day who is qualified to administer medication and/or assist with self-administration of medication, and has knowledge of emergency procedures, basic first-aid, cardiopulmonary resuscitation, and the Heimlich maneuver.

**Staff Ratios.** *No minimum ratios.* Facilities must provide a sufficient number of staff who are adequately trained, certified, or licensed to meet residents' needs and to comply with applicable state laws and regulations. At least one awake qualified staff person must be on site 24 hours per day.

## Training Requirements

Orientation is required for regular and temporary resident assistants. It must cover several topics, including fire and life safety and emergency disaster plans; infection control; basic food service; first-aid and the Heimlich maneuver; job responsibilities; residents' health and psychosocial needs; the assessment process; use of service agreements; resident rights and reporting of abuse, neglect, and mistreatment; and hospice services. A minimum of 12 hours of annual training must be provided.

## Provisions for Apartments and Private Units

Living units may be single-occupancy or double-occupancy; no more than two residents may share a room. Bathrooms must be available to residents either in their individual living units or in an area accessible to each resident. There must be at least one bathroom for every four residents. Residents must have access to a microwave or stove/conventional oven, refrigerator, and sink in their own living unit and/or a readily accessible central kitchen. Bedrooms and all bathrooms used by residents, except in specialized care units for memory impairment, must be equipped with an intercom or other mechanical means of communication for emergencies.

## Provisions for Serving Persons with Dementia

**Dementia Care Staff and Facility Requirements.** *No provisions identified.*

**Dementia Staff Training.** Facilities that provide direct health care services to persons diagnosed with dementia must provide dementia-specific training each year to health care providers, who must also participate in continuing education programs. The training must cover topics relevant to dementia care, including communicating with persons diagnosed with various forms of dementia; their psychological, social, and physical needs; and required safety measures.

## Background Checks

Facilities must obtain a report of each employee's entire criminal history record from the Delaware Bureau of Identification and a report from DHSS regarding its review of any report of any person's entire federal criminal history record. Facilities must also comply with the state's mandatory drug testing law for all employees. The licensing

agency may impose civil money penalties for violations of the criminal background check and drug testing laws.

## **Inspection and Monitoring**

Facilities are surveyed annually. When investigating abuse, neglect, mistreatment, or financial exploitation reports, the Division may make unannounced visit(s) to the facility.

## **Public Financing**

The Delaware Diamond State Health Plan Plus is a Medicaid managed long-term care program, which is currently being implemented throughout the state through an 1115 demonstration waiver. The program covers services provided in assisted living.

### ***Room and Board Policy***

In 2015, the state pays a maximum optional state supplement of \$140 to Supplemental Security Income recipients who reside in ALFs; Medicaid-eligible residents are allowed to keep a \$131 personal needs allowance. Family supplementation is allowed.

## **Location of Licensing, Certification, or Other Requirements**

Delaware Department of Health and Social Services, Division of Long Term Care Residents Protection website: Regulations. This site has links to the regulations for ALFs and both types of rest homes--family care and residential care.  
<http://www.dhss.delaware.gov/dltcrp/regqs.html>

## **Information Sources**

Yrene Waldron  
Delaware Health Care Facilities Association

Robert H. Smith  
Licensing and Certification Administrator  
Delaware Division of Long Term Care Resident Protection

## DISTRICT OF COLUMBIA

### Licensure Terms

Assisted Living Residence, Community Residence Facility

### General Approach

The Department of Health, Health Regulation and Licensing Administration licenses assisted living residences (ALRs) and community residence facilities; ALRs can provide a higher level of care than community residence facilities. The District of Columbia (DC) does not state in law or in regulation a minimum number of residents that triggers a requirement for licensure, but an agency source confirmed that the minimum number is one resident. There is no separate licensure for adult foster care; the DC licenses small facilities as ALRs or community residence facilities.

*This profile includes summaries of selected regulatory provisions for ALRs and community residence facilities. The complete regulations are online at the links provided at the end. However, the online sources do not yet reflect some changes that have been made to the regulatory provisions--either through rule-making or statutory change. Some of these changes are included in this profile and indicated with footnotes.*

### Definitions

**Assisted living residence** means an entity, whether public or private, that combines housing, health services, and personal assistance--in accordance with individually developed service plans--for the support of individuals who are unrelated to the owner or operator of the entity. The definition does not include a group home for persons with intellectual disabilities or a mental health community residence.

The philosophy of assisted living emphasizes personal dignity, autonomy, independence, privacy, and freedom of choice. Further, the services and physical environment of an ALR should enhance a person's ability to age in place in a home-like setting by increasing or decreasing the amount of assistance in accordance with the individual's changing needs.

**Community residence facility** means a residence that provides safe, hygienic, sheltered living arrangements for one or more individuals aged 18 years or older who are not related by blood or marriage to the residence director, and who are ambulatory and able to perform activities of daily living (ADLs) with minimal assistance.

The definition includes facilities for the elderly and physically disabled and group homes for persons with intellectual disabilities that provide a sheltered living arrangement for persons who desire or require supervision or assistance within a protective environment because of physical, mental, familial, or social circumstances, or intellectual disability.

## Resident Agreements

***Assisted Living Residences.*** A written contract/resident agreement must be provided prior to admission. It must include a range of topics, including the residence's organizational affiliation, the nature of any special care offered, services included or excluded, residents' rights and grievance process, unit assignment procedures, admission and discharge policies, responsibilities for coordinating health care, obligations for handling finances, coordinating and contracting for services not provided by the residence, and policies and procedures for payments and refunds.

***Community Residence Facilities.*** *No provisions identified.*

## Disclosure Provisions

***Assisted Living Residences.*** Facilities must disclose contract terms and billing practices to residents.

***Community Residence Facilities.*** Facilities must provide a written copy of residents' rights and privileges to each resident and his or her representative, if any, upon admission.

All residents, next of kin, and representatives (if any) must be given the address and telephone number of the DC government office that licenses health care facilities.

Facilities must develop a statement on the following topics: program and facilities; staffing patterns; consultant services; activities offered; fees and charges; payment and refund policies; characteristics of populations served; admission and discharge policies, including parameters of length of stay; and formal and informal relationships to community health services and social services.

## Admission and Retention Policy

*Both types of facilities* may involuntarily discharge residents if they are unable to: (1) meet a resident's documented health care needs; (2) provide services in accordance with the prescribed level of care; or (3) safeguard the resident or other residents from physical or emotional injury.

**Assisted Living Residences.** Prior to admission, the facility must determine that it can meet the needs of an individual in addition to the needs of the other residents. The facility may admit only individuals to whom it can provide appropriate services, unless it (or the individuals, with the agreement of the facility) arranges for third-party services. Facilities may not admit or retain individuals who: (1) are dangerous to themselves or others; (2) exhibit behavior that negatively impacts the lives of others; (3) are at risk for health or safety complications that cannot be addressed by the facility; (4) require more than 35 hours a week of skilled nursing and home health aide services combined, provided on less than a daily basis; and (5) require more than intermittent skilled nursing care; treatment of Stage III or IV skin ulcers; ventilator services; or treatment for an active, infectious, and reportable disease or condition that requires more than contact isolation.

A facility must facilitate aging in place to the best of its ability with the understanding that there may be a point reached where adequate and appropriate services cannot be marshalled to support the resident safely, making transfer to another setting necessary. A facility may involuntarily discharge residents if it cannot continue to meet the care needs of the resident as provided in the individual service plan. But, residents have the right to remain in the residence despite a recommendation to transfer, if they obtain additional services that are acceptable to the residence.

**Community Residence Facilities.** Prospective residents, the residence director and the resident's physician must agree that the prospective resident does not need professional nursing care and can be assisted safely and adequately within a community residence facility.

Short-term nursing care--up to 72 consecutive hours--may be provided when needed if the facility can provide or arrange for the provision of the physical environment and professional services appropriate to the resident's condition.

Residents must be able to perform ADLs with minimal assistance, generally be oriented as to person and place, and capable of exercising proper judgment in taking action for self-preservation under emergency conditions.

By special permission of the licensing body, persons who are not generally oriented or who are substantially ambulatory but need minimal ADL assistance may be admitted if sufficient staff are available.

## Services

**Assisted Living Residences.** Services include 24-hour supervision and oversight to meet scheduled and unscheduled needs, some assistance with ADLs and instrumental activities of daily living (IADLs), and laundry/housekeeping services. ALR also must facilitate access to appropriate health/medical, rehabilitation, and psychosocial services as established in a resident's individualized service plan (ISP),

and ensure appropriate oversight, monitoring, and coordination of all components of the ISP, including necessary transportation and the delivery of needed supplies.

**Community Residence Facilities.** Meals, housekeeping, laundry, and dietary services are provided. Short-term nursing care--up to 72 consecutive hours--may be provided or arranged by the facility. Facilities with fewer than 30 residents must assist residents in obtaining needed social services.

### **Service Planning**

**Assisted Living Residences.** Within 30 days prior to admission, an individual's physician must conduct a medical, rehabilitation, and psychosocial assessment and the facility must conduct a functional assessment. The facility must complete another assessment within 30 days after admission. An ISP must be developed prior to admission and updated following the completion of the "post move-in" assessment. The ISP must include the services to be provided, and when, how often, how, and by whom they will be provided and assessed.

The ISP must be reviewed 30 days after admission and at least every 6 months thereafter. It must be updated more frequently if there is a significant change in the resident's condition.

A shared responsibility agreement is a formal written agreement that outlines the responsibilities and actions of all parties. The agreement is a process for resolving discrepancies between the individual resident's right to independence and the provider's concerns for the safety and well-being of the individual and others. It is a tool for facilities to recognize an individual resident's right to autonomy by respecting his or her right to make individual decisions regarding lifestyle, personal behavior, and ISPs.

In some cases, a resident's decision may involve increased risk of personal harm and therefore potentially increase the risk of liability by the facility absent an agreement between the resident and the facility concerning such decisions or actions. In such instances, the facility must explain to the resident, or surrogate, why the decision or action may pose risks, suggest alternatives, and discuss with the resident, or surrogate, how the facility might mitigate potential risks.

If the resident decides to take action that may involve increased risk of personal harm and conflict with the facility's usual responsibilities, the facility describes to the resident the action or range of actions subject to negotiation and negotiates a shared responsibility agreement--with the resident as a full partner--that is acceptable to the resident and the facility and meets all reasonable requirements implicated. The shared responsibility agreement must be signed by the resident or surrogate and the ALR.

**Community Residence Facilities.** All residents must have a medical examination by a physician not more than 30 days prior to admission and an examination at least once each year after admission. If a resident is unable to make

arrangements for his or her annual examination, the residence director must make the arrangements and assist the resident in complying with this requirement.

Each resident's personal physician must certify that the resident is free of communicable disease and provide the community residence facility with a written report containing sufficient information concerning the resident's health to assist the facility in providing adequate care, including any treatment orders, prescribed drugs, prescribed special diets, and any rehabilitation program.

### ***Third-Party Providers***

***Assisted Living Residences.*** Facilities with 17 beds or more are responsible for providing or coordinating personalized care to individuals who reside in their own living units. Under certain conditions, residents have the right to arrange directly for medical and personal care with an outside agency.

***Community Residence Facilities.*** Short-term nursing care--up to 72 consecutive hours--may be provided when needed if the facility can furnish or arrange for the provision of the physical environment and professional services appropriate to the resident's condition.

## **Medication Provisions**

***Assisted Living Residences.*** Within 30 days prior to admission, the facility must consult with the prospective resident's health care practitioner regarding his or her current medication profile, including a review of non-prescription drugs, possible adverse interactions, common expected or unexpected side effects, and the potential that such medications have to act as chemical restraints.

Facilities must assess whether a resident: (1) is capable of self-administering his or her own medications; (2) is capable of self-administering his or her own medication, but requires a reminder to take medications or requires physical assistance with opening and removing medications from the container, or both; or (3) requires that medications be administered by a licensed nurse, physician, physician assistant, or trained medication employee.

Facilities must arrange for an on-site review by a registered every 45 days to supervise medication administration by trained medication employees, and to assess resident responses to medications and residents' ability to self-administer medications.

A trained medication employee is an individual employed to work in an ALR who has successfully completed a DC training program approved by the Board of Nursing, and who is certified to administer medication to residents. To maintain certification trained medication employees must complete a DC-approved clinical update or refresher course every 2 years.

**Community Residence Facilities.** Assisting with self-administration is considered to be an ADL. Trained medication employees may assist residents with the self-administration of medication and may administer medications.

## Food Service and Dietary Provisions

**Assisted Living Residences.** Facilities must provide three nutritious meals and additional snacks, modified to individual dietary needs as-necessary, on a daily basis; and a variety of fresh and seasonal foods, adapted to the food habits, preferences, and physical abilities of the residents.

**Community Residence Facilities.** Facilities must provide for the reasonable nutritional, emotional, religious, cultural, and therapeutic dietary requirements of its residents. They must serve, provide for, or arrange for on a daily basis, at least three meals that are nutritious and suited to residents' special needs.

Facilities that admit and retain residents who need special or therapeutic diets must provide for those diets to be planned, prepared, and served as prescribed by the attending physician. Facilities must consult regularly with a dietitian, who must have access to the resident's permanent record containing the physician's prescriptions for medications and special diet and must document in that record all observations, consultations, and instructions regarding the resident's acceptance and tolerance of prescribed diets.

The dietitian and the residence director, or a qualified person designated by the residence director, must review residents' therapeutic diets at least every 6 months.

## Staffing Requirements

### **Assisted Living Residence**

**Type of Staff.** An *assisted living administrator*--the licensee or person designated by the licensee--is responsible for the management of personnel and services within the facility. During periods of temporary absence of the assisted living administrator, when residents are on the premises, a staff member who is at least 18 years of age and meets the staffing standards of the assisted living administrator required in statute must assume the responsibilities of the administrator.

**Staff Ratios.** *No minimum ratios.* Sufficient staff must be employed and a staffing plan developed to ensure residents' safety and proper care based on their scheduled and unscheduled needs, the size and layout of the facility, and staff capabilities and training. A sufficient number of staff must be on the premises at all times to implement evacuation and emergency management plans and emergency procedures. At least

one staff member who is certified in first-aid and cardiopulmonary resuscitation must be in the facility at all times.

### **Community Residence Facility**

**Type of Staff.** A *residence director* must be responsible for the daily overall management of the facility. Each facility with more than 30 residents must provide the services of a *social worker* for a minimum of 8 hours per week; with more than 80 residents, 20 hours per week; with more than 100 residents, the facility must provide the services of a social worker on a full-time basis.

Each facility with 50 or more residents must employ a full-time *resident activities specialist* with current registration in the National Therapeutic Recreation Society as a therapeutic recreation specialist, or possess the qualifications necessary for that registration.

Each facility with 30 or more residents must, by written agreement, retain the services of a *licensed physician* who must advise on medical matters, review the community residence facility's program of residential health care, and handle medical emergencies if a resident's personal physician is unavailable.

**Staff Ratios.** *No minimum ratios.* A sufficient number of qualified employees and other adults must be present in each facility to provide for residents' welfare, comfort, and safety at all times of the day and night.

## **Training Requirements**

**Assisted Living Residences.** Within 7 days of employment, facilities must train new staff members on the following topics: specific duties and assignments; purpose and philosophy of the ALR; services provided; daily routines; residents' rights; emergency procedures and disaster drills and techniques of complying, including evacuating residents when applicable; elementary body mechanics, including proper lifting and in place transfer; choking precautions and methods to remove airway obstructions, including the Heimlich maneuver; and infection control.<sup>52</sup>

After the first year of employment, and at least annually thereafter, each staff member must complete 12 hours of in-service training annually on emergency procedures and disaster drills and residents' rights, and 4 hours training on cognitive impairment in an in-service training approved by a nationally recognized and creditable expert such as the Alzheimer's Disease and Related Disorder Association.

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<sup>52</sup> A regulatory requirement (in DC Statute) that staff receive 40 hours of training on specific topics has been superseded by a 2012 law requiring all staff in ALRs to be either a certified medication aide or a certified home health aide. We were unable to ascertain if the new law also applies to staff in community residence facilities.

**Community Residence Facilities.** Facilities with more than six unrelated occupants must have written personnel policies that include plans for the orientation of all employees. *No other training provisions identified.*

*Provisions for dementia training below.*

## Provisions for Apartments and Private Units

**Assisted Living Residences.** Apartment-style units are not required and shared units are allowed. Roommate choice is not required.

An ALR must have one full bathroom for every six residents, including live-in family or staff. Additional full or half-baths must be available to non-live-in staff. Residents must not be required to traverse more than one flight of stairs to access a bathroom, and appropriate accommodations must be made for residents who are unable to climb stairs.

Facilities serving more than 16 residents have specific requirements. They may offer living units that include a kitchenette, living room, and bathroom, and no more than two persons may share a bedroom. Units that do not include bathrooms must limit sharing of bathrooms to four residents. Shared bathrooms must be in close proximity and on the same floor as living units or bedrooms. Living units or bedrooms may be locked at the discretion of the residents, except when the resident's assessment documents indicate otherwise.

**Community Residence Facilities.** Roommate choice is not required. No more than four persons may share a bedroom. At least one sink, one toilet, and one bathing facility must be provided for the use of each six occupants of the facility. Each facility employing more than three full-time employees (including the residence director) must provide toilet and sink facilities separate from the rooms used by residents.

In each community residence facility with more than 30 residents, when residents have the use of common living or eating space on floors other than floors on which their bedrooms are located, additional toilets and sinks must be provided on those floors in the proportion of one toilet and sink for each 30 residents.

## Provisions for Serving Persons with Dementia

*No provisions identified for either type of facility.*

## Background Checks

Both ALRs and community residence facilities must conduct criminal background checks during the 45-day period preceding hiring or contracting with an unlicensed person. Facilities may not employ or use the contract services of unlicensed persons if they: (1) have been convicted of a criminal offense listed in the rules within 7 years prior to the criminal background check being conducted; or (2) if the person is listed in the DC Nurse Aide Abuse Registry.<sup>53</sup> Individuals subject to background checks must submit a sworn statement affirming that there are no criminal matters pending against them and denying the existence of any relevant convictions.

## Inspection and Monitoring

***Assisted Living Residences.*** Residences are inspected pre-licensure and re-inspected within 6 months of the effective date of the initial license. The licensing agency may also inspect a facility at its discretion to ensure compliance and to investigate complaints.

***Community Residence Facilities.*** Any authorized official of the applicable DC Department has the right to enter a facility with or without notice before licensure, at license renewal, and in response to complaints, to investigate and determine compliance with requirements.

## Public Financing

The Medicaid Elderly and Persons with Disabilities 1915(c) Waiver program covers assisted living services in ALRs. These services include any combination of 24-hour supervision and oversight; scheduled and unscheduled assistance with ADLs and IADLs; laundry and housekeeping services; medication administration; therapeutic social and recreational services; facilitating access to appropriate health and social services, including social work, home health agencies, nursing, rehabilitative, hospice, medical, dental, dietary, counseling, and psychiatric services; and coordinating scheduled transportation to community-based activities.

### ***Room and Board Policy***

In 2014, the DC provided an optional state supplement of \$585 for residents in facilities with 50 or fewer beds, and \$695 in facilities with more than 50 beds.<sup>54</sup>

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<sup>53</sup> New statutory requirements are not yet reflected in the online regulations. A link to the new requirements is at the end of the profile.

<sup>54</sup> Information regarding which facilities--ALRs, community residential facilities, or both--was not available.

In 2009, residents were allowed to retain a \$100 per month personal needs allowance (PNA), and the DC had no policy regarding family supplementation.<sup>55</sup>

## Location of Licensing, Certification, or Other Requirements

*District of Columbia Municipal Regulations*, Title 22, Chapter 31: Licensing of Health Care and Community Residence Facilities.

[http://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/Licensing\\_%20of\\_%20Health\\_%20Care\\_%20and\\_%20Community\\_%20Residence\\_%20Facilities.pdf](http://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/Licensing_%20of_%20Health_%20Care_%20and_%20Community_%20Residence_%20Facilities.pdf)

*District of Columbia Municipal Regulations*, Chapter 22-B34: Community Residential Facilities.

<http://www.dcregs.dc.gov/Gateway/ChapterHome.aspx?ChapterNumber=22-B34>

Department of Health website with link to *D.C. Statutes*, Section 44-101.01, Chapter 1: Assisted Living Residences Regulation.

<http://doh.dc.gov/node/187502>

*District of Columbia Municipal Regulations*, Title 22, Chapter 47: Health Care Facility Unlicensed Personnel Criminal Background Checks.

<http://doh.dc.gov/publication/unlicensed-health-care-facility-personnel-criminal-background-checks>

## Information Sources

The DC has revised many regulatory provisions and these revisions are not yet reflected in the information provided at the websites listed above, nor are they accessible by any search engine. The information in this profile is from the websites listed above, unless otherwise noted.

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<sup>55</sup> Mollica, R.L. (2009). *State Medicaid Reimbursement Policies and Practices in Assisted Living*, National Center for Assisted Living, American Health Care Association.  
<http://www.ahcancal.org/ncal/resources/Documents/MedicaidAssistedLivingReport.pdf>. Current information about Medicaid room and board policies, the PNA, and family supplementation policy, was not available online or from other sources.

## FLORIDA

### Licensure Terms

Assisted Living Facilities

### General Approach

The state views assisted living facilities (ALFs) as an important part of the continuum of its long-term care system, to be operated and regulated as residential environments with supportive services and not as medical or nursing facilities.

The Bureau of Health Facility Regulation licenses several types of ALFs, which can range in size from one resident to several hundred. Facilities are licensed to provide routine personal care services under a “standard” license or more specific services under the authority of “specialty” licenses. ALFs meeting the requirements for a standard license may also qualify for specialty licenses.

The purpose of specialty licenses is to allow individuals to “age in place” in familiar surroundings that can adequately and safely meet their continuing health care needs. Specialty licenses include limited nursing services (LNS), extended congregate care (ECC), and limited mental health (LMH) services. To obtain a specialty license, facilities must meet additional requirements, including those related to staffing and staff training.

*Adult Foster Care.* An adult family care home (AFCH) is a licensed, full-time, family-type living arrangement in a private home, under which individuals who own or rent a home provide room, board, and personal care on a 24-hour basis to no more than five disabled adults or frail elders who are not relatives. Each AFCH must designate at least one licensed space for a resident receiving an optional state supplement (OSS). AFCH operators must live in the home; if they do not, the home must be licensed as an ALF. If an AFCH provides room, board, and personal services for only 1-2 adults who do *not* receive an OSS, it does not have to be licensed. *Regulatory provisions for adult family homes are not included in this profile but a link to the provisions can found at the end.*

*Unless noted as a provision for one of the specialty licenses, this profile includes summaries of selected regulatory provisions for ALFs with a standard license. The complete regulations are online at the links provided at the end.*

## Definitions

**Assisted living facility** means any building or buildings, section or distinct part of a building, private home, boarding home, home for the aged, or other residential facility, which undertakes through its ownership or management to provide housing, meals, and one or more personal services (e.g., assistance with activities of daily living (ADLs) and self-administered medication) for a period exceeding 24 hours to one or more adults who are not relatives of the owner or administrator. An ALF can have a standard license or a specialty license as defined below.

**Standard** means a facility licensed to provide housing, meals, and one or more personal care services for a period exceeding 24 hours. Personal care services include direct physical assistance with or supervision of a resident's ADLs and the self-administration of medication and similar services. The facility may employ or contract with licensed persons to administer medication and perform other nursing tasks, such as taking vital signs, managing individual weekly pill organizers for residents who self-administer medication, giving pre-packaged enemas ordered by the physician, and observing residents.

**Limited nursing services** means a facility licensed to provide any of the services under a standard license and additional LMH specified in rules, which include: conducting passive range of motion exercises; applying ice caps or collars and heat; cutting toenails of diabetic residents or residents with a documented circulatory problem, if approved in writing by the resident's health care provider; performing ear and eye irrigations; conducting a urine dipstick test; replacing established self-maintained in-dwelling catheter or performing intermittent urinary catheterizations; applying and changing routine dressings that do not require packing or irrigation; caring for Stage II pressure sores; conducting nursing assessments if conducted by, or under the direct supervision of, a registered nurse (RN); and providing any nursing service permitted within the scope of the nurse's license, including 24-hour supervision, for hospice patients.

**Extended congregate care** means a facility licensed to provide any of the services under a standard license and LNS license, including any nursing service permitted within the scope of the nurse's license consistent with ALF residency requirements and the facility's written policy and procedures. A facility with this type of license enables residents to age in place in a residential environment despite mental or physical limitations that might otherwise disqualify them from residency under a standard or LNS license. This definition creates a higher level of care in assisted living.

**Limited Mental Health.** A facility licensed to provide any of the services under a standard license must obtain an LMH license to serve three or more residents who receive Social Security Disability Insurance or Supplemental Security Income (SSI) benefits due to a mental disorder, and who also receive a state SSI supplement--called the OSS. The facility must meet additional requirements, including the development of a community living support plan with the mental health resident and a case manager,

which specifies the resident's needs that must be met to enable the resident to live in an ALF and the community.

## **Resident Agreements**

The resident contract must contain a list of specific services, supplies, and accommodations to be provided--including those provided under any specialty license; the daily, weekly or monthly rate and the notice policy for rate increases; additional services available and their cost; residents' rights, duties and obligations; refund policies and procedures; the bed hold policy; a statement of the organization's religious affiliation and related requirements, if any; and discharge policies and procedures.

## **Disclosure Provisions**

A facility that advertises that it provides special care for persons who have Alzheimer's disease or other dementias must disclose in its advertisements or in a separate document those services that distinguish the care as being especially applicable to, or suitable for, such persons. The facility must give a copy of all such advertisements or a copy of the document to each person who requests information about programs and services for persons with Alzheimer's disease or other dementias offered by the facility and must maintain a copy of all such advertisements and documents in its records. The licensing agency examines all such advertisements and documents in the facility's records as part of the license renewal procedure.

## **Admission and Retention Policy**

Facilities must determine the appropriateness of admission and retention based on the ability of the facility to meet an individual's needs and preferences.

To be admitted and retained, an individual must be capable of performing ADLs, including transfers, with supervision or assistance; not require 24-hour nursing supervision; be free of Stage II, III, or IV pressure sores; be able to participate in social and leisure activities; be ambulatory; and not display violent behavior or be a danger to self or others.

Terminally ill residents may continue to reside in any ALF if the arrangement is mutually agreeable to the resident and the facility, additional care is rendered through a licensed hospice, and the resident is under the care of a physician who agrees that the resident's physical needs are being met.

In standard and LNS facilities, people who are bedridden more than 7 days or develop a need for 24-hour nursing supervision may not be retained. Residents with Stage II pressure sores may remain if the facility has a limited nursing license or

resident contracts with a home health agency or RN. Residents in ECC facilities may not be retained if they are bedridden for more than 14 days.

ECC facilities must promote aging in place by determining the appropriateness of continued residency based on a comprehensive review of the resident's physical and functional status; the ability of the facility, family members, friends, or any other pertinent individuals or agencies to provide the care and services required; and documentation that a written service plan consistent with facility policy has been developed and implemented to ensure that the resident's needs and preferences are addressed.

## Services

Facilities provide different services depending on their licensure types. Standard facilities provide personal care services and assistance with self-administration of medications.

Facilities with an LNS license can provide additional nursing services specified in regulations, such as applying and changing routine dressings that do not require packing or irrigation, but are for abrasions, skin tears, and closed surgical wounds; caring for Stage II pressure sores; catheter, colostomy, and ileostomy care and maintenance; caring for casts, braces, and splints; conducting nursing assessments if conducted by an RN or under the direct supervision of an RN; and providing any nursing service permitted under the facility's license and total help with ADLs for residents admitted to hospice.

Facilities with an ECC license can provide more extensive ADL assistance and additional nursing services if required by the resident's service plan: total help with bathing, dressing, grooming and toileting; nursing assessments conducted more frequently than monthly; measurement and recording of basic vital functions and weight; dietary management, including provision of special diets, monitoring nutrition, and observing the resident's food and fluid intake and output; assistance with self-administered medications; or the administration of medications and treatments pursuant to a health care provider's order.

ECC facilities may not provide oral or nasopharyngeal suctioning, assistance with nasogastric tube feeding, monitoring of blood gasses, intermittent positive pressure breathing therapy, skilled rehabilitative services; or treatment of surgical incisions, unless the surgical incision and the condition which caused it have been stabilized and a plan of care developed.

## ***Service Planning***

Within 60 days prior to admission, but no later than 30 days after admission, residents must be examined by a physician or advanced RN practitioner who must provide the administrator with a medical examination report.

Licensed nurses who are employed by or under contract with a facility must, on a routine basis or at least monthly, perform a nursing assessment of the residents for whom they are providing nursing services ordered by a physician (except administration of medication), and must document such assessment, including any substantial changes in a resident's status which may necessitate relocation to a nursing home, hospital, or specialized health care facility.

ECC facilities are allowed to use managed risk agreements, which are defined as "the process by which the facility staff discuss the service plan and the needs of the resident with the resident and, if applicable, the resident's representative or designee or the resident's surrogate, guardian, or attorney-in-fact, in such a way that the consequences of a decision, including any inherent risk, are explained to all parties and reviewed periodically in conjunction with the service plan, taking into account changes in the resident's status and the ability of the facility to respond accordingly."

"Shared responsibility" means exploring the options available to a resident within a facility and the risks involved with each option when making decisions pertaining to the resident's abilities, preferences, and service needs, thereby enabling the resident and, if applicable, the resident's representative or designee, or the resident's surrogate, guardian, or attorney-in-fact, and the facility to develop a service plan which best meets the resident's needs and seeks to improve the resident's quality of life.

## ***Third-Party Providers***

Residents or their representative, designee, surrogate, guardian, or attorney-in-fact may arrange, contract, and pay for services provided by a third-party of the resident's choice, provided the resident meets the criteria for appropriate placement in the facility and complies with the facility's policy relating to the delivery of services in the facility by third parties. The facility's policies must require the third-party to coordinate with the facility regarding the resident's condition and the services being provided.

When residents require specified care or services from a third-party provider and when requested by residents or their representatives, the facility administrator or designee must assist in facilitating the provision of those services and coordinate with the provider to meet the specific service goals.

## Medication Provisions

Licensed nursing staff may administer medications. Unlicensed staff may assist with self-administration of routine, regularly scheduled medications that are intended to be self-administered by residents with a medically stable condition. Unlicensed persons may not assist with certain types of medication administration, described in detail in the regulations, including “as-needed” (PRN) medications and injections.

Assistance with self-administration is described in detail in the regulations and includes taking previously dispensed, properly labeled containers from where they are stored and bringing them to the resident; reading the label, opening the container, removing a prescribed amount of medication, and closing the container; placing an oral dosage in the resident’s hand or in another container and helping the resident lift the container to his or her mouth; applying topical medications; and keeping a record of when a resident receives assistance with self-administration.

Assistance with self-administration of medication by an unlicensed person is allowed only if: (1) he or she has met training requirements--4 hours upon hire and 2 hours of training annually; and (2) upon a documented request by, and the written informed consent of, a resident or the resident’s surrogate, guardian, or attorney-in-fact.

Informed consent means advising the resident, or the resident’s surrogate, guardian, or attorney-in-fact that an ALF is not required to have a licensed nurse on staff, that the resident may be receiving assistance with self-administration of medication from an unlicensed person, and that such assistance, if provided by an unlicensed person, will or will not be overseen by a licensed nurse.

## Food Service and Dietary Provisions

The facility must provide a variety of regular meals that meet the nutritional needs of residents, and therapeutic diets as ordered by the resident’s health care provider for residents who require special diets. Meals must be adapted to residents’ food habits, preferences, and physical abilities.

The meals must be planned based on the current U.S. Department of Agriculture Dietary Guidelines for Americans, 2010 and the current summary of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies. Therapeutic diets must meet these nutritional standards to the extent possible.

All regular and therapeutic menus must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional requirements. Daily food servings may be divided among three or more

meals per day, including snacks, as-necessary to accommodate resident needs and preferences.

## Staffing Requirements

**Type of Staff.** Every facility must be under the supervision of an *administrator* who is responsible for its operation and maintenance, including the management of all staff and the provision of adequate care to all residents. Facilities must employ *direct care staff*. A staff member who has completed courses in first-aid and cardiopulmonary resuscitation must be in the facility at all times.

LNS and ECC facilities must employ or contract with a *nurse*, who must be available to provide nursing services as-needed by residents. In addition, the ECC facility nurse must participate in the development of resident service plans and perform monthly nursing assessments. An ECC staff member must serve as the *ECC supervisor* who is responsible for the general supervision of the day-to-day management of an ECC program and ECC resident service planning, if the administrator does not perform this function.

**Staff Ratios.** In all ALFs, sufficient staff must be employed to ensure the safety and proper care of individual residents and to implement the evacuation and emergency management plan, and at least one employee certified in first-aid must be present at all times.

The rules contain minimum staff hours per week for different numbers of residents, for example: (1) up to five residents, 168 staff hours per week; (2) 6-15 residents, 212 hours; (3) 16-25 residents, 253 hours; and (4) 26-35 residents, 294 hours. For every 20 residents over 95, 42 staff hours must be added each week, which equates to about one full-time employee per 20 residents. Notwithstanding the minimum staffing requirements, facilities must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and all required resident care standards.

ECC facilities must have enough qualified staff to meet the needs of ECC residents and to provide the services established in each resident's service plan. Facilities must ensure that adequate staff are awake during all hours to meet residents scheduled and unscheduled needs. If the licensing agency determines that service plans are not being followed or that residents' needs are not being met because of insufficient staffing, facilities must immediately provide additional or appropriately qualified staff.

## Training Requirements

The ALF core training requirements established by the Department of Elder Affairs consists of a minimum of 26 hours of training plus a competency test. Administrators must complete the core training and competency test no later than 90 days after becoming employed as a facility administrator. Administrators must also receive 12 hours of continuing education every 2 years on topics related to assisted living.

Staff who provide direct care to residents--other than nurses, certified nursing assistants, or home health aides--must receive a minimum of 1 hour in-service training in infection control, including universal precautions, and facility sanitation procedures before providing personal care to residents; and must receive 3 hours of in-service training within 30 days of employment that covers resident behavior and needs and providing assistance with ADLs.

Staff who have not taken the core training program, and who provide direct care to residents, must receive within 30 days of employment a minimum of 1 hour in-service training that covers resident rights in an ALF and recognizing and reporting resident abuse, neglect, and exploitation; and a minimum of 1 hour in-service training that covers reporting major incidents, reporting adverse incidents, and facility emergency procedures, including chain-of-command and staff roles relating to emergency evacuation.

In addition to the core training, the administrator of an ECC facility and the ECC supervisor must complete 6 hours of initial training on the physical, psychological, or social needs of frail elders or persons with Alzheimer's disease and adults with disabilities, and 6 hours of continuing training every 2 years. In ECC facilities, direct care staff must complete at least 2 hours of in-service training within 6 months of beginning employment in the facility. The training must address ECC concepts and requirements, including statutory and rule requirements, and delivery of personal care and supportive services in an ECC facility.

The administrator, managers and staff who have direct contact with mental health residents in an LMH facility must receive a minimum of 6 hours of specialized training in working with individuals with mental health diagnoses within 6 months of the facility's receiving an LMH license or within 6 months of employment in an LMH facility, and a minimum of 3 hours of continuing education on mental health topics, including diagnoses, treatments, services, behaviors and appropriate interventions.

All facility staff must receive in-service training regarding the facility's resident elopement response policies and procedures within 30 days of employment.

## Provisions for Apartments and Private Units

Standard and LNS facilities do not have to provide apartment-style units or private rooms. Facilities licensed prior to October 1999 may provide rooms shared by four people; one toilet and sink must be provided for every six residents and bathing facilities for every eight residents. Facilities licensed after October 1999 may provide rooms shared by a maximum of two persons and must have bathrooms shared by no more than four residents.

ECC facilities must provide a private room or apartment, or a semi-private room or apartment, shared with a roommate of the resident's choice. Bathrooms with a toilet, sink, and bathtub or shower can only be shared by a maximum of four residents.

*Medicaid Requirements.* Apartment-style units are not required for ALFs that provide assistive care services through the Medicaid State Plan program. Facilities participating in the Managed Long-Term Care (MLTC) Waiver program must offer a private room or apartment or a unit that is shared only with the approval of the waiver participant.

## Provisions for Serving Persons with Dementia

***Dementia Care Staff.*** A facility that advertises that it provides special care for persons with dementia must meet the following staffing requirements: (1) it must have 24-hour staffing capability; (2) if the facility has 17 or more residents, it must have an awake staff member on duty at all hours of the day and night; or (3) if the facility has fewer than 17 residents, it must have an awake staff member on duty at all hours of the day and night, or have mechanisms in place to monitor and ensure residents' safety.

***Dementia Staff Training.*** Facilities that advertise that they provide special care for persons with dementia or who maintain secured areas are required to ensure that staff who have regular contact with or provide direct care to residents with dementia have specialized training.

In addition to core training requirements, staff in special care units must receive 4 hours of initial training covering the characteristics of Alzheimer's disease, communicating with residents who have dementia, family issues, the residents' environment, and ethical issues. Direct caregivers must obtain an additional 4 hours training within 9 months of employment covering behavior management, assistance with ADLs, activities for residents, stress management for the caregiver, and medical information.

Direct care staff must receive 4 hours of continuing education each year that includes one or more topics covered in the dementia-specific training developed or approved by the Department, in which the caregiver has not received previous training.

Employees of facilities that provide special care for residents with dementia but who have only incidental contact with such residents, must be given, at a minimum, general information on interacting with individuals with dementia within 3 months after beginning employment.

The Department, or its designee, must approve the initial and continuing education courses and providers. Any facility with more than 90 percent of its residents receiving monthly optional supplementation payments is not required to pay for the training and education programs. A facility that has one or more such residents may pay a reduced fee that is proportional to the percentage of such residents in the facility. A facility that does not have any residents who receive monthly optional supplementation payments must pay a reasonable fee, as established by the Department, for such training and education programs.

***Dementia Facility Requirements.*** Facilities must offer activities specifically designed for persons who are cognitively impaired and have a physical environment that provides for the safety and welfare of the facility's residents.

## **Background Checks**

Florida law has extensive criminal background screening provisions for ALFs. All ALF owners (if individuals), administrators, financial officers, and employees must have a criminal history record check obtained through a fingerprint search through the Florida Department of Law Enforcement and the Federal Bureau of Investigation, to determine whether screened individuals have any disqualifying offenses. An analysis and review of court dispositions and arrest reports may be required to make a final determination. The cost of the state and national criminal history records checks are born by the licensee or the person being fingerprinted. All individuals who are required to have an initial background screen, must be re-screened every five years.

## **Inspection and Monitoring**

Facilities are inspected prior to licensure and at any time deemed necessary by the licensing agency to determine compliance with requirements. Inspections that are conducted for reasons other than initial licensure must be unannounced. Inspections for re-licensure must be conducted every 2 years, unless otherwise specified by authorizing statutes or applicable rules.

An RN or appropriate designee representing the licensing agency must visit ECC facilities quarterly to monitor residents and to determine facility compliance. An RN representing the agency must also visit LNS facilities twice a year to monitor residents who are receiving LNS and to determine facility compliance.

## **Public Financing**

Florida covers services in ALFs with a standard license and with a specialty license under a statewide 1915(b)(c) MLTC program. This program replaced two 1915(c) Waiver programs--Assisted Living for the Elderly and Nursing Home Diversion. Only facilities with a standard license and private or semi-private rooms and bathrooms are allowed to participate in the MLTC program. Waiver participants must be offered a private room or apartment or a unit that is shared only with their approval.

The state also covers services in ALFs and licensed adult family homes under a Medicaid State Plan program--called Assistive Care Services--that includes health support, assistance with ADLs and instrumental activities of daily living, and assistance with self-administration of medication.

Facilities may serve residents eligible for either program--MLTC and Assistive Care Services--or both. Residents eligible for both must have a service plan which separately identifies the services that will be provided under each program.

### ***Room and Board Policy***

Medicaid does not cap the room and board rate. For waiver participants, room and board and service rates are negotiated by the provider and the MLTC plan.

To help pay for room and board, the state provides an OSS to residents in ALFs and AFCHs who are receiving the federal SSI benefit or who are determined by the Department of Children and Family Services to be eligible for the supplement.

The Department establishes the base rate of the OSS payment, which was \$78.40 in 2014. Additional amounts may be provided for mental health residents in facilities designed to provide LMH services. The base rate of payment does not include the personal needs allowance of \$54, which is retained by the resident.

### ***Family Supplementation***

Supplementation by families or other third parties is permitted to contribute to the cost of care. This supplementation may be provided under the following conditions:

- Payments are made to the ALF or to the operator of an AFCH on behalf of the person and not directly to the OSS recipient.
- Contributions made by third parties are entirely voluntary and must not be a condition of providing proper care to the resident.
- The additional supplementation must not exceed two times the provider rate recognized under the OSS program.

The state does not count supplementation in accordance with these provisions as income to the resident for purposes of determining eligibility for, or computing the amount of, OSS benefits. The state does not increase an OSS payment to offset the reduction in SSI benefits that will occur because of the third-party contribution.

## Location of Licensing, Certification, or Other Requirements

Agency for Health Care Administration. Assisted Living Facility. *The following website contains links to all applicable statutes, regulations, and other information about assisted living facilities.*  
[http://www.ahca.myflorida.com/MCHQ/Health\\_Facility\\_Regulation/Assisted\\_Living/alf.shtml](http://www.ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Assisted_Living/alf.shtml)

Agency for Health Care Administration. Adult Family Care Home. *The following website contains links to all applicable statutes and regulations about adult family care homes.*  
[http://www.ahca.myflorida.com/MCHQ/Health\\_Facility\\_Regulation/Assisted\\_Living/afc.shtml](http://www.ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Assisted_Living/afc.shtml)

## Information Sources

Lee Ann Griffin  
Director  
Quality and Regulatory Services  
Florida Health Care Association

Keith Young  
Government Analyst  
Federal Authorities Section  
Bureau of Medicaid Services  
Agency for Health Care Administration

## GEORGIA

### Licensure Terms

Assisted Living Community, Personal Care Homes

### General Approach

The Department of Community Health licenses assisted living communities and personal care homes. Requirements for these two settings differ with regard to admission thresholds, required services, medication management, and physical plant requirements. Facilities that provide “memory care” services must meet additional requirements.

*Adult foster care* providers that serve two or more adults are licensed as a type of personal care home.

*This profile includes summaries of selected assisted living and personal care home regulatory provisions. Unless otherwise indicated, the provisions apply to both settings. The complete regulations can be viewed online using the links provided at the end.*

### Definitions

**Assisted living community** means a personal care home that serves 25 or more persons and is licensed to provide “assisted living care,” defined as the provision of personal services, the administration of medications by a certified medication aide, and the provision of assisted self-preservation. Assisted self-preservation defines the capacity of a resident to be evacuated to a designated point of safety within an established period of time, as determined by the Office of the Fire Safety Commissioner.

**Personal care home** means a setting that provides or arranges for the provision of housing, food service, and one or more personal services for two or more adults who are not related to the owner or administrator. Personal services include individual assistance with or supervision of self-administered medication, and assistance with essential activities of daily living (ADLs), such as eating, bathing, grooming, dressing, toileting, ambulation, and transfer.

**Memory care unit** means the specialized unit of an assisted living community or personal care home that either presents itself as providing memory care services or provides personal services in secured surroundings to persons with diagnoses of

probable Alzheimer's disease or other dementia. Memory care services means the additional watchful oversight systems, program, activities, and devices that are required for residents who have cognitive deficits that may impact memory, language, thinking, reasoning, or impulse control, and which place the residents at risk of eloping (i.e., engaging in unsafe wandering activities outside the home).

## Resident Agreements

In both settings, the residency agreement must provide information about services and fees; policies for changes in services or fees; assessment provisions; complaints; transportation services and fees; refund policies; house rules; medication management provisions, including staff responsibility for refilling prescriptions; and requirements for the use of proxy caregivers (i.e., an unlicensed staff person; see *Staffing section below*).

The agreement must be written to be understandable to the resident and his/her representative or legal guardian.

## Disclosure Provisions

In both settings, marketing materials must disclose the facility's licensure classification; and the facility must disclose whether or not proxy caregivers are permitted to perform certain health maintenance activities that the facility is not required to provide. A personal care home which is not licensed as an assisted living community must not use the term "assisted living" in its name or marketing materials.

Facilities with memory care units must disclose information about the following: building design and safety features; staffing and staff training; and specific admission requirements, post-admission assessments, individual service plans, and therapeutic activities.

## Admission and Retention Policy

**Assisted living community** administrators must assess prospective residents prior to move-in to determine if they are capable of transferring with minimal assistance and able to participate in the facility's social activities. Individuals may not be admitted if a physical examination--which must be conducted by a licensed physician, nurse practitioner, or physician's assistant within the 30-day period prior to admission--determines that an individual requires continuous medical or nursing care and services or has active tuberculosis. If an emergency placement is made at the request of the Adult Protective Services Section of the Division of Aging Services or another licensed facility, the facility may defer the physical examination for up to 14 days.

**Personal care home** residents must be ambulatory and must not have a behavioral condition that requires the use of physical or chemical restraints, isolation, or confinement. Residents must not be bedridden or require continuous medical or nursing care and treatment. No home is permitted to admit or retain a resident who needs care beyond which the home is permitted to provide.

Residents of memory care units in both settings must have a physician's report of a physical examination completed within 30 days prior to admission to the assisted living community or personal care home, on forms made available by the Department. The physical examination must clearly reflect that the resident has a diagnosis of probable Alzheimer's disease or other dementia, and has symptoms that demonstrate a need for placement in the specialized unit. However, the unit may also care for a resident who does not have a probable diagnosis of Alzheimer's disease or other dementia, but desires to live in this unit and waives his or her right to live in a less restrictive environment. In addition, the physical examination report must establish that the potential resident of the unit does not require 24-hour skilled nursing care.

## Services

**Assisted living communities** must provide assisted living care, described as personal services, the administration of medications by a certified medication aide, and the provision of assisted self-preservation.

**Personal care homes** must provide personal services and social activities, and assist with or supervise self-administration of medications.

**Memory care units** in both settings must provide activities appropriate to the needs of the individual residents and adapt the activities, as-necessary, to encourage resident participation in the following at least weekly, with at least some therapeutic activities occurring daily:

- Gross motor activities, such as exercise, dancing, gardening, cooking.
- Self-care activities, such as dressing, personal hygiene, grooming.
- Social activities, such as games, music.
- Sensory enhancement activities, such as distinguishing pictures and picture books, reminiscing, and scent and tactile stimulation.

## Service Planning

Both settings require an assessment to determine the resident's functional capacity with regard to ADLs, physical care needs, medical needs, cognitive and behavioral impairments, personal preferences relative to care needs, and whether

family supports are available. A written care plan must document the assessment findings and be updated at least annually and when there is a change in the resident's needs.

Memory care units must review care plans quarterly and modify them as changes in the residents' needs occur. The residents' written care plan will be developed or updated by a staff team that includes at least one member of the specialized memory care staff providing direct care.

### ***Third-Party Providers***

Residents of licensed facilities may directly hire a "proxy caregiver" to assist with or administer medications and provide personal care.

Assisted living community staff may not provide medical and nursing health services (other than care plans, staff training, and medication administration) that are required on a periodic or short-term basis. When such services are required, residents must purchase them from licensed providers that are neither owned nor operated by the facility.

## **Medication Provisions**

***Assisted living community*** residents who have the cognitive and functional capacity to self-administer medications must be allowed to store and self-administer their own medications. Communities must assist residents with self-administration if requested. Specific tasks for assisting residents with self-administration include storage of medications, placing an oral dosage in the resident's hand, applying topical medications, and assisting with an Epi pen. Unlicensed staff may provide this assistance only if unit dose or multi-dose packaged medications are used.

If the facility provides medication administration, certified medication aides must be employed. Certified medication aides may administer medications using only unit dose or multi-dose packaging, and perform the following tasks:

- Administer physician-ordered medications.
- Administer insulin, epinephrine, and B-12 according to physicians' orders and protocols.
- Administer medications via a metered dose inhaler.
- Conduct finger stick blood glucose testing following an established protocol.
- Administer a commercially prepared disposable enema ordered by a physician.

A licensed pharmacist must conduct quarterly drug regimen reviews, which include the following duties: (1) report any irregularities to the assisted living community administration; (2) remove for proper disposal any drugs that are expired, discontinued, or in a deteriorated condition; (3) establish or review policies and procedures for safe and effective drug therapy, distribution, use, and control; and (4) monitor compliance with established policies and procedures for medication handling and storage.

Personal care homes have the same provisions regarding self-administration and assistance with self-administration of medications described above. However, personal care homes may not administer medications, nor do they require pharmacist review.

Medications for residents living in a memory care unit must be provided by either or both of the following: (1) a licensed registered nurse (RN) or a licensed practical nurse who is working under the supervision of a licensed physician or RN; and (2) a proxy caregiver employed by the facility in compliance with the rules and regulations for proxy caregivers.

## Food Service and Dietary Provisions

At least three meals, one nutritious snack, and any therapeutic diets ordered by a resident's health care provider must be provided each day.

## Staffing Requirements

**Type of Staff.** Each facility must have a full-time *administrator* who is responsible for daily operations and may designate a *house manager* to be responsible when the administrator is absent. *Direct care staff* provide assistance with personal services, but not health maintenance activities. *Certified medication aides* may administer medications in assisted living communities only.

*Proxy caregivers* are defined as unlicensed persons who have been determined to possess the necessary knowledge and skills, acquired through training by a licensed health care professional, to perform health maintenance activities. They may not administer medications but may assist residents with self-administration of medications. Residents or their representatives must provide written informed consent before using a proxy caregiver. The facility must disclose whether or not proxy caregivers are permitted to perform certain health maintenance activities that the facility is not required to provide.

**Staff Ratios.** Facilities must staff according to residents' needs. At least one administrator, on-site manager, or responsible staff person must be on the premises 24 hours a day. The minimum on-site, staff-to-resident ratio is 1:15 during waking hours and 1:25 during non-waking hours. Facilities must exceed these minimum ratios, if needed, in order to meet residents' specific ongoing health, safety, and care needs.

## Training Requirements

All staff must have training within the first 60 days of employment on the following topics:

- Residents' rights and identification of conduct constituting abuse, neglect, or exploitation of a resident, and reporting requirements.
- General infection control principles, including the importance of hand hygiene in all settings, and attendance policies when ill.
- Training necessary to carry out assigned job duties and emergency preparedness.

In addition to the above, direct care staff must receive training within the first 60 days of employment on the following topics:

- Medical and social needs and characteristics of the resident population, including the special needs of residents with dementia.
- Residents' rights and the provision of resident care that is individualized and helpful.
- Training specific to assigned job duties, such as, but not limited to, assistance with medications, assisting residents in transferring and ambulation, and proper food preparation.

They must also receive training and be certified to provide emergency first-aid and cardiopulmonary resuscitation.

Direct care staff who work as proxy caregivers must have training in health maintenance activities.

All assisted living community staff offering hands-on personal services to the residents, including the administrator or on-site manager, must complete 24 hours of continuing education during the first year and 16 hours annually thereafter. All personal care home directors and employees involved with the provision of personal services to the residents must have at least 16 hours of training per year.

## Provisions for Apartments and Private Units

***Assisted Living Communities.*** Apartment-style units are not required. Living units may be single-occupancy or double-occupancy. At least one toilet and sink must

be provided for each four residents, and at least one bathing/showering room for each eight residents, based on the facility's licensed capacity. Communities that serve persons dependent on a wheelchair or walker must have fully accessible bathrooms for their use.

***Personal Care Homes.*** Apartment-style units are not required. Living units may be single-occupancy or have up to four residents. If a resident chooses in writing to share a private bedroom or living space with another resident of the home, then the residents must be permitted to share the room, subject to the usable square feet requirement and the limitation that no more than four residents may share any bedroom or private living space.

At least one toilet and sink must be provided for each four residents, and at least one bathing/showering room for each eight residents. At least one toilet and sink must be provided on each floor having residents' bedrooms.

## Provisions for Serving Persons with Dementia

***Dementia Care Staff.*** The unit must have a sufficient number of specially trained staff to meet residents' unique needs, including, at a minimum, certified medication aides to administer certain medications. At least one staff member must be awake and supervising the unit at all times, and sufficient numbers of trained staff must be on-duty at all times.

***Dementia Staff Training.*** In addition to general training requirements, staff in Memory Care Units must be trained in the philosophy of care for residents with dementia and facility-specific policies and procedures. Required training topics include:

- Alzheimer's disease and other dementias, including the definition of dementia, and dementia-specific care needs.
- Common behavior problems and recommended behavior management techniques.
- Communication skills for resident-staff relations.
- Positive therapeutic interventions and activities such as exercise, sensory stimulation, and ADL skills.
- The role of the family and family needs.
- Environmental modifications that can avoid problematic behavior and create a more therapeutic environment.
- Individualized service planning.

- New developments in dementia care that impact the approach to caring for residents in the special unit.
- Skills for recognizing residents' physical or cognitive changes that warrant seeking medical attention.
- Skills for maintaining the safety of residents with dementia.

***Dementia Facility Requirements.*** Memory care units must be designed to accommodate residents with severe dementia or Alzheimer's disease in a home-like environment that includes the following:

- A multipurpose room(s) for dining, group and individual activities.
- Secured outdoor spaces and walkways that are wheelchair accessible and allow residents to ambulate safely and prevent undetected egress.
- Appropriate floor and wall surfaces with the exception of fire exits, door, and access ways, which may be designed to minimize contrast to conceal areas where the residents should not enter.
- Lighting that minimizes glare and shadows.
- The opportunity for the resident's free movement between the common space and the resident's room.
- Individually identified entrances to residents' rooms to assist them in identifying their own personal spaces.
- An automated device or system to alert staff to individuals entering or leaving the unit in an unauthorized manner.
- A communication system(s) that permits staff to communicate with staff outside the unit and with emergency services personnel as needed.

## **Background Checks**

Criminal history background checks, including a satisfactory fingerprint records check, are required for owners, administrators, managers, and all staff. Any owner or employee who acquires a criminal record must report it to the Department and undergo another fingerprint records check.

## Inspection and Monitoring

An on-site inspection is required before an initial license is approved. Facilities must be available for review and examination by properly identified representatives of the Department. Inspections may be conducted both on an announced and unannounced basis.

## Public Financing

The state has two Elderly and Disabled 1915(c) Medicaid Waiver programs that pay for services (referred to as alternative living services) in personal care homes with up to 24 beds: (1) the Community Care Services Program is managed by the Department of Community Health's Division of Medical Assistance Plans and partners with the Division of Aging Services; and (2) the Service Options Using Resources in a Community Environment (SOURCE) program, an enhanced primary care case management program that serves frail elderly and disabled beneficiaries. The SOURCE program works to improve the health outcomes of persons with chronic health conditions, by linking primary medical care with home and community-based services through case management agencies.

In addition, the Independent Care Waiver Program is a 1915(c) Waiver program managed by the Department of Community Health that provides alternative living services primarily for adults ages 21-64 who reside in small personal care homes for 2-6 people.

### ***Room and Board Policy***

The state does not provide a supplement to the federal Supplemental Security Income (SSI) benefit for individuals in residential care settings. In 2015, room and board rates are capped at the federal monthly SSI benefit rate of \$733 less a personal needs allowance of \$114. Family supplementation is permitted.

## Location of Licensing, Certification, or Other Requirements

Georgia Department of Community Health website: Official Rules and Regulations for the State of Georgia, including Assisted Living Communities and Personal Care Homes.

<https://dch.georgia.gov/hfr-laws-regulations>

Georgia Department of Community Health website: Waivers, with links to the various waiver programs that provide alternative living services. [January 24, 2014]

<https://dch.georgia.gov/waivers>

## Information Sources

Brian Dowd  
Program Director  
Waiver Programs  
Division of Medicaid/Aging and Special Populations  
Georgia Department of Community Health

Jon Howell  
Georgia Health Care Association

Darcy J. Watson  
Georgia Health Care Association

## HAWAII

### Licensure Terms

Assisted Living Facilities, Adult Residential Care Homes

### General Approach

The Department of Health, Office of Health Care Assurance, licenses two residential care settings: assisted living facilities (ALFs) and adult residential care homes (ARCHs). Type I ARCHs are licensed for five or fewer residents and Type II for six or more residents. In addition, the state has provisions for licensure of expanded adult residential care homes (E-ARCHs) that provide professional health services similar to those provided by nursing facilities.

*Adult Foster Care.* The Department certifies private homes as community care foster family homes (CCFFHs) to serve one to three adults who have been certified by a physician to need care in a nursing facility. Both Medicaid-eligible and private pay clients entering a CCFFH must have a case management agency licensed by the Department of Human Services to coordinate health care requirements. If a CCFFH is certified for 2-3 persons, the home is allowed to have one private pay resident in addition to Medicaid waiver participants. *This profile does not include the regulatory provisions for Type I ARCHs or for CCFFHs, but a link to the provisions can found at the end.*

*This profile includes summaries of selected regulatory provisions for ALFs and for Type II ARCHs. The complete regulations are online at the links provided at the end.*

### Definitions

**Assisted living facility** means a community setting that provides 24-hour access to services based on the individual needs of each resident. The facility must be designed to maximize the independence and self-esteem of limited-mobility persons who may no longer be capable of independent living.

**Adult residential care home** means a facility providing 24-hour living accommodations to adults, unrelated to the provider, who require at least minimal assistance in activities of daily living (ADLs). E-ARCH are licensed to serve a limited number of residents who need an intermediate level of nursing facility care.

## Resident Agreements

**Assisted Living Facilities.** A residents' agreement is required prior to and upon move-in. It must describe the services to be provided and their cost, and the conditions under which additional services may be provided and fees charged. The facility must describe services that it does not provide but will assist with arranging or coordinating.

**Adult residential care homes** must have a written agreement that explains the resident's rights, the provider's responsibilities, and services to be provided based on the resident's care plan.

## Disclosure Provisions

*No provision identified.*

## Admission and Retention Policy

**Assisted living facilities** must develop discharge policies and procedures that include a written 14-day notice when: (1) a resident's behavior poses an imminent danger to self or others; (2) a resident's needs exceed what the facility is able to meet with available support services; or (3) a resident has an established pattern of not abiding by agreements necessary for assisted living. Each facility may use its professional judgment and take into account the capacity and expertise of its staff in determining who may be served.

**Adult residential care homes** are for individuals who need assistance with personal care below an intermediate level of nursing facility care. Homes must develop admission and discharge policies and procedures. E-ARCHs may admit individuals who meet nursing facility level of care criteria as determined and certified by a physician or an advanced practice registered nurse (RN). No more than 20 percent of residents in Type II E-ARCHs may need a nursing facility level of care, though exceptions are possible.

## Services

**Assisted living facilities** must provide laundry and housekeeping services; opportunities for individual and group socialization; assistance with ADLs; nursing assessment, health monitoring, and routine nursing tasks; medication administration; services for residents with behavior problems (staff support, intervention, and supervision); and recreational and social activities. Facilities must also arrange or provide transportation, ancillary services for medically-related care (physician, therapy, pharmacist, and podiatry), and hospice care.

**Adult residential care homes** provide personal care services, medication services, assistance with self-administration of medications, laundry and housekeeping, transportation to health care appointments, supervision, and social activities. E-ARCHs provide additional health-related services needed by residents who meet nursing facility level of care criteria; the facility must make arrangements for such residents to visit a medical doctor every 4 months for a medical evaluation.

### **Service Planning**

**Assisted living facilities** must conduct a comprehensive assessment of each resident's needs, plan and implement responsive services, and periodically update the service plan. The service plan should be developed with the resident's involvement and should support dignity, privacy, choice, individuality, and independence. Managed risk is described as the process of negotiating and developing a plan to address residents' needs, decisions, or preferences to reduce the probability of a poor outcome for the resident or others at risk for adverse consequences based on the residents' actions.

**Adult residential care homes** must conduct a comprehensive assessment of each resident's needs and develop a schedule of activities that describes the services to be provided. For E-ARCHs, a care plan is developed by the resident's case management agency and--at a minimum--monthly visits are required to assess and evaluate residents' care and services.

### **Third-Party Providers**

**Assisted living facilities** may arrange access to ancillary services for medically-related care (e.g., physician, podiatrist) and social work services.

**Adult Residential Care Homes.** Residents who require therapeutic services prescribed by a physician may receive these services provided by an outside agency at the facility.

## **Medication Provisions**

**Assisted living facilities** may provide assistance with self-administration of medications and unlicensed assistive personnel may provide this assistance as delegated by an RN under state administrative rules and the state's Nursing Model Act. Residents who self-administer may keep medications in their unit. Medications in units shared by two residents must be kept in a locked container in the unit. An RN or physician must review all residents' medications at least every 90 days.

**Adult residential care homes** may make medications available<sup>56</sup> unless the resident is capable of and prefers to self-administer. E-ARCHs require licensed nurses

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<sup>56</sup> The term "may make medications available" is not defined.

to administer medications by injection unless the resident is capable of self-administration. In addition, this task may be delegated to unlicensed assistive personnel according to state administrative rules and the state's Nursing Model Act.

## Food Service and Dietary Provisions

**Assisted living facilities** provide three meals a day, modified diets,<sup>57</sup> and snacks, which are evaluated and approved by a dietitian on a semi-annual basis and are appropriate to the residents' needs and choices.

**Adult residential care homes** provide three meals a day, snacks, and may offer meals recommended or prescribed by a physician.

## Staffing Requirements

### Assisted Living Facility

**Type of Staff.** Facilities must employ *direct care staff* and an *administrator* who is accountable for providing training for all facility staff in the provision of services and principles of assisted living. All staff must be qualified in cardiopulmonary resuscitation and first-aid.

Facilities must make arrangements for a *registered nurse* to conduct resident assessments and to train and supervise staff.

**Staff Ratios.** *No minimum ratios.* Licensed nursing staff must be available 7 days a week to meet residents' care management and monitoring needs, and sufficient direct care staff must be available 24 hours daily to meet residents' needs.

### Residential Care

**Type of Staff.** An *administrator* of a Type II ARCH manages and oversees all staff and residents. Facilities must make arrangements for an *registered nurse* to conduct resident assessments. E-ARCHs must have an RN or case manager available to train and supervise caregivers. A case manager is a person who is licensed by the state as an RN or social worker. Other staff include *nurse aides* and *direct care staff* who assist residents with personal care needs and some nursing tasks.

**Staff Ratios.** *No minimum ratios.* Sufficient staff must be on-duty 24 hours a day to meet residents' needs. At least one nurse aide must be on each shift.

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<sup>57</sup> Modified diets include low-fat, low-sodium, and diabetic diets, any special diet ordered by a physician.

## Training Requirements

**Assisted Living Facilities.** All facility staff must complete an orientation to acquaint them with the philosophy, organization, practice, and goals of assisted living; and a minimum of 6 hours annually of regularly scheduled in-service training.

**Adult Residential Care Homes.** For E-ARCHs, an RN must train and monitor primary caregivers. All Type II ARCH staff must have 6 hours of annual training on specified topics, including personal care; infection control; pharmacology; medical and behavioral management of residents; diseases and chronic illnesses; and community services and resources.

## Provisions for Apartments and Private Units

**Assisted living facilities** must provide apartment units with a bathroom (sink, shower, and toilet), refrigerator, and cooking capacity; and a call system monitored 24 hours per day by staff. The cooking appliances may be removed or disconnected depending on residents' needs.

**Adult residential care homes** may have up to four residents sharing a room. One toilet is required for every eight residents, one sink for every ten residents, and one shower for every 14 residents.

## Provisions for Serving Persons with Dementia

*No provisions identified.*

## Background Checks

**Assisted Living Facilities.** Licensure may be denied for convictions in a court of law or substantiated findings of abuse, neglect, or misappropriation of resident funds or property.

**Adult Residential Care Homes.** All staff, including the licensee, must have no history of confirmed abuse, neglect, or misappropriation of funds.

## Inspection and Monitoring

**Assisted Living Facilities.** Facilities are inspected by the Department of Health no less than every 2 years for re-licensing. The Department representative, without prior notice, may enter the premises at any reasonable time to ensure compliance with regulations.

**Adult residential care homes** are inspected annually or based on requests or complaints. Inspections are unannounced except for the annual re-licensing inspection.

## Public Financing

The state has a Medicaid 1115 demonstration waiver program called QUEST Expanded Access, which is a managed care program that covers services in ALFs, E-ARCHs, and continuing care foster family homes.

### **Room and Board Policy**

The state provides an optional state supplement (OSS) to Supplemental Security Income (SSI) recipients, who reside in CCFFHs and ARCHs, and limits room and board charges for Medicaid-eligible residents to the combined SSI and OSS payment minus a personal needs allowance (PNA). In 2015, the federal SSI benefit is \$733 and the maximum OSS is \$759.90.<sup>58</sup> In 2009, family supplementation was not allowed.<sup>59</sup>

## Location of Licensing, Certification, or Other Requirements

*Hawaii Administrative Rules*, Title 11, Chapter 90: Assisted Living Facility and Chapter 101.1: Adult Residential Care Homes.

<http://health.hawaii.gov/ohca/type-of-hawaii-state-licensed-and-or-federal-certified-facilities-or-agencies/>

*Hawaii Administrative Rules*, Chapter 1454: Regulation of Home and Community-Based Care Case Management Agencies and Community Care Foster Family Homes.

<http://health.hawaii.gov/ohca/files/2014/07/17-1454-Case-Mgmt-and-CCFFH-Current-Admin-Rules.pdf>

## Information Sources

Rachael Wong  
Hawaii Health Care Association

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<sup>58</sup> Social Security Administration. *Supplemental Security Income in Hawaii*, 2015. <http://www.socialsecurity.gov/pubs/EN-05-11108.pdf>. The amount of the PNA was not available online or from other sources.

<sup>59</sup> Mollica, R.L. (2009). *State Medicaid Reimbursement Policies and Practices in Assisted Living*, National Center for Assisted Living, American Health Care Association. <http://www.ahcancal.org/ncal/resources/Documents/MedicaidAssistedLivingReport.pdf>. Current information about family supplementation policy was not available online or from other sources.

## IDAHO

### Licensure Terms

Residential Care/Assisted Living Facilities

### General Approach

The Idaho Department of Health and Welfare licenses residential care/assisted living facilities (RCFs/ALFs). The purpose of a RCF/ALF is to provide choice, dignity, and independence to individuals needing assistance with daily activities and personal care. The licensing rules set standards for providing services that maintain a safe and healthy environment.

*Adult Foster Care.* The Department of Health and Welfare sets standards for certified family homes to provide care to 1-2 adults who are unable to reside on their own and require help with personal care, protection, and security. *Regulatory provisions for certified family homes are not included in this profile but a link to the provisions can found at the end.*

*This profile includes summaries of selected regulatory provisions for RCFs/ALFs. The complete regulations are online at the links provided at the end.*

### Definitions

***Residential care/assisted living facility*** means a residence, however named, operated on either a profit or non-profit basis for the purpose of providing necessary supervision, personal assistance, meals, and lodging to three or more adults not related to the owner.

### Resident Agreements

Admission agreements must include information on the following: (1) provided services, including medications; (2) staffing patterns and qualifications; (3) rates for basic and additional services or supplies; (4) management of resident funds; (5) conditions for emergency transfers; and (6) resident's responsibilities.

## **Disclosure Provisions**

*No provisions identified.*

## **Admission and Retention Policy**

Facilities may not admit or retain residents who require ongoing skilled nursing services or services that are not within the facility's legally licensed authority, for example, care of gastrostomy tubes and certain shunts or catheters inserted within the previous 21 days; continuous total parenteral nutrition or intravenous therapy; physical restraints; tracheotomy care; syringe feeding; and care for Stage III or IV pressure ulcers.

Residents may also not be admitted or retained if they have physical, emotional, or social needs that are not compatible with the facility's other residents, or who are violent or a danger to themselves or others.

Residents who require assistance in ambulation must reside on the first story unless the facility complies with specified fire safety rules.

## **Services**

Facilities must have the capacity and capability to provide needed and appropriate services to all residents. Basic services must include assistance with activities of daily living (ADLs); supervision; first-aid; assistance with and monitoring of medications; emergency interventions; coordination of outside services; and routine housekeeping and laundry.

### ***Service Planning***

Facilities must perform a uniform assessment that covers a wide range of areas, including: (1) the level and frequency of ADL support and other services; (2) the need for health services; (3) the level of medication assistance; (4) specific behavioral symptoms and interventions for each behavioral symptom; and (5) physicians' orders. Negotiated service agreements are based on the results of the uniform assessment. Facilities serving residents whose care is funded by the state must use a uniform assessment form provided by the licensing Department.

### ***Third-Party Providers***

Residents are permitted to contract for services with third parties.

## Medication Provisions

Residents may self-administer medications, receive assistance with self-administration, or have medications administered. Unlicensed staff who successfully complete an assistance with medications course and have been delegated to provide assistance with medications by a licensed nurse, are permitted to assist residents with self-administration of medication. A licensed professional nurse is required to administer medications and to check residents' medication regimens on at least a quarterly basis.

Facilities must use medi-sets or blister packs filled by a pharmacy or licensed nurse. Psychotropic or behavior-modifying medications must not be the first resort to address behavioral issues; the facility must attempt non-drug interventions to assist and redirect the resident's behavior and must monitor the need for and potential side effects of psychotropic medication.

## Food Service and Dietary Provisions

Each resident on a therapeutic diet must have an order from a physician or authorized provider. Prior to serving a therapeutic diet, the facility must have a therapeutic diet menu planned or approved, signed, and dated by a registered dietitian. Food selections must include those served in the community and in season, and must take into account residents' food habits and preferences, and their physical abilities. Snacks must be offered between meals and at bedtime.

## Staffing Requirements

**Type of Staff.** Each facility must have one *administrator* to supervise all staff, including contract personnel, unless a variance has been issued allowing the administrator to cover more than one facility. The administrator must be on site for the time required to provide for safe and adequate care to residents. A *licensed nurse* must be available to administer medications and review medication services, and to delegate qualified staff to assist residents with self-administration. Trained *staff* must be available to provide resident services and at least one *direct care staff* with certification in first-aid and cardiopulmonary resuscitation must be in the facility at all times.

**Staff Ratios.** Facilities licensed for 15 or fewer beds must have at least one or more qualified and trained staff immediately available during resident sleeping hours. If any resident has been assessed as having night needs or is incapable of calling for assistance, staff must be awake. For facilities licensed for 16 or more beds, qualified and trained staff must be awake and immediately available during resident sleeping hours. For facilities with residents housed in detached buildings or units, at least one qualified and trained staff person must be present and available in each building.

## Training Requirements

Staff must have a minimum of 16 hours job-related orientation training before they are allowed to provide unsupervised personal assistance to residents, and each employee must receive 8 hours of job-related continuing training per year.

Licensed administrators must receive 12 hours of continuing education each year as approved by the Bureau of Occupational Licenses.

A facility admitting and retaining residents with a diagnosis of developmental disability, mental illness, or traumatic brain injury must train staff to meet these residents' specialized needs. Examples of training topics in the regulations include: (1) overview of illness or disability; (2) symptoms and behaviors; (3) resident's adjustment to the new living environment; (4) behavior management; (5) communication; (6) integration with rehabilitation services; (7) ADLs; (8) promotion of independence; (9) use of adaptive equipment; and (10) stress reduction for facility personnel and residents.

## Provisions for Apartments and Private Units

Apartment-style units are not required. A maximum of two residents is allowed per resident unit, unless a facility was licensed prior to July 1, 1991, in which case four residents can be housed per room. One toilet must be provided for every six residents.

## Provisions for Serving Persons with Dementia

***Dementia Care Staff.*** No provisions identified.

***Dementia Staff Training.*** If the facility admits or retains residents with a diagnosis of dementia, staff must be trained in the following topics:

- Overview of dementia.
- Symptoms and behaviors of people with memory impairment.
- Communication with people with memory impairment.
- Resident's adjustment to the new living environment.
- Behavior management.
- Stress reduction for facility personnel and residents.

If a resident is admitted with a diagnosis of dementia or if a resident acquires this diagnosis, and staff have not received relevant training, they must be trained within 30 calendar days. In the interim, the facility must meet the resident's needs.

***Dementia Facility Requirements.*** If the facility accepts and retains residents who have cognitive impairment, the facility must provide an interior environment and exterior yard that is secure and safe.

## **Background Checks**

A RCF or ALF must complete a criminal history and background check on employees and contractors who have direct patient access to residents in the RCF or ALF. Criminal history and background checks must, at a minimum, be fingerprint-based and include a search of the following record sources: Federal Bureau of Investigation, National Criminal History Background Check System, Nurse Aide Registry, and other specified state registries.

## **Inspection and Monitoring**

Surveys are conducted within 90 days from initial licensure, followed by a survey within 15 months. Facilities receiving no core issue deficiencies during both the initial and the subsequent survey will then enter the 3-year survey cycle (i.e., surveys are conducted at least every 36 months for those facilities with no core issue deficiencies for two or more consecutive surveys).

For facilities receiving core issue deficiencies during any survey, the Licensing and Survey Agency may conduct surveys as frequently as it determines necessary.

## **Public Financing**

The state pays for personal care provided in RCFs/ALFs through both the Medicaid State Plan Personal Care option and the Medicaid Aged and Disabled 1915(c) Waiver program. State Plan services are available to residents who meet the state's definition of medical necessity, which requires that the resident may need no more than 16 hours of personal care services per week.

### ***Room and Board Policy***

The state's suggested room and board limit for Medicaid-eligible residents was \$623 per month in 2014, the personal needs allowance for Medicaid participants living in a RCF/ALF was \$98.

The state provides an optional state supplement (OSS) to recipients of the federal Supplemental Security Income benefit who reside in RCFs/ALFs or certified family homes. In 2014, the OSS ranged from \$319 to \$453.<sup>60</sup>

Family supplementation is allowed.

## Location of Licensing, Certification, or Other Requirements

*Idaho Administrative Code*, Idaho Administrative Procedure Act 16, Title 03, Chapter 22: Residential Care or Assisted Living Facilities in Idaho.

<http://adminrules.idaho.gov/rules/current/16/0322.pdf>

*Idaho Administrative Code*, Idaho Administrative Procedure Act 16, Title 03, Chapter 19: Rules Governing Certified Family Homes.

<http://adminrules.idaho.gov/rules/current/16/0319.pdf>

## Information Sources

Robert VandMerwe  
Idaho Health Care Association

Susie Choules  
Idaho Division of Medicaid  
Bureau of Long Term Care

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<sup>60</sup> Idaho State Plan Amendment Transmittal Number 14-002.

## ILLINOIS

### Licensure Terms

Assisted Living Establishment, Shared Housing Establishment, Sheltered Care Facility, and Supportive Living Facility

### General Approach

The Illinois Department of Public Health regulates assisted living establishments and shared housing establishments through one set of rules; assisted living requires single-occupancy private apartment units and shared housing does not. Sheltered care facilities are licensed under the Nursing Home Care Act to provide personal care services and are typically co-located with a nursing facility.

Supportive living facilities are certified by the Department of Healthcare and Family Services to provide residential care and supportive services to either low-income older adults or younger adults with disabilities who are eligible for Medicaid. Facilities must designate which of these two populations it will serve.

There is no separate licensure category for adult foster care.

*This profile includes summaries of selected regulatory provisions for assisted living establishments, shared housing establishments, sheltered care facilities, and supportive living programs. The complete regulations are online at the links provided at the end.*

### Definitions

**Assisted living establishment** means a residence for three or more unrelated adults (at least 80 percent of whom are 55 years of age or older) that provides single-occupancy living units with a private bathroom and space for small kitchen appliances. Residents should be able to age in place within the parameters set by the licensing rules.

**Shared housing establishment** means a publicly or privately operated freestanding residence for 3-16 adults (at least 80 percent of whom are 55 years of age or older) who are unrelated to the facility owners and/or managers. Shared housing provides the same services as assisted living.

**Sheltered care facilities** provide maintenance and personal care but do not provide routine nursing care.

**Supportive living facilities** are residential settings that provide or coordinate personal care services, 24-hour supervision and assistance (scheduled and unscheduled), activities, and health-related services. Facilities must be designed and operated to minimize the need for residents to move within or from the setting.

## Resident Agreements

**Assisted Living and Shared Housing Establishments.** Resident agreements must provide information about the contract duration; the base rate and services included; additional services available and their cost; the complaint resolution process; residents' rights and obligations; billing and payment procedures; admission, risk management, and termination policies and procedures; the Department's annual on-site review process; terms of occupancy; payment and refund policies; notice requirements for fee changes; and policies for notifying relatives about changes in the resident's condition.

**Sheltered Care Facilities.** Resident agreements must include information about services and charges; residents' rights and obligations; whether the facility accepts Medicaid; and termination policies.

**Supportive Living Facilities.** Resident agreements must describe the services provided under Medicaid; payment arrangements; grievance procedures; termination provisions; and residents' rights. The agreement includes services available for an additional fee and arrangements for sharing units.

## Disclosure Provisions

*The following rule applies to all settings.*

A facility that offers to provide care for persons with Alzheimer's disease and other dementias through an Alzheimer's special care unit or center must disclose to the state agency responsible for licensing or certification--and to a potential or actual resident of the facility or such a resident's representative--the following information in writing:

- Form of care or treatment that distinguishes the facility as suitable for persons with Alzheimer's disease and other dementias.
- Philosophy of the facility concerning the care or treatment of persons with Alzheimer's disease and other dementias.
- Facility's pre-admission, admission, and discharge procedures.

- Facility's assessment, care planning, and implementation guidelines in the care and treatment of persons with Alzheimer's disease and other dementias.
- Facility's minimum and maximum staffing ratios, specifying the general licensed health care provider-to-resident ratio and the trainee health care provider-to-resident ratio.
- Facility's physical environment.
- Activities available to residents at the facility.
- Role of family members in the care of residents at the facility.
- Costs of care and treatment under the program or at the center.

## Admission and Retention Policy

***Assisted Living and Shared Housing Establishments.*** Facilities may not admit or retain residents who are a danger to themselves or others; are not able to communicate their needs and do not have a representative residing in the facility; require total assistance with two or more activities of daily living (ADLs); require assistance of more than one paid caregiver with any ADL; or require more than minimal assistance in moving to a safe area in an emergency. Persons with severe mental illness may not be admitted.

Facilities may not admit or retain residents who need the following health services unless self-administered or administered by a qualified licensed health care professional who is not employed by the facility owner or operator: intravenous (IV) therapy or feedings; gastrostomy feedings; catheters, except for routine maintenance of urinary catheters; sterile wound care; sliding scale insulin; routine insulin injections; and Stage III or IV decubitus ulcers.

Residents may not be accepted who need five or more skilled nursing visits a week for 3 or more weeks unless the course of treatment is rehabilitative and the need is temporary. An exception to these admission and discharge provisions is made for terminally ill individuals who are receiving or would qualify for hospice care provided by a licensed hospice provider.

Facilities may not serve people with dementia whose mental or physical condition is detrimental to the health, welfare, or safety of the resident or other residents, as determined by the resident's physician prior to admission and annually thereafter.

***Sheltered Care Facilities.*** Persons needing nursing care; or who have a communicable disease; or who are mentally ill, need treatment for mental illness, are

likely to harm self or others; or who are destructive of property may not be admitted or retained.

**Supportive living facilities** may serve residents age 22 or older who have been screened and determined to meet Department-defined eligibility criteria. Applicants must have their name checked against the sex offender registry data base. Residents may be discharged if they are a danger to self or others or have needs that the facility cannot meet. Residents, with the exception of a spouse or significant other, must have a dementia diagnosis from a physician.

## Services

**Assisted Living and Shared Housing Establishments.** Mandatory services include housekeeping, laundry, security, emergency response systems, and assistance with ADLs. Optional services include medication reminders, supervision of self-administered medications, medication administration, and non-medical services.

Facilities must ensure that residents have the right to direct the scope of services they receive and to make individual choices based on their needs and preferences. Establishments must be operated in a manner that provides the least restrictive and most home-like environment and that promotes independence, autonomy, individuality, privacy, dignity, and the right to negotiate risk-taking in residential surroundings.

**Sheltered Care Facilities.** Facilities may provide personal care; group and individual activities, including restorative and therapeutic activities; medical services; and assistance with self-administration of medications or administration by a physician or licensed nurse.

**Supportive living facilities** must provide personal and health-related services, including nursing services; personal care; medication oversight and assistance in self-administration; social and recreational programs; 24-hour response/security staff; emergency call systems; health promotion and referral; exercise; transportation; daily checks; and maintenance services. Nursing services include resident assessment and service planning; a quarterly health status evaluation; administration of medication when residents are temporarily unable to self-administer; medication setup; health counseling; episodic and intermittent health promotion or disease prevention counseling; and teaching self-care to meet routine and special health care needs.

### Service Planning

**Assisted Living and Shared Housing Establishments.** A comprehensive assessment that includes an evaluation of a prospective resident's physical, cognitive, and psychosocial condition must be completed by a physician. This assessment must be updated by a physician annually or upon a significant change in condition.

“Negotiated risk” is described as a process by which a resident, or his or her representative, may formally negotiate with providers what risks each are willing and unwilling to assume in service provision and the resident’s living environment. The provider must ensure that the resident and the resident’s representative, if any, are informed of the potential consequences of activities that the provider considers to pose risks to health and/or safety. A risk agreement describes the problem, issue, or service that is covered; the choices available to the resident and their risks/consequences; the resulting agreement; mutual responsibilities; and a specific time for reviewing the agreement. The agreement must be limited to the resident’s care and personal environment and cannot waive regulatory requirements.

Before admission, persons with dementia must be assessed with any one or a combination of assessment tools based upon the resident’s condition and stage in the disease process. Specified tools include the Functional Activities Questionnaire, Clock Drawing Test, and Functional Assessment Staging, among others.

***Sheltered Care Facilities.*** The role of family in the care of persons with dementia must be described in the service plan. *No other provisions identified.*

***Supportive Living Facilities.*** Residents must receive an initial assessment within 24 hours of admission and a comprehensive assessment within 14 days. Assessments must be completed by a licensed practical or registered nurse and be updated at least annually. Facilities are expected to involve family members in service planning.

### ***Third-Party Providers***

***Assisted Living and Shared Housing Establishments.*** Home health agencies unrelated to the facility may provide services under contract with residents.

***Sheltered Care and Supportive Living Facilities.*** *No provisions identified.*

## **Medication Provisions**

***Assisted Living and Shared Housing Establishments.*** Facilities may provide medication reminders, supervision of self-administered medications, and medication administration. Medication reminders include reminding residents to take pre-dispensed, self-administered medication; observing the resident; and documenting whether or not the resident took the medication. Only a licensed health care professional employed by the facility may administer medications, including injections, oral medications, topical treatments, eye and ear drops, or nitroglycerin patches.

Supervision of self-administered medication includes assisting the resident with any combination of the following activities: reminding residents to take medication; reading the medication label to residents; checking the self-administered medication dosage against the label of the medication; confirming that residents have obtained and

are taking the dosage as prescribed; and documenting in writing that the resident has taken (or refused to take) the medication. If residents are physically unable to open a container, the container may be opened for them. Supervision of self-administered medication must be under the direction of a licensed health care professional.

***Sheltered Care Facilities.*** Residents must be capable of self-administering medications or receive medications administered by licensed personnel. At admission, all residents must be capable of self-administration. Facility staff may assist a resident in medication self-administration by taking the medication from the locked area where it is stored and handing it to the resident, and they may open containers for residents who are physically incapable of doing so.

***Supportive Living Facilities.*** Residents must be capable of self-administering medications or receive medications administered by a licensed nurse. Unlicensed facility staff may remind the resident to take medications; take medication from where it is stored and hand it to the resident when requested to do so by the resident; and open medication containers. Only a licensed nurse may remove medication from a container and assist the resident in consuming or applying the medication.

## Food Service and Dietary Provisions

***Assisted Living and Shared Housing Establishments.*** Facilities must provide three daily meals.

***Sheltered care facilities*** must provide three meals a day or two meals and a breakfast bar. Meals must meet the adult general diet requirements recommended by the National Academy of Science's Food and Nutrition Board. Facilities must provide therapeutic diets ordered by a physician.

***Supportive living facilities*** must offer three meals per day, or two meals per day (noon and evening meals) and a breakfast bar. The menu must provide food choices and therapeutic diets as ordered by a resident's physician. The menu must comply with the National Academy of Science's Food and Nutrition Board recommendations.

## Staffing Requirements

### ***Assisted Living and Shared Housing Establishments***

***Type of Staff.*** Facilities must employ a full-time *manager* responsible for daily operations and *direct care staff* to provide services to residents. If the facility offers medication administration or specified treatments (e.g., injections, IV therapy), a *licensed health care professional* must be available. At least one staff member certified in cardiopulmonary resuscitation must be awake and on-duty at all times.

**Staff Ratios.** *No minimum ratios.* Staff must be sufficient in number and qualifications, awake, and on-duty all hours of each day to provide services that meet residents' scheduled and unscheduled needs.

### **Sheltered Care Facility**

**Type of Staff.** An *administrator* is required and an *assistant administrator* is optional. *Personnel* to assist with personal care are required.

**Staff Ratios.** *No minimum ratios.* Facilities must have staffing patterns that are sufficient to meet residents' needs. At least one awake staff member is required at all times.

### **Supportive Living Facility**

**Type of Staff.** A *manager* is required to manage daily operations. Personal care services and assistance with self-administration of medications must be provided by *certified nursing assistants* (CNAs). *Licensed nurses* are required to administer medications and provide other nursing tasks. *Response/security staff* who are certified in emergency resuscitation are required to respond to scheduled or unpredictable needs and to emergency calls from residents. A trained staff person must be responsible for planning and directing social and recreation activities.

**Staff Ratios.** One CNA must be on-duty during all shifts. At least one response/security staff person is required for facilities with 1-75 residents, a second staff person for facilities with 76-150 residents, and a third staff person for facilities with 151 or more residents. Facilities must provide a sufficient number of licensed and certified staff to meet residents' needs in accordance with their contractual agreements.

## **Training Requirements**

**Assisted Living and Shared Housing Establishments.** All staff must complete an orientation that addresses service philosophy and goals; promotion of dignity, independence, self-determination, privacy, choice, and resident rights; confidentiality; hygiene and infection control; abuse and neglect prevention and reporting; and disaster procedures. An additional orientation is required to cover residents' need and service plans; internal policies; job responsibilities and limitations; and ADL assistance. Eight hours of annual training is required on the topics listed above. Managers must complete 20 hours of training every 2 years.

**Sheltered Care Facilities.** Supervisory personnel must annually attend appropriate education programs on supervision, nutrition, and other pertinent subjects. Staff must attend an orientation to the facility and its policies, and receive skill training and continuing education on topics relevant to their duties.

**Supportive Living Facilities.** Staff must receive documented training by qualified individuals in their area(s) of responsibility and on infection control; crisis intervention; prevention and notification of abuse and neglect; behavior intervention; negotiated risk; encouraging independence; and techniques for working with persons with disabilities and elderly populations. In facilities serving persons with disabilities, disability-specific sensitivity training must be provided at least annually. Nursing assistants must be certified or enrolled in a course that will result in certification.

## Provisions for Apartments and Private Units

**Assisted living establishments** require single-occupancy units that may be shared by choice. Units must accommodate small kitchen appliances and have a sink, toilet, and private bathing or washing facilities.

**Shared housing establishments** may have shared bathrooms (one for every four residents) and shared tubs/shower facilities (one for every six residents).

**Sheltered Care Facilities.** No more than four persons may share a room. One sink and toilet is required for every ten residents and one shower/bath is required for every 15 residents. A sink and toilet and shower/bath is required on each floor.

**Supportive Living Facilities.** Units in facilities licensed on or after October 18, 2004 must have a full bathroom, lockable doors, an emergency call system, a sink, microwave oven or stove, a refrigerator, and a separate bedroom for each unrelated occupant.

## Provisions for Serving Persons with Dementia

### **Dementia Care Staff**

**Assisted Living and Shared Housing Establishments.** A manager and sufficient numbers of staff, with qualifications, adequate skills, education, and experience must be available to meet residents' 24-hour scheduled and unscheduled needs. Facilities must provide at least 1.4 hours of services per resident per day.

**Sheltered Care Facilities.** Facilities must have staff with the skills required to meet residents' needs.

**Supportive Living Facilities.** There must be one licensed nurse available at all times on site or on call to meet medication administration needs, and at least one CNA on each shift for every ten residents.

## ***Dementia Staff Training***

***Assisted Living and Shared Housing Establishments.*** All staff members must receive 4 hours of dementia-specific orientation prior to assuming job responsibilities without direct supervision. Following orientation, direct care staff must receive 16 hours of on-the-job supervision and training within the first 16 hours of employment following orientation. Training must cover the following topics: encouraging independence in ADLs and providing ADL assistance; emergency and evacuation procedures specific to the dementia population; techniques for minimizing challenging behaviors; rights and choice for persons with dementia, working with families, and caregiver stress; and communication skills.

Direct care staff must annually complete 12 hours of in-service education regarding Alzheimer's disease and other types of dementia. Topics may include: (1) assessing resident capabilities and developing and implementing service plans; (2) promoting resident dignity, independence, individuality, privacy and choice; (3) planning and facilitating activities appropriate for persons with dementia; (4) communicating with families and other persons interested in the resident; (5) residents' rights and principles of self-determination; (6) care of elderly persons with physical, cognitive, behavioral and social disabilities; (7) residents' medical and social needs; (8) common psychotropic medications and side effects; and (9) local community resources.

The manager or supervisor must complete--in addition to other training requirements--6 hours of annual continuing education regarding dementia care.

***Sheltered Care Facilities.*** *No provisions identified.*

***Supportive Living Facilities.*** Staff must receive a 4-hour orientation that includes information about dementia; communication techniques; planning activities; behavior management techniques; reducing safety risks; personal care; and how to partner with families and the community. Staff must receive 12 hours of annual in-service training on these and other relevant topics, including pharmacological and non-pharmacological interventions, and medical and social aspects of dementia.

## ***Dementia Facility Requirements***

*No provisions identified for assisted living, shared housing, or sheltered care facilities.*

***Supportive Living Facilities.*** A dementia care unit may not have more than 20 apartments and all exterior doors must be alarmed. Apartments must include a sink, microwave, and refrigerator, although each resident's ability to use these appliances must be assessed.

## Background Checks

All licensed programs must follow the rules established by the state's Health Care Worker Background Check law.

## Inspection and Monitoring

**Assisted Living and Shared Housing Establishments.** Facilities are inspected annually.

**Sheltered Care Facilities.** Facilities are inspected annually.

**Supportive Living Facilities.** Facilities participating in the Medicaid program must be certified and monitored, at least annually, by the Department of Healthcare and Family Services.

## Public Financing

Medicaid does not pay for services in assisted living establishments, shared housing establishments, and sheltered care facilities.

A Medicaid 1915(c) waiver called the Supported Living Program and a 1915(b) waiver called the Managed Long-Term Services and Supports program pay for assisted living services for eligible residents in supportive living facilities.

### **Room and Board Policy**

In 2015, Medicaid limits room and board rates for eligible residents to the federal Supplemental Security Income (SSI) benefit--\$733--minus a \$90 personal needs allowance. Family supplementation is permitted.

The state provides an optional state supplement (OSS) to SSI recipients and other low-income residents in sheltered care facilities. The OSS amount is based on a state-approved allowance provided for individual needs.<sup>61</sup>

## Location of Licensing, Certification, or Other Requirements

*Administrative Code*, Title 77, Chapter I, Subchapter c, Part 295: Assisted Living and Shared Housing Establishment Code. [August 16, 2012]  
<http://www.ilga.gov/commission/jcar/admincode/077/07700295sections.html>

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<sup>61</sup> Social Security Administration. *State Assistance Programs for SSI Recipients*, January 2011.  
[http://www.socialsecurity.gov/policy/docs/progdsc/ssi\\_st\\_asst/2011/il.html](http://www.socialsecurity.gov/policy/docs/progdsc/ssi_st_asst/2011/il.html).

*Administrative Code*, Title 77, Chapter I, Subchapter c, Part 330: Sheltered Care Facilities Code. [March 29, 2013]

<http://www.ilga.gov/commission/jcar/admincode/077/07700330sections.html>

*Administrative Code*, Title 89, Chapter I, Subchapter d, Part 146, subpart B: Supportive Living Facilities. [December 2, 2014]

<http://www.ilga.gov/commission/jcar/admincode/089/08900146sections.html>

Illinois Supportive Living Program website.

<http://www.slfillinois.com/>

*Illinois Compiled Statutes* 4, Chapter 210: Alzheimer's Disease and Related Dementias Special Care Disclosure Act. [July 2, 2010]

<http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1215&ChapAct=210%C2%A0ILCS%C2%A04/&ChapterID=21&ChapterName=HEALTH+FACILITIES&ActName=Alzheimer%92s+Special+Care+Disclosure+Act%2E>

*Illinois Compiled Statutes* 7, Chapter 225: Board and Care Home Act. [August 13, 2009]

<http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1292&ChapAct=225%C2%A0ILCS%C2%A07/&ChapterID=24&ChapterName=PROFESSIONS%20AND%20OCCUPATIONS&ActName=Board%20and%20Care%20Home%20Act>

Illinois Department of Public Health website: Health Care Worker Registry.

<http://www.idph.state.il.us/nar/>

## Information Sources

Ashley Navelly

Illinois Health Care Association

## INDIANA

### Licensure Terms

Residential Care Facilities

### General Approach

An Indiana residential care provider that desires to use the term “assisted living” must file a disclosure form with the Family and Social Services Agency (FSSA) Division of Aging. It is then considered a registered housing with services establishment. This is not a certification or licensure process, but instead helps the FSSA to learn about the number and types of facilities in Indiana. This type of residential setting provides three meals per day and a number of additional services.

If a housing with services establishment wants to provide medication administration and nursing care, it must be licensed by the Indiana State Department of Health as a residential care facility (RCF) under the licensure category for health facilities. The rules also require that RCF administrators be licensed by the Indiana State Board of Health Facility Administrators.

However, an unlicensed housing with services establishment may contract with a licensed home health agency to provide medication administration or nursing care, regardless of whether the facility and the home health agency have common ownership; provided, however, that residents are given the opportunity to contract with other home health agencies at any time during their stay at the facility.

Assisted living services are available under the state’s Medicaid Aged and Disabled (A&D) and Traumatic Brain Injury (TBI) 1915(c) Waiver programs designed to provide options for alternative long-term care to individuals who meet nursing facility level of care and whose needs can be met in a home-like environment. Providers of Medicaid waiver assisted living services must be licensed as RCFs.

*Adult Foster Care.* The FSSA certifies adult family care homes (AFCHs) that serve Medicaid-eligible residents under the A&D and TBI Waiver programs. Adult family care includes the provision of personal care, homemaker, chore, attendant care and companion services, and medication oversight, to the extent permitted under state law. Providers may serve up to four residents who are elderly or have physical and/or cognitive disabilities and who are not members of the provider’s or primary caregiver’s family. Providers that serve only private pay residents are not required to be certified. *Regulatory provisions for AFCHs are not included in this profile but a link to the provisions can found at the end.*

*This profile includes summaries of selected regulatory provisions for licensed RCFs. The complete regulations are online at the links provided at the end.*

## Definitions

**Housing with services establishments** provide room and board to at least five residents and offer, or provide for a fee, at least one regularly scheduled health-related service or at least two regularly scheduled supportive services, whether offered or provided directly by the establishment or by another person arranged for by the establishment.

Health-related services include home health services, attendant and personal care services, professional nursing services, and distribution of medications. Unlicensed housing with services establishments cannot provide medication administration but can assist residents with administering their own medications. However, an unlicensed establishment can contract with a licensed home health agency to provide medication administration and other medical care and bill the resident for the service or include the service cost in the monthly fee; or residents may choose to contract with licensed home health agencies themselves.

Supportive services include help with personal laundry; handling or assisting with personal funds; and arranging for medical services, health-related services, or social services; but do not include making referrals, assisting a resident in contacting a service provider the resident has chosen, or contacting a service provider in an emergency.

**Residential care facilities** are housing with services establishments that are licensed to provide nursing care or administration of physician-prescribed medication.

## Resident Agreements

Prior to admission, facilities must provide the resident or the resident's representative a copy of the contract between the resident and the facility. The contract must provide information about a range of topics, including services to be provided in the base rate; additional services available and their cost; the process for changing the contract; the complaint resolution process; the facility's retention, discharge, and referral policies and procedures; and billing and payment policies and procedures.

## Disclosure Provisions

Facilities must provide each resident with a copy of the annual disclosure document that the facility files with the Division of Aging and must advise residents, upon admission, of residents' rights specified in Indiana law and regulation.

The required disclosure form includes the name and address of the owner and managing agent and a statement describing the facility's licensure status as well as the other information previously described under Resident Agreements.

Facilities that provide specialized care for individuals with Alzheimer's disease or dementia must prepare a disclosure statement on required topics that include: (1) the facility's mission or philosophy statement with regard to dementia care; (2) admission, retention, transfer, and discharge criteria and processes; (3) the process for the assessment, establishment, and implementation of a plan of Alzheimer's or dementia special care, including how and when changes are made to a plan of care; (4) the positions and classifications of staff and the staff-to-patient ratio for each shift; (5) the initial training or special education requirements of the staff and required continuing staff education and in-service training; (6) the frequency and types of activities offered, including family support programs; and (7) any other distinguishing features and services of the Alzheimer's and dementia special care unit (SCU).

This statement must be filed with the FSSA Division of Aging annually and made available to anyone seeking information on services for individuals with dementia.

## **Admission and Retention Policy**

Facilities may not admit or retain individuals who are medically unstable or require 24-hour-a-day comprehensive nursing care or comprehensive nursing oversight. Residents must be discharged if they require comprehensive nursing care, comprehensive nursing oversight, or rehabilitative therapies on a less than 24-hour-a-day basis and *have not* contracted with an appropriately licensed provider to provide the care, oversight, and therapies.

Additionally, unless the resident is medically stable and the facility can meet the resident's needs, residents must be discharged if they are a danger to self or others or meet two of the following three criteria: (1) require total assistance with eating, (2) require total assistance with toileting, and/or (3) require total assistance with transferring.

## **Services**

Services offered must meet residents' needs regarding scope, frequency, and preferences. A facility that retains appropriate professional staff may provide comprehensive nursing care to residents needing care for a self-limiting condition, notwithstanding the items listed under the admission and retention policy.

If administration of medications and/or nursing services are needed, a licensed nurse must be involved in the determination and documentation of needed services.

The administration of medications and the provision of nursing services must be ordered by a physician and supervised by a licensed nurse on the premises or on call.

Nursing care may include, but is not limited to: (1) identifying responses to actual or potential health conditions; (2) a nursing diagnosis; (3) executing a minor regimen based upon a nursing diagnosis or as prescribed by a physician, physician's assistant, chiropractor, dentist, optometrist, podiatrist, or nurse practitioner; and (4) administering, supervising, delegating, and evaluating nursing activities.

A minor regimen may include, but is not limited to: assistance with self-maintained catheter care for a chronic condition; prophylactic and palliative skin care; routine dressings of wounds that do not require packing or irrigation; general maintenance ostomy care; routine blood glucose testing; bowel therapies; general maintenance care in connection with braces, splints, and plaster casts; administration of subcutaneous and intramuscular injections; and self-administered metered dose inhalers and nebulizer/aerosol treatments.

The facility must provide activities programs appropriate to residents' abilities and interests. Scheduled transportation for community-based activities must be provided or coordinated.

### ***Service Planning***

Prior to admission, the facility must evaluate prospective residents to determine if they can be admitted. If admitted, the evaluation must be updated at least semi-annually or when a significant change in condition occurs. Subsequent evaluations must determine that the care a resident requires continues to be within the capability of the facility. Based on the evaluation, the facility must identify the type, scope, and frequency of services that will be provided, and the resident's preferences regarding service provision.

Providers of Medicaid assisted living services through a waiver program must establish a negotiated risk plan with a resident if deemed appropriate and determined to be necessary by a resident's interdisciplinary team.

### ***Third-Party Providers***

A resident has the right to choose his or her own attending physician and providers for on-site health care services, including home health, hospice, and personal care.

## **Medication Provisions**

Medications may be administered under physician's order by licensed nursing personnel or qualified medication aides. Other treatments may be given by certified nurse aides upon delegation by licensed nursing personnel except for injectable

medications, which may be given only by licensed staff. The resident must be observed for effects of medications and undesirable effects must be documented and the resident's physician notified.

Administration of medications means preparation and/or distribution of prescribed medications. Administration does not include reminders, cues, and/or opening of medication containers or assistance with eye drops, such as steadying the resident's hand, when requested by a resident.

Residents who self-medicate may keep and use prescription and non-prescription medications in their unit as long as they are kept secure.

## Food Service and Dietary Provisions

Facilities must provide three meals a day, 7 days a week, that provide a balanced distribution of the daily nutritional requirements. Facilities must meet daily dietary requirements and requests, with consideration of food allergies, reasonable religious, ethnic, and personal preferences, and the temporary need for meals to be delivered to the resident's room. All modified diets must be prescribed by a physician.

## Staffing Requirements

**Type of Staff.** Each facility must have one *licensed administrator* who is responsible for overall administration. Administrators must have either a nursing facility administrator's license or a RCF administrator's license. Those with the latter must complete a specialized course in residential care administration approved by the Indiana State Board of Health Facility Administrators prior to employment.

If 50 or more residents require nursing services and/or medication administration, at least one *nursing staff person* (a registered nurse, licensed practical nurse, or certified nurse aide) must be on staff at all times. Any unlicensed employee providing more than limited assistance with activities of daily living must be either a certified nursing assistant or a home health aide.

A consultant *pharmacist* must be employed or under contract. The facility must designate an *activities director* who is a recreational therapist, an occupational therapist or a certified occupational therapist assistant, or someone who will complete, within 1 year, a state-approved activities director training course. Facilities may employ dining assistants who may only serve residents who do not have complicated eating problems, which include, but are not limited to, the following: difficulty swallowing, recurrent lung aspirations, or tube or parenteral/intravenous feedings.

**Staff Ratios.** As noted above, for 50 or more residents requiring nursing services and/or medication administration, at least one nursing staff person must be on staff at

all times, For every additional 50 residents, at least one additional awake nursing staff person must be on-duty at all times.

*No minimum ratios are specified for other staff.* Staff must be sufficient in number, qualifications, and training to meet residents' 24-hour scheduled and unscheduled needs. A minimum of one awake staff person with cardiopulmonary resuscitation and first-aid certifications must be on-duty at all times.

## **Training Requirements**

Administrators must complete 40 hours of continuing education every 2 years.

Prior to working independently, each employee must be given an orientation to the facility by the supervisor, which includes:

- Instructions on the needs of the specialized populations served in the facility.
- A review of the facility's policies and procedures.
- Instructions in first-aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures.
- A detailed review of the appropriate job description, with a demonstration of equipment and procedures required of the specific position.
- A review of ethical considerations and confidentiality requirements in resident care and records.
- A personal introduction to and instruction in the particular needs of each resident to whom the employee will be providing care for direct care staff.

Ongoing training must cover several topics, including resident's rights, prevention and control of infection, fire safety and accident prevention, the needs of specialized populations served, medication administration, and nursing care. Nursing personnel must have at least 8 hours of training per calendar year and non-nursing personnel must have at least 4 hours per calendar year.

## **Provisions for Apartments and Private Units**

Providers of Medicaid waiver assisted living services must offer individual residential units that include a bedroom, private bath, a substantial living area, and a kitchenette that contains a refrigerator, food preparation area, a microwave, and access to a stove top or oven. Fifty percent of units must have roll-in shower capability and units must be wheelchair accessible. Apartments can be shared only by choice.

Otherwise, for facilities licensed after April 1, 1997, each unit must have a private toilet, sink, and tub or shower. Facilities licensed prior to April 1, 1997, must abide by certain resident-to-bathtub/shower and resident-to-toilet/sink ratios as set forth in regulation.

For facilities and additions to facilities for which construction plans are submitted for approval after July 1, 1984, resident rooms must not contain more than four beds, and one toilet and sink is required for every eight residents. At least one toilet and one sink of the appropriate height for a resident seated in a wheelchair must be available for each sex on each floor utilized by residents.

Bathing facilities for residents not served by bathing facilities in their room are provided as follows: 1-22 residents, one bathtub or shower; 23-37 residents, two bathtubs or showers; 38-52 residents, three bathtubs or showers; 53-67 residents, four bathtubs or showers; 68-82 residents, five bathtubs or showers; and 83-97 residents, six bathtubs or showers.

A resident has the right to share a room with his or her spouse when: (1) married residents live in the same facility and both spouses consent to the arrangement; and (2) a room is available for residents to share. The facility must have written policy and procedures to address the circumstances in which persons of the opposite sex, other than husband and wife, will be allowed to occupy a bedroom if such an arrangement is agreeable to both.

## Provisions for Serving Persons with Dementia

***Dementia Care Staff.*** Facilities that are required to submit an Alzheimer's and dementia SCU disclosure form must designate a *director*.

***Dementia Staff Training.*** The director of the Alzheimer's and dementia SCU must have a minimum of 12 hours of dementia-specific training within 3 months of initial employment, and 6 hours annually thereafter to meet the needs and preferences of cognitively impaired residents and to gain an understanding of the current standards of care for persons with dementia.

Staff caring for residents in dementia-specific units must have a minimum of 6 hours of dementia-specific training within 6 months of hire and 3 hours annually thereafter.

***Dementia Facility Requirements.*** *No provisions identified.*

## Background Checks

The facility must not employ individuals who have: (1) been found guilty by a court of law of abusing, neglecting, or mistreating residents or misappropriating residents' property; or (2) had a finding entered into the state nurse aide registry concerning abuse, neglect, mistreatment of residents, or misappropriation of their property. The facility must report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff, to the state nurse aide registry or licensing authority.

An individual applying for an RCF administrator's license must submit to a national criminal history background check at his or her cost. Criminal history background checks are not required for renewal applications.

## Inspection and Monitoring

The Department of Health conducts a pre-licensure survey and then a licensure renewal survey every 9-15 months.

Providers of Medicaid waiver assisted living services must permit the office of Medicaid policy and planning, the Division of Aging, the Ombudsman, and other state representatives to enter the facility without prior notification in order to: (1) monitor compliance with relevant administrative rules; and (2) conduct complaint investigations, including, but not limited to, observing and interviewing residents and accessing residents' records.

## Public Financing

The Residential Care Assistance Program (RCAP) is a state-funded program that provides financial assistance to eligible individuals residing in licensed RCFs and other housing with services establishments that have an approved RCAP contract with the Division of Aging. The program covers limited services for residents who are aged, blind, mentally ill or disabled, low-income, and unable to live alone, but do not qualify for nursing home care. RCAP funding can cover room, board, and laundry, as well as care coordination provided on behalf of eligible individuals. An applicant for RCAP funding must not meet Medicaid nursing facility level of care eligibility criteria or have income and resources that exceed established Medicaid guidelines.

The state's Medicaid A&D and TBI 1915(c) Waiver programs cover services--called assisted living services--in licensed RCFs and also covers services provided in AFCHs.

## **Room and Board Policy**

In 2014, the room and board rate for Medicaid-eligible residents was capped at the federal Supplemental Security Income (SSI) payment of \$721 less a \$52 per month personal needs allowance retained by the resident.

The state does not provide a supplement to the federal SSI payment and has not set a policy on income supplementation by family members or other third parties.

## **Location of Licensing, Certification, or Other Requirements**

*Indiana Code*, Title 12, Article 10, Chapter 5.5: Alzheimer's and Dementia Special Care Disclosure. [2014]

<https://iga.in.gov/legislative/laws/2014/ic/titles/012/articles/010/chapters/5.5/>

*Indiana Code*, Title 12, Article 10, Chapter 15: Filing Disclosure Documents for Housing With Services Establishments. [2014]

<https://iga.in.gov/legislative/laws/2014/ic/titles/012/articles/010/chapters/015/>

*Indiana Administrative Code*, Title 405, Article 1: Medicaid Providers and Services. Office of the Secretary of Family and Social Services. [October 23, 2013]

<http://www.in.gov/legislative/iac/T04050/A00010.PDF>

*Indiana Administrative Code*, Title 410, 16.2-5: Residential Care Health Facility Regulations. Indiana State Department of Health, Division of Long Term Care. [2008]

[http://www.inassistedliving.org/pdfs/2008/RCF\\_Rules.pdf](http://www.inassistedliving.org/pdfs/2008/RCF_Rules.pdf)

*Indiana Administrative Code*, Title 455, Article 3: Assisted Living Medicaid Waiver Services. Division of Aging. [July 1, 2011]

[http://www.in.gov/legislative/iac/iac\\_title?iact=455&iaca=3](http://www.in.gov/legislative/iac/iac_title?iact=455&iaca=3)

Indiana State Department of Health. *Application for a New Facility Residential Care Facility*.

[http://www.in.gov/isdh/files/Application\\_for\\_New\\_Facility\\_Residential\\_Care\\_Facility.pdf](http://www.in.gov/isdh/files/Application_for_New_Facility_Residential_Care_Facility.pdf)

Indiana State Department of Health website: information and contacts for *Residential Care Facility Licensing Program*.

<http://www.in.gov/isdh/20227.htm>

Indiana Professional Licensing Agency website: *Residential Care Administrator Application and Instructions*.

<http://www.in.gov/pla/2952.htm>

Indiana Family and Social Services Administration, Division of Aging: Approval Request for Providers of Adult Family Care. [August 5, 2014]

[https://secure.in.gov/fssa/files/AFC\\_Survey\\_Tool-2010.pdf](https://secure.in.gov/fssa/files/AFC_Survey_Tool-2010.pdf)

## Information Sources

Becky Koors  
Assistant Director  
Long-Term Care Operations  
Division of Aging

Jim Leich  
President/CEO  
LeadingAge Indiana

Zachary I. Cattell  
General Counsel  
Director of Regulatory Affairs and Reimbursement Services  
Indiana Health Care Association  
*and*  
Indiana Center for Assisted Living

## IOWA

### Licensure Terms

Assisted Living Program and Residential Care Facility

### General Approach

The Department of Inspections and Appeals, Health Facilities Division, licenses assisted living programs (ALPs) and residential care facilities (RCFs). ALPs serve a primarily elderly population and RCFs serve a younger adult population, including persons with physical and/or intellectual disabilities, persons with mental illness, as well as older persons.

ALPs may be certified as a dementia care unit if they meet additional requirements. RCFs may provide memory care services in a designated unit or a stand-alone facility. The Department approves the memory care program after reviewing the facility's policies, staffing plan, admission and discharge criteria, safety procedures, and service plan.

*Adult Foster Care.* Elder group homes are licensed as a single-family residence operated to provide room, board, and personal care and health-related services for 3-5 elderly residents who are not related to the person providing the service. Homes must be staffed by an on-site manager 24 hours per day, 7 days per week. *Regulatory provisions for elder group homes are not included in this profile but a link to the provisions can found at the end.*

*This profile includes summaries of selected regulatory provisions for ALPs and RCFs. The complete regulations are online at the links provided at the end.*

### Definitions

**Assisted living programs** provide housing with services to three or more residents in a physical structure that offers a home-like environment. ALPs encourage family involvement and resident self-direction and participation in decisions that emphasize choice, dignity, privacy, individuality, shared risk, and independence.

ALPs certified as dementia-specific may serve between 5 and 55 residents who have dementia between Stages 4 and 7 on the Global Deterioration Scale; or 55 or more residents of whom 10 percent or more have Stage 4-7 dementia based on the

Global Deterioration Scale; or offer specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

**Residential care facilities** provide personal assistance and other essential daily living activities to individuals who are unable to sufficiently or properly care for themselves because of illness, disease, or physical or mental impairment.

## Resident Agreements

**Assisted Living Programs.** The resident agreement includes the costs of services and terms of payment, as well as refunds and third-party provider agreements; occupancy and transfer criteria; grievance policies; emergency response policy; staffing policies, including whether or not staff are available 24 hours a day; staff delegation policies; and how staffing will be adjusted to meet changing needs.

Dementia-specific ALPs must, in addition, describe the services and programming for social activities that will be provided to meet residents' life skill needs.

**Residential Care Facilities.** The resident agreement must include the costs of services, payment terms, and refund policies; bed hold policies; discharge criteria; and facility-specific policies.

## Disclosure Provisions

*No provisions identified for either facility type.*

## Admission and Retention Policy

**Assisted Living Programs.** Programs may not admit or retain residents who require total assistance with four or more activities of daily living (ADLs) for more than 21 days; are bedbound; require two-person assistance with standing, transfer, or evacuation; pose a danger to self or others; are in an acute stage of alcoholism, drug addiction, or uncontrolled mental illness; have unmanageable incontinence on a routine basis; require more than part-time or intermittent health-related care (21 days); or meet the program's discharge criteria.

Part-time or intermittent nursing care includes licensed nursing care for unstable conditions; daily medication injections (except for stable diabetes); daily assessment or treatment of conditions, such as an open wound or a pressure ulcer; total care for unmanageable incontinence; or routine two-person assistance with standing, transfer, or evacuation.

Programs may request exceptions to the part-time or intermittent health care limit for residents who need hospice care or who temporarily need more than part-time or intermittent health care for more than 21 days. The Department may give approval for limited time periods if the resident makes an informed choice to remain, the program has the staff to meet the extended needs, and the health and welfare of other residents is not jeopardized.

**Residential Care Facilities.** Individuals may be admitted only on a written order signed by a physician certifying that the individual being admitted requires no more than personal care and supervision and does not require nursing care.

## Services

**Assisted living programs** must provide assistance with personal care (ADLs) and health-related services. Health-related services mean less than daily skilled nursing services and professional therapies for temporary but not indefinite periods of time of up to 21 days a month. Programs must also provide resident access to a 24-hour personal emergency response system.

**Residential care facilities** must provide personal care services, including assistance with ADLs; social and recreational activities; and medication services.

### Service Planning

**Assisted living programs** must assess residents' functional, cognitive, and health status at specified intervals and upon a significant change in condition, and develop individualized service plans. A multidisciplinary team (including a health professional and human services professional) must be involved in service planning when residents require personal care or health-related services.

As needed, a managed risk agreement may be negotiated between the resident and facility. The agreement includes the resident's or responsible person's signed acknowledgment of the shared responsibility for identifying and meeting needs and the process for managing risk and upholding resident autonomy when resident's decisions may result in poor outcomes for the resident or others.

Service plans for residents with dementia must include planned and spontaneous activities based on the resident's abilities and personal interests.

**Residential Care Facilities.** Before admission, applicants must be examined by a physician to provide information about the individual's medical status and diagnoses. Staff must develop a written, individualized, and integrated program of ongoing services for the resident that addresses the resident's priorities, goals, and assessed needs.

### ***Third-Party Providers***

***Assisted Living Programs.*** A program may contract with third-party providers of personal care and health-related services; however, the program is accountable for meeting all minimum standards. If the resident contracts with a third-party provider, the resident assumes the responsibility and risk for the employment or contractual relationship. All contracted services must be specified in the service plan and health-related services must be documented in the medication record.

***Residential Care Facilities.*** *No provisions identified.*

## **Medication Provisions**

***Assisted Living Programs.*** Residents may self-administer medications or have medications administered by facility staff. The Iowa Nurse Practice Act allows nurses to delegate medication administration to unlicensed staff. Medication administration includes medication “setup,” described as routine prompting, cueing, and reminding; opening containers or packaging at the resident’s direction; reading instructions or other label information; and/or transferring medications from the original container into suitable medication dispensing containers.

A program that administers medications or provides health care professional-directed or health-related care must provide for a registered nurse (RN) to monitor each resident who receives program-administered medications for adverse reactions and ensure that the medication orders are current and properly administered. Monitoring must occur at least every 90 days or after a significant change in condition.

***Residential Care Facilities.*** Residents may self-administer medications or have medications administered by facility staff. The following personnel may administer medications:

- A licensed nurse or physician or an individual who has completed a Department-approved medication aide course.
- Injectable medications must be administered by a qualified nurse, physician, pharmacist, or physician assistant.
- Freestanding facilities licensed for 15 or fewer beds may permit a person who has completed a state-approved medication manager course to administer medications.

## Food Service and Dietary Provisions

**Assisted Living Programs.** Facilities must provide hot meals at least once a day or coordinate with other community providers to make arrangements for the availability of meals. All meals must follow recommendations of the National Academy of Science's Food and Nutrition Board. If therapeutic diets are provided, a health care provider must prescribe the diet and a licensed dietitian must be available to write and approve the therapeutic menu and review food preparation and service procedures.

**Residential Care Facilities.** Three daily meals must be served that meet recommended daily dietary allowances of the National Academy of Science's Food and Nutrition Board.

## Staffing Requirements

### **Assisted Living Program**

**Type of Staff.** A *program manager* is required to oversee daily operations and staffing. Programs administering medications or providing health-related services must provide for a *registered nurse* to monitor medications, delegate medication administration, ensure that physician orders are current, and assess and monitor health status. *Personnel* are required to assist residents with daily activities.

**Staff Ratios.** *No minimum ratios.* A sufficient number and type of staff must be available 24 hours a day to meet residents' scheduled and unscheduled needs.

### **Residential Care Facility**

**Type of Staff.** Facilities must have a full-time *administrator* who is responsible for daily operations and staffing; *staff* to provide personal care; an *activity coordinator* to organize and monitor the activities program; and either a *licensed nurse, physician, or certified medication aide* to administer medications.

**Staff Ratios.** Minimum staff-to-resident ratios are 1:25 during the day; 1:35 during the evening; and 1:45 during the night. The Department may require additional staffing based on residents' needs. Staff must be awake when on duty in facilities with 15 or more residents.

## Training Requirements

**Assisted Living Programs.** Program managers and/or delegating nurses hired after January 1, 2010, must complete an assisted living management or nursing course within 6 months of hire. All personnel must be trained on the program's accident, fire safety, and emergency procedures.

**Residential Care Facilities.** The administrator must provide monthly in-service training for staff.

## Provisions for Apartments and Private Units

**Assisted Living Programs.** Private apartments are not required. Resident rooms may be single-occupancy or double-occupancy and must have a bathroom, including a toilet, sink, and bath or shower. Kitchens are optional.

**Residential Care Facilities.** No more than four residents may share a room. Bathrooms and bathing facilities may be shared, with at least one bathtub or shower for every 15 residents and one sink and toilet for every ten residents.

## Provisions for Serving Persons with Dementia

### **Dementia Care Staff**

**Assisted living programs and residential care facilities** must have at least one staff person on duty and awake 24 hours a day in the dementia care unit.

### **Dementia Staff Training**

**Assisted Living Programs.** All personnel employed by or contracting with a dementia-specific program must receive a minimum of 8 hours of dementia-specific education and training within 30 days of employment. Direct care staff must receive at least 8 hours of annual continuing education and all other personnel at least 2 hours of dementia-specific continuing education. Specific topics include explanation of dementia; the service philosophy and program; communication skills; family issues; planned and spontaneous activities; ADL assistance; service planning and social history; working with challenging residents; cuing and redirecting; and staff support and stress reduction.

**Residential Care Facilities.** Staff must have at least 6 hours of special training appropriate to their job descriptions within 30 days of hire and 6 hours of annual training on the same topics described above.

### **Dementia Facility Requirements**

**Assisted Living Programs.** An operating alarm system must be connected to each exit door in a dementia-specific program. Staff must have the means to disable or remove the lock on an entrance door and do so if the presence of the lock presents a danger to residents' health and safety. If kitchens are provided in apartments, the program must be able to disable or remove appliances if needed to protect the resident and others.

**Residential Care Facilities.** No provisions identified.

## Background Checks

**Assisted Living Programs and Residential Care Facilities.** Before hiring an individual, the manager must request a criminal history check by the Department of Public Safety and a child and dependent adult abuse record check by the Department of Human Services (DHS). If the applicant has a record, DHS determines whether the crime warrants prohibiting the individual's employment.

## Inspection and Monitoring

**Assisted Living Programs.** Facilities receive a conditional certification and are inspected by the Department within 3 months. Pending a successful inspection, facilities receive a 2-year license and are then inspected every other year unless there is a complaint.

**Residential Care Facilities.** Facilities receive a conditional certification and are inspected by the Department within 3 months to receive license. Inspections must be conducted at least every 30 months.

## Public Financing

Services in both assisted living and RCFs are covered through a Medicaid 1915(c) Elderly Waiver program administered by DHS.

### **Room and Board Policy**

Iowa provides an optional state supplement (OSS) for eligible RCF residents but not for ALP residents. The amount of the OSS is based on the allowable costs of residential care, plus a personal needs allowance (PNA) that is retained by the resident, minus the federal Supplemental Security Income payment. In 2015, the maximum monthly OSS is \$299.55. In 2011, the PNA was \$93 a month.<sup>62</sup>

Family supplementation is permitted.

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<sup>62</sup> Social Security Administration. *State Assistance Programs for SSI Recipients*, January 2011. [http://www.socialsecurity.gov/policy/docs/progdesc/ssi\\_st\\_asst/2011/ia.html](http://www.socialsecurity.gov/policy/docs/progdesc/ssi_st_asst/2011/ia.html). Current information about the PNA was not available online or from other sources.

## Location of Licensing, Certification, or Other Requirements

*Iowa Administrative Code*, Title 481, Chapter 69: Assisted Living Programs. [January 1, 2010]  
<https://www.legis.iowa.gov/docs/ACO/IAC/LINC/09-23-2009.Chapter.481.69.pdf>

*Iowa Code*, Chapter 231C: Assisted Living Programs. [2011]  
[http://www.state.ia.us/government/dia/231C\\_2011Code.pdf](http://www.state.ia.us/government/dia/231C_2011Code.pdf)

*Iowa Administrative Code*, Title 481, Chapter 57: Residential Care Facilities. [December 10, 2014]  
<https://www.legis.iowa.gov/law/administrativeRules/rules?agency=481&chapter=57&pubDate=07-24-2013>

Iowa Finance Authority website: Affordable Assisted Living Operator Toolkit, includes information for providers and links to regulations and resources.  
<http://www.iowafinanceauthority1.com/AALOperatorsToolkit.asp>

## Information Sources

Cindy Baddeloo  
Deputy Director  
Iowa Health Care Association  
*and*  
Iowa Center for Assisted Living

## KANSAS

### Licensure Terms

Adult Care Home, Assisted Living Facility, Residential Health Care Facility

### General Approach

The Secretary of Aging and Disability Services licenses a broad range of residential service delivery settings under the term adult care homes (ACHs), including assisted living facilities (ALFs) and residential health care facilities. The regulations differentiate among the many types of ACHs.

Small private residences--called boarding care homes and home plus--are also licensed under the ACH rules. These residences serve up to ten and 12 residents, respectively, who are not related to the operator or owner by blood or marriage. They do not provide the level of services available in assisted living and residential health care facilities. *Regulatory provisions for boarding care home and home plus settings are not included in this profile but a link to the provisions are provided at the end.*

*This profile includes summaries of selected regulatory provisions for ALFs and residential health care facilities. The complete regulations can be viewed online using the links provided at the end.*

### Definitions

**Assisted living facility** means any place or facility caring for six or more individuals not related to the administrator, operator, or owner by blood or marriage, and who, by choice or because of functional impairments, may need personal care and supervised nursing care. An ALF must provide apartments with kitchens for residents and provide or coordinate a range of services that are available 24 hours a day, 7 days a week to support resident independence.

**Residential health care facility** means any place or facility, or a contiguous portion of a place or facility, caring for six or more individuals. Resident units are not required to have a kitchen. Residential health care facilities provide the same services that are furnished in ALFs.

## Resident Agreements

All facilities must provide residents with a written admission agreement--at or before admission--that describes the providers' general responsibilities, the services provided, and their daily or monthly cost. In addition, an initial negotiated service agreement must be developed at admission, which is based on a resident assessment that describes resident preferences, who provides services, and any recommended services that the resident refuses.

Residents are liable only for the charges disclosed to them, or the residents' legal representative, and documented in a signed admission agreement.

## Disclosure Provisions

*No provisions identified.*

## Admission and Retention Policy

No facility may admit or retain individuals with the following conditions unless a negotiated service agreement specifies that services are sufficient to meet their needs:

- Incontinence, when the resident cannot or will not participate in its management.
- Immobility requiring total assistance in exiting the building.
- Any ongoing condition requiring two or more persons to physically assist the resident.
- Any ongoing skilled nursing intervention needed 24 hours a day for an extended period of time.
- Any behavioral symptom that cannot be managed by facility staff.
- Any person whose clinical condition requires the use of physical restraints.

The state does not license or certify dementia care units, but facilities may serve persons with "special needs" if their admission and discharge criteria identify the diagnosis, behavior, or specific clinical needs of the residents to be served. A written physician's order is required for admission, and a medical diagnosis, medical care provider's progress notes, or both may be used to justify admission to the special care section of the facility. Prior to admission, the resident or his/her legal representative must be informed of the services and programs available.

## Services

General services include health care services based on an assessment by a licensed nurse, housekeeping, medical, dental, social transportation, planned activities, and other services needed to support residents' health and safety. Health care services provided by or coordinated by a licensed nurse may include personal care, supervised nursing care, and wellness and health monitoring.

### ***Service Planning***

Facilities must develop a negotiated service agreement with each resident in collaboration with the resident, the residents' legal representative (if any), family members (if agreed to by the resident), or case manager (if any). The agreement describes the services that will be provided, the service provider, and the parties responsible for payment when services are provided by an outside agency.

The negotiated service agreement is reviewed at least annually or when requested by any of the participating parties and must address services that are refused by the resident, the potential negative consequences of the refusal, and the resident's acceptance of the risks involved.

If the resident requires health care services, a licensed nurse must develop a health care service plan. Health care services include personal care as well as nursing care tasks. The health care service plan must specify the skilled nursing services to be provided and the licensed person or agency providing the services.

### ***Third-Party Providers***

If the resident's negotiated service agreement includes outside resources, the facility must provide the resident with a list of providers available to furnish needed services; assist the resident, if requested, in contacting outside resources for services; and monitor the services provided by outside resources and act as an advocate for the resident if services do not meet professional standards of practice.

## Medication Provisions

The facility may administer medications or a resident may self-administer medications if a licensed nurse has assessed and determined his or her ability to do so. If the facility is responsible for administering some or all of the resident's medications, a licensed nurse or medication aide must administer and manage the resident's medications. Licensed nurses may delegate nursing procedures not included in the medication aide curriculum to medication aides under the state's Nurse Practice Act, but medication aides may not administer intravenous or subcutaneous medications.

A licensed pharmacist must conduct a medication regimen review at least quarterly for each resident whose medication the facility manages, and each time the resident experiences a significant change in condition. Residents who self-administer must be offered this service. The review covers the following areas, and adverse findings must be communicated to the care provider:

- Lack of clinical indication for use of medication.
- The use of a subtherapeutic dose of any medication.
- Failure of the resident to receive an ordered medication.
- Medications administered in excessive dosages, including duplicate therapy, or in excessive duration.
- Adverse medication reactions and medication interactions.
- Lack of adequate monitoring.

Health care services, including medication administration and personal care assistance, may be provided without charge by the resident's friends or family members.

## Food Service and Dietary Provisions

Residents must have input into the selection of food served and the timing of meals. Therapeutic diets are provided if included in the negotiated service agreement, based on instructions from a physician or licensed dietician. Menus must be planned based on *The Dietary Guidelines for Americans*, 4th edition, published by the U.S. Department of Agriculture and the U.S. Department of Health and Human Services. A dietetic services supervisor or licensed dietician must provide scheduled on-site supervision in facilities with 11 or more residents.

## Staffing Requirements

**Type of Staff.** Both types of facilities must have an *administrator*. A full-time *operator* (not required to be a licensed administrator if fewer than 61 residents are in the facility) must be employed by the facility. A *registered nurse* must be available to provide supervision to *licensed practical nurses*.

**Staff Ratios.** *No minimum ratios.* Both assisted living and residential health care administrators must ensure that a sufficient number of qualified personnel are available to provide each resident with services and care in accordance with his or her functional capacity screening, health care service plan, and negotiated service agreement. Staff must be awake and responsive at all times.

## Training Requirements

Facilities must provide orientation to new employees and regular in-service training for all employees. Topics for orientation and in-service training must include the principles of assisted living; fire prevention and safety; disaster procedures; accident prevention; residents' rights; infection control; and the prevention of abuse, neglect, or exploitation of residents. Administrators must complete 50 hours of continuing education every 2 years. Operators do not have any continuing education requirements.

## Provisions for Apartments and Private Units

**Assisted living facility** units are apartments that must have a living area, storage area, full and accessible bathroom, kitchen (with sink, refrigerator, stove or microwave, and space for storage of utensils and supplies), lockable door, and operable window. The regulations do not specify whether these units must be private.

**Residential health care facility** units are not required to have a kitchen but must have an accessible private bathroom with a bathing facility.

Facilities licensed prior to January 1, 1995, as an intermediate personal care facility, are not required to offer kitchens and private baths.

## Provisions for Serving Persons with Dementia

**Dementia Care Staff.** *No provisions identified.*

**Dementia Staff Training.** Facilities that admit persons with dementia must provide in-service education for all employees on the treatment of behavioral symptoms.

**Dementia Facility Requirements.** Exits must be controlled in the least restrictive manner possible.

## Background Checks

A criminal background check is required for all facility staff, including contract staff.

## Inspection and Monitoring

The authorized agents and representatives of the licensing agency must conduct at least one unannounced inspection of each facility within 15 months of any previous inspection for the purpose of determining whether the facility is complying with

applicable statutes and rules and regulations relating to residents' health and safety. The statewide average interval between inspections must not exceed 12 months.

## Public Financing

The state's KanCare program expanded managed care to almost all Medicaid State Plan populations for physical, behavioral, and long-term care services. KanCare also provides managed care authority for the state's concurrent 1915(c) Home and Community-Based Services waivers, creating the first section 1115(a)/1915(c) combination waiver program. KanCare pays for services in an ALF.<sup>63</sup>

### Room and Board Policy

In 2009, waiver program participants negotiated the room and board rate and the personal needs allowance (PNA) with the facility. Family supplementation was allowed for non-covered services.<sup>64</sup>

The state does not provide an optional supplement to residents of residential care settings.

## Location of Licensing, Certification, or Other Requirements

*Kansas Statutes Annotated*, Chapter 39: Statutes and Regulations for the Licensure and Operation of Assisted Living and Residential Health Care Facilities.

[http://www.aging.ks.gov/PolicyInfo\\_and\\_Regs/ACH\\_Current\\_Regs/ALF\\_Regs\\_Complete.pdf](http://www.aging.ks.gov/PolicyInfo_and_Regs/ACH_Current_Regs/ALF_Regs_Complete.pdf)

Kansas Department for Disability and Aging Services website: Adult Care Home Licensure Information, including links to regulations and other information about all types of adult care homes mentioned in this profile.

[http://www.aging.ks.gov/AdultCareHomes/ACH\\_Licensure\\_index.html](http://www.aging.ks.gov/AdultCareHomes/ACH_Licensure_index.html)

## Information Sources

Linda Mowbray  
Kansas Health Care Association

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<sup>63</sup> It was not possible to determine from online or other sources whether KanCare pays for services in residential health care facilities, boarding care homes, or home plus settings.

<sup>64</sup> Mollica, R.L. (2009). *State Medicaid Reimbursement Policies and Practices in Assisted Living*, National Center for Assisted Living, American Health Care Association. <http://www.ahcancal.org/ncal/resources/Documents/MedicaidAssistedLivingReport.pdf>. Current information about Medicaid room and board policies, the amount of the PNA, and family supplementation policy, was not available online or from other sources.

Patty Brown  
Regional Manager  
Kansas Department for Aging and Disability Services

## KENTUCKY

### Licensure Terms

Assisted Living Communities (certified), Personal Care Homes (licensed)

### General Approach

Assisted living communities must be certified by the Kentucky Department for Aging and Independent Living. Assisted living communities are considered private business entities and no public funding is available for services provided in this setting.

Personal care homes are licensed as long-term care facilities by the Kentucky Cabinet for Health Services, Office of Inspector General, Division of Health Care. Services may be reimbursed from the state general fund.

*Adult Foster Care.* Family care homes are licensed by the Cabinet for Health and Family Services and provide 24-hour supervision and personal care services in a residential accommodation to no more than three individuals who, because of impaired capacity for self-care, elect to have or require a protective environment but do not have an illness, injury, or disability for which constant medical care or skilled nursing services are required. Residents must be ambulatory or mobile non-ambulatory, and able to manage most of the activities of daily living (ADLs). Services may be reimbursed from the state general fund. *Regulatory provisions for family care homes are not included in this profile but a link to the provisions can found at the end.*

*This profile includes summaries of selected regulatory provisions for assisted living communities and personal care homes. The complete regulations are online at the links provided at the end.*

### Definitions

**Assisted living community** means a number of living units on the same site, operated as one business entity, and certified to provide services for five or more adults not related within the third degree of consanguinity to the owner or manager. Services include assistance with ADLs and instrumental activities of daily living (IADLs), housekeeping, scheduled daily social activities, and assistance with self-administration of medication.

**Personal care home** means an establishment located in a permanent building, which has resident beds. Services provided include continuous supervision, basic

health and health-related services, personal care services, residential care services,<sup>65</sup> and social and recreational activities.

## Resident Agreements

**Assisted Living Communities.** Lease agreements are required and must include information about a large number of topics, including: general services and fee structure; information regarding specific services that will be provided and associated fees; policies and procedures for payment, non-payment, refunds, and cancellations; discharge policies and procedures; terms of occupancy; reasonable rules of conduct for staff, management, and tenants; grievance policies and procedures; and tenant's rights.

Assisted living communities may not provide health care services. Upon entering into a lease agreement, an assisted living community must inform the resident in writing about policies relating to contracting or arranging for additional services.

**Personal Care Homes.** Upon admission to a personal care home, the resident and a responsible family member must be informed in writing of the home's policies, fees, reimbursement policies, visiting hours and visitation rights during serious illness, types of diets offered, and services to be provided.

## Disclosure Provisions

**Assisted Living Communities.** An assisted living community must provide any interested person with a copy of relevant sections of the statute and administrative regulations; and a description of any special programming, staffing, or training if the assisted living community markets itself as providing care for residents with particular needs or conditions.

**Personal Care Homes.** No provisions identified.

## Admission and Retention Policy

**Assisted Living Communities.** A resident must be ambulatory or mobile non-ambulatory, unless due to a temporary health condition for which health services are being provided in accordance with the relevant statute, and not be a danger to self or others.

**Personal care homes** may admit persons who are ambulatory or mobile non-ambulatory and whose care needs do not exceed the home's capability. Residents must

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<sup>65</sup> Residential care means services which include but are not limited to: room accommodations, housekeeping and maintenance services, dietary services, and laundering of resident's clothing and bed linens.

be able to manage most of their ADLs. Residents whose care is not within the scope of services of a personal care home must be transferred to an appropriate facility.

## Services

**Assisted Living Communities.** Services offered by assisted living communities include: help with personal ADLs such as bathing, dressing, grooming and hygiene, transferring, toileting, and eating; assistance with household and related activities, such as housekeeping, shopping, laundry, chores, and transportation; scheduled social activities determined by resident preferences; and assistance with self-administration of medications.

**Personal Care Homes.** All homes must provide basic health and health-related services, including: continuous supervision and monitoring of residents to ensure their health care needs are met, supervision of self-administration of medications, and arrangements for obtaining therapeutic services ordered by the resident's physician, which are not available in the facility. Other services include personal care, housekeeping, and laundry.

A personal care home must provide social and recreational activities to: (1) stimulate physical and mental abilities to the fullest extent; (2) encourage and develop a sense of usefulness and self-respect; (3) prevent, inhibit, or correct the development of symptoms of physical and mental regression due to illness or old age; and be of sufficient variety to meet the needs of the various types of residents.

### Service Planning

**Assisted Living Communities.** An assisted living community must complete a functional needs assessment prior to entering into a lease and at least annually for all residents, including those living in special programming units. The assessment must be updated to meet the ongoing needs of the resident.

**Personal Care Homes.** Residents must have a complete medical evaluation within 14 days prior to admission or upon admission.

### Third-Party Providers

**Assisted Living Communities.** Residents may arrange for additional services under direct contract or arrangement with an outside agent, professional provider, or other individual designated by the resident if permitted by the facility's policies.

**Personal Care Homes.** *No provisions identified.*

## Medication Provisions

**Assisted Living Communities.** Medication administration is not permitted. The statute allows assistance with self-administration of medications which means: reminding the resident to take medications; reading the medication's label; confirming that medication is being taken by the resident for whom it is prescribed; opening the dosage packaging or medication container, but not removing or handling the actual medication; storing the medication in a manner that is accessible to the resident; and making available the means of communicating with the resident's physician and pharmacy for prescriptions by telephone, facsimile, or other electronic device.

**Personal Care Homes.** *No provisions identified.*

## Food Service and Dietary Provisions

**Assisted Living Communities.** *No provisions identified.*

**Personal Care Homes.** Three meals a day and snacks are required and therapeutic diets may be provided. If provided, consultation with a qualified dietician or nutritionist is required unless the person responsible for food service has those qualifications. Menus must meet residents' nutrition needs as contained in the current recommended dietary allowances of the Food and Nutrition Board. Training for food staff must cover therapeutic diets.

## Staffing Requirements

### **Assisted Living Community**

**Type of Staff.** An assisted living community must have a designated *manager*.

**Staff Ratios.** *No minimum ratios.* Staffing in assisted living communities must be sufficient in number and qualification to meet residents' 24-hour scheduled and unscheduled needs and to provide all needed services. One awake staff member must be on site at all times.

### **Personal Care Home**

**Type of Staff.** All personal care homes must have an *administrator* who is responsible for the facility's operation and who must delegate such responsibility in his or her absence. The administrator must designate a staff person responsible for each of the following areas: the activities program, basic health and health-related services, food service, and record-keeping.

**Staff Ratios.** *No minimum ratios.* Staffing patterns are based on residents' needs. One attendant must be awake and on-duty on each floor in the facility at all times, and staffing must be sufficient in number and qualifications to meet resident's 24-hour scheduled needs.

## Training Requirements

**Assisted Living Communities.** All staff and management must receive orientation within 90 days of hire. Annual in-service education is required on topics appropriate to employees' assigned duties, including residents' rights, community policies, adult first-aid, cardiopulmonary resuscitation, adult abuse and neglect, Alzheimer's disease and other types of dementia, emergency procedures, the aging process, and assistance with ADLs and IADLs.

**Personal Care Homes.** All employees must receive in-service training corresponding to the duties of their respective jobs. In-service training must cover a range of topics, including:

- Facility policies in regard to the performance of employees' duties.
- Facility services.
- Procedures for reporting abuse, neglect, or exploitation.
- Residents' rights.
- Methods of helping residents to achieve maximum abilities in ADLs.
- Procedures for the proper application of physical restraints.
- Procedures for maintaining a clean, healthful, and pleasant environment.
- The aging process; the emotional problems of illness; use of medication; and therapeutic diets.

## Provisions for Apartments and Private Units

**Assisted Living Communities.** Each living unit in an assisted living community must include at least one unfurnished room with a lockable door, private bathroom with a tub or shower, provisions for emergency response, window to the outdoors, and a telephone jack. If an assisted living community has more than 20 units, each living unit must have an individual thermostat control. Any assisted living community that was open or under construction on or before July 14, 2000, is exempt from the requirement for each living unit to have a bathtub or shower. Such communities must have a minimum of one bathtub or shower for every five residents.

Most assisted living community units are single-occupancy. Dual-occupancy units are available only for married couples or for residents of the same sex who wish to share a unit. A maximum of two residents is allowed per unit and only by mutual agreement.

**Personal Care Homes.** The maximum number of beds per room is four. No more than 34 percent of beds in a facility may have rooms with more than two beds. In single-occupancy and dual-occupancy bedrooms with a private toilet room, the sink may be located in the toilet room. Where two residents' rooms share a common toilet, a sink must be provided in each resident room.

Facilities with central bathing areas must have bathrooms and showers/baths for each sex on each floor. One toilet is required for every eight residents, a sink for every 16 residents, and a shower/bathtub for every 12 residents. One shower stall and at least one toilet for each sex must be designed for wheelchair use.

## Provisions for Serving Persons with Dementia

### ***Dementia Care Staff and Unit Requirements***

*No provisions identified for either setting.*

### ***Dementia Staff Training***

**Assisted Living Communities.** The assisted living community must maintain a description of dementia-specific staff training that is provided, including at a minimum the content of the training, the number of offered and required hours of training, the schedule for training, and the staff who are required to complete the training.

**Personal Care Homes.** *No provisions identified.*

## Background Checks

Each assisted living community or personal care home must request all conviction information from the Justice and Public Safety Cabinet for any applicant for employment. Persons are precluded from employment if they have been convicted of a felony offense related to theft; abuse or sale of illegal drugs; abuse, neglect, or exploitation of an adult; or a sexual crime.

## Inspection and Monitoring

**Assisted Living Communities.** Unless there is a formal complaint lodged against a facility, the state does not conduct oversight and monitoring of the quality of care in assisted living communities. The state conducts a certification review upon application, and a recertification review every 2 years. These reviews ensure compliance with the certification requirements. The initial and recertification review process for assisted living communities includes an unannounced on-site visit.

**Personal Care Homes.** The regional offices of the Division of Health Care are responsible for conducting annual on-site visits of all long-term care facilities in the state, including personal care homes, to determine compliance with applicable licensing regulations. All inspections are unannounced.

## Public Financing

The state does not use Medicaid to cover services in assisted living communities or personal care homes. Services in personal care homes and family care homes are covered in part through the State Assistance Programs for Supplemental Security Income (SSI) recipients as described below.

### **Room and Board Policy**

The state provides an optional state supplement (OSS) to every aged, blind, and disabled person who is an SSI recipient and resides in a personal care home or a family care home. In 2014, the maximum amount paid to a personal care home was \$1,241 a month--\$520 from the state and \$721 from the resident's federal SSI payment.<sup>66</sup> A personal care home must accept as full payment for room, board, and cost of care the amount of the combined OSS and SSI payment less a \$60 personal needs allowance (PNA) that is retained by the resident.

## Location of Licensing, Certification, or Other Requirements

*Kentucky Revised Statutes*, Title XVII, Chapter 194A, 700 to 729: Assisted Living Communities. [November 23, 2014]  
<http://www.lrc.ky.gov/Statutes/chapter.aspx?id=38056>

*Kentucky Administrative Regulations*, Title 902, Chapter 20:036: Operation and services; personal care homes. [January 19, 1999]  
<http://www.lrc.state.ky.us/kar/902/020/036.htm>

*Kentucky Administrative Regulations*, Title 902, Chapter 20:03: Facility specifications; personal care homes. [January 12, 1990]  
<http://www.lrc.state.ky.us/kar/902/020/031.htm>

*Kentucky Administrative Regulations*, Title 902, Chapter 20:041: Operation and services; family care homes. [March 17, 1999]  
<http://www.lrc.state.ky.us/kar/902/020/041.htm>

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<sup>66</sup> In 2014, the combined OSS and SSI payment for an eligible resident of a family care home was \$893 and the PNA was \$40. The OSS amount was \$132.

*Kentucky Revised Statutes 216.789*: Prohibition against employing certain felons at long-term care facilities, in nursing pools providing staff to nursing facilities, or in assisted-living communities. [July 15, 1994]

<http://www.lrc.ky.gov/statutes/statute.aspx?id=9114>

*Kentucky Administrative Regulations*, Title 921, Chapter 2:015: Supplemental programs for persons who are aged, blind, or have a disability. [February 19, 2014]

<http://www.lrc.ky.gov/kar/921/002/015.htm>

## Information Sources

Bob White  
Executive Director  
Kentucky Assisted Living Facilities Association

Marilyn Ferguson, RN, NCI  
Department for Medicaid Services  
Division of Community Alternatives

## LOUISIANA

### Licensure Terms

Adult Residential Care Providers

### General Approach

All adult residential care facilities (RCFs) (also known as board and care facilities, assisted living facilities (ALFs), personal care homes, shelter care homes, foster homes, and other names) must be licensed, including facilities or agencies owned or operated by any governmental, profit, non-profit, private, or church organization.

The Department of Health and Hospitals, Health Standards Section, licenses four “levels” of adult residential care: personal care homes (Level 1), shelter care homes (Level 2), ALFs (Level 3), and adult residential care (Level 4).

The Level 4 licensing was adopted in December 2008 as a result of legislation filed in 2004 to launch a Medicaid-funded assisted living service. This “medical” model of adult residential care/assisted living allows for Level 4 facilities to administer medications (by licensed nursing personnel only) and perform limited nursing services--tasks that are not allowed in facilities licensed at Levels 1-3.

The regulations for adult residential care include: (1) core requirements for all four levels; and (2) separate requirements regarding administrators, staff training, and living units for the first three levels, which are described in this profile.

Requirements for Level 4 licensure are not included in this profile because the state imposed a 5-year moratorium on the Level 4 Adult Residential Care License on April 25, 2012. At the time the moratorium was enacted, only three providers in the state had applied for licensure under the Level 4 regulations and they were “grandfathered” under the moratorium’s provisions. Additionally, the state is currently revising the regulations--including those related to medication administration--and they are not expected to be finalized until late 2015.

Adult foster care is provided in a personal care home, which is a Level 1 adult residential care home (ARCH) that provides room and board and personal services to two but no more than eight residents in a group living and dining setting, and is located in a home that is designed as any other private dwelling in the neighborhood.

The regulations for adult residential care include: (1) core requirements for all four levels; and (2) separate requirements regarding administrators, staff training, and living units for the first three levels, which are described in this profile.

*This profile includes summaries of selected regulatory provisions for adult residential care providers. The complete regulations are online at the links provided at the end.*

## Definitions

**Adult residential care provider** means a facility, agency, institution, society, corporation, partnership, company, entity, residence, person or persons, or any other group that provides residential care for compensation to two or more adults who are unrelated to the licensee or operator. Depending on the level of licensure, adult residential care includes but is not limited to the following services: lodging, meals, housekeeping, laundry, medication administration, intermittent nursing services, assistance with personal hygiene, assistance with transfers and ambulation, and assistance with dressing.

**Level 1. A personal care home** is an adult RCF that provides room and board and personal services to two but not more than eight residents in a group living and dining setting, and is located in a home that is designed as any other private dwelling in the neighborhood.

**Level 2. A shelter care home** is an adult RCF that provides room and board and personal services to nine or more residents in a group living and dining setting.

**Level 3. An assisted living home/facility** is an adult RCF that provides room and board and personal services to two or more residents who reside in individual living units that contain, at a minimum, one room with a kitchenette and a private bathroom.

**Level 4. An adult residential care facility** furnishes lodging, meals, housekeeping, laundry, medication administration, intermittent nursing service, and assistance with personal hygiene, transfers, ambulation, and dressing.

**Alzheimer's Special Care Unit (ASCU)** means any adult residential care provider that segregates or provides a special program or special unit for residents with a diagnosis of probable Alzheimer's disease or other dementia so as to prevent or limit access by a resident to areas outside the designated or separated area, or that advertises, markets, or otherwise promotes the facility as providing specialized Alzheimer's/dementia care services.

## Resident Agreements

The state requires providers to have admission agreements that specify the facility's policies and rules, the rights and responsibilities of the facility and resident, the

cost of basic and optional services and payment provisions, and the terms and conditions of continued occupancy.

## **Disclosure Provisions**

*No provisions identified.*

## **Admission and Retention Policy**

Residents may include those who need or wish to have available room, board, personal care, and supervision due to age, infirmity, physical disability, or social dependency. Residents with advanced or higher care needs beyond routine personal care may be accepted or retained if they can provide or arrange for care through appropriate private duty personnel, do not need continuous nursing care for more than 90 days, and if the provider can meet their needs.

Providers may discharge residents when: (1) the resident's physician certifies that the resident needs continuous nursing care, other than on a temporary basis not to exceed 90 days, and the resident or responsible person is unable or unwilling to provide private duty care and assume full responsibility for such care. In this situation, plans for another placement must be made as soon as possible; (2) the resident's condition is such that he or she is a danger to self or others or is consistently disruptive to the peace and order of the facility, staff services, or other residents; or (3) when it comes to the provider's attention that a resident is being neglected due to the failure of the family or the contracted outside agency to provide needed services.

## **Services**

Providers must furnish adequate services and oversight/supervision, including adequate security measures, around the clock as needed for any resident.

Providers at Levels 1-3 are licensed to provide assisted living services that are described as a coordinated array of supportive personal services, 24 hour supervision and assistance (scheduled and unscheduled), activities, and health-related services that are designed to allow the individual to reside in the least restrictive setting of his/her choice, to accommodate individual resident's changing needs and preferences, to maximize the resident's dignity, autonomy, privacy and independence, and to encourage family and community involvement.

Basic services provided include assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs), basic personal laundry services, opportunities for individual and group socialization and utilization of community

resources, housekeeping, transportation, services for residents who have behavior problems, recreational activities, and assistance with self-administration of medications.

Providers must plan or arrange for health assessments, health care monitoring, and assistance with health tasks as needed or requested. Facilities must have the capacity to provide transportation for medical services, personal services (barber/beauty), personal errands, and social/recreational activities.

### ***Service Planning***

Providers must complete a pre-admission appraisal of each applicant to assess his or her needs and appropriateness for admission. Once admitted, the provider must conduct an assessment of the resident's needs and preferences to develop a service plan. The service plan must include the scope, frequency, and duration of services and monitoring that will be provided to meet the resident's needs, and the staff/providers responsible for furnishing the services, inclusive of third-party providers.

The service plan must be revised when a resident's condition or preferences change. Providers must conduct a documented review of the service plan at least quarterly, and make changes at any time as needed.

### ***Third-Party Providers***

Family members may provide services not available through the facility, or residents may arrange for such care at their own expense, as long as the resident remains in compliance with the conditions of residency. Facilities may not arrange or contract for health-related services in addition to those allowed by regulation but they must ensure that the needed services are provided, even if those services are to be provided by the resident's family or by an outside source under contract with the resident.

## **Medication Provisions**

As allowed by state laws and regulations, staff may assist residents in the self-administration of prescription and non-prescription medication as agreed to in their contract or service plan. Assistance with self-administration of medication is limited to the following:

- The resident may be reminded to take his/her medication.
- The medication regimen, as indicated on the container, may be read to the resident.
- The dosage may be checked according to the container label.

- Staff may open the medicine container (i.e., bottle, medi-set, blister pack, etc.) if the resident lacks the ability to open the container.
- The resident may be physically assisted in pouring or otherwise taking medications, so long as the resident understands what the medication is and why they are taking the medication.

A resident's family, other relatives, or the resident's personal representative may transfer medication from the original container to a medication reminder container (pill organizer box), if desired by the resident. Residents may contract with an outside source for medication administration; however, facilities may not contract for this service.

Staff who provide assistance with the self-administration of medications by residents must have documented training on the medication assistance policies and procedures, including the limitations of this assistance. This training must be repeated at least annually.

## Food Service and Dietary Provisions

Facilities must provide three meals a day. Menus must be reviewed and approved by a nutritionist or dietician to ensure nutritional appropriateness. Facilities must make reasonable accommodations to meet dietary requirements and religious and ethnic preferences; to meet residents' temporary schedule changes and preferences; to make snacks, fruit, and beverages available when requested; and to provide meals in a resident's room, if needed on a temporary basis. The facility must furnish medically prescribed special diets for which it contracts in the resident's contract or service plan; these menus must be planned or approved by a registered licensed dietician.

## Staffing Requirements

**Type of Staff.** Each facility must have a *director*, designated *recreational/activity staff*, and *direct care staff*. Direct care staff may include care assistants, social workers, activities personnel, or other staff who clearly provide direct care services to residents on a regular basis. One person may occupy more than one position.

**Staff Ratios.** *No minimum ratios.* Facilities must be sufficiently staffed to properly safeguard residents' health, safety, and welfare. Providers must demonstrate that sufficient staff are scheduled and available to meet residents' 24-hour scheduled and unscheduled needs and show adequate coverage for each day and night shift. Assisted living and shelter care facilities must have at least one staff person on duty and awake 24 hours a day. A direct care staff person who is not in the facility, but who is on call, must not be included as direct care staff on any shift.

## Training Requirements

Directors must complete 12 hours of continuing education per year in areas related to the field of geriatrics, assisted living concepts, specialized training in the population served, and/or supervisory/management techniques.

An orientation program for all staff must include but not be limited to thorough coverage of the following topics: facility policies and procedures, emergency and evacuation procedures, residents' rights, procedures for and legal requirements concerning the reporting of abuse and critical incidents, and instruction in the specific responsibilities of each employee's job. The provider must review the procedures with existing staff at least once in each 12-month period.

The facility must provide an additional 5 days of supervised training for direct care staff. At a minimum this training must include training in resident care services (ADLs and IADLs), infection control, and any specialized training to meet resident needs. All direct care staff must be certified in adult first-aid within the first 30 days of employment.

The orientation and 5 days of supervised training meets the first year's annual training requirements. In subsequent years, the provider must ensure that each direct care worker receives annual training that includes the topics covered by the orientation and the additional 5 days of supervised training stated above.

## Provisions for Apartments and Private Units

***Shelter Care Facilities and Personal Care Homes.*** Apartment-style units are not required. Rooms are shared by no more than two residents, and in shelter care facilities they must agree in writing to share a room (husbands and wives do not have to sign such an agreement). There must be adequate toilet, bathing, and hand-washing facilities in accordance with the current edition of the state Sanitary Code.

***Assisted living facilities*** must offer apartment-style units with lockable doors to ensure privacy, dignity, and independence. Each unit must include at a minimum: (1) a food preparation area consisting of a sink with hot and cold running water, electrical outlets, mini refrigerator, cooking appliance (such as microwave or stove), food storage cabinets, and counter space; (2) an Americans with Disabilities Act-accessible private bath which includes a toilet, sink, and shower or tub; (3) dining/sitting/bedroom area; (4) storage/closet space; (5) an operating emergency call system (wired or wireless) that is easily accessible to the resident in the event of an emergency and that registers at a location that is monitored at all hours of the day and night; and (6) HVAC thermostats that can be individually controlled by the resident and at least one telephone outlet.

There must be no more than two bedrooms per living unit and residents in double-occupancy units must have the right to select their roommates. Entrance to a bathroom from one bedroom must not be through another bedroom. An efficiency/studio living unit or a bedroom designed for one individual may be shared with another individual only if he or she is a spouse/relative or live-in companion and only if both parties agree, in writing. Residents sharing a living unit with a two-person bedroom must be allowed to choose their roommate. Both individuals must agree, in writing.

## Provisions for Serving Persons with Dementia

***Dementia Care Staff.*** No provisions identified.

***Dementia Staff Training.*** Staff of facilities that operate ASCUs or market themselves as providing Alzheimer's/dementia care must have specified training. Staff who provide direct face-to-face care to residents must obtain at least 8 hours of dementia-specific training within 90 days of employment and 8 hours of dementia-specific training annually. The training must include the following topics: an overview of Alzheimer's disease and other dementias, communicating with persons with dementia, behavior management, promoting independence in ADLs, and understanding and dealing with family issues.

Staff who have regular contact with residents, but who do not provide direct face-to-face care, must obtain at least 4 hours of dementia-specific training within 90 days of employment and 2 hours of dementia training annually. This training must include the following topics: an overview of dementias and communicating with persons with dementia. Staff who have only incidental contact with residents must receive general written information provided by the facility on interacting with residents with dementia.

***Dementia Facility Requirements.*** If a facility accepts residents with dementia or residents at risk of wandering, an enclosed area must be provided adjacent to the facility so that the residents may safely go outside.

## Background Checks

Prior to licensure and hiring, all board members, owners, and staff must have criminal background checks conducted in accordance with state law. Licenses may be denied or revoked based on: (1) a criminal conviction of any board member, owner, or staff if the act that caused the conviction would cause harm to a resident if repeated; or (2) a criminal conviction of any board member, owner or staff member against a resident if that board member, owner or staff member remains associated with the facility.

## Inspection and Monitoring

Before a license is issued, a licensure survey must be conducted to verify compliance with licensing standards. The Bureau of Licensing may perform an on-site survey and inspection upon annual renewal of a license and inspects facilities at regular intervals, not to exceed one year or such shorter periods as may be necessary, and without prior notice. Complaints are reviewed and investigated by the appropriate state agency. The Bureau develops and facilitates coordination of its inspections with other authorized local, state, and federal agencies making inspections of ARCHs.

## Public Financing

The state does not currently use Medicaid to cover services in RCFs under either the Medicaid State Plan or a 1915(c) waiver program, and does not supplement the federal Supplemental Security Income payment.

## Location of Licensing, Certification, or Other Requirements

*Louisiana Administrative Code*, Title 48, Chapter 88: Adult Residential Care Minimum Standards. [March 31, 1999]

<http://new.dhh.louisiana.gov/index.cfm/directory/detail/702>

*Louisiana Administrative Code*, Title 48, Chapter 68: Adult Residential Care Providers Licensing Standards, Alzheimer's Special Care Units. [August 20, 2009]

<http://new.dhh.louisiana.gov/assets/medicaid/hss/docs/ARCP/ARCDementiaTrngRuleLAReg200908.pdf>

## Information Sources

Christopher Vincent, RN, BSN  
Medical Certification Program Manager  
Department of Health and Hospitals  
Health Standards Section

## MAINE

### Licensure Terms

Assisted Housing Program, which includes the following types: Assisted Living Programs; Residential Care Facilities Levels I, II, III, and IV; and Private Non-Medical Institutions Levels I, II, III, and IV

### General Approach

The Maine Department of Health and Human Services (DHHS), Division of Licensing and Regulatory Services licenses nine types of facilities that provide assisted living services under the umbrella licensing term of assisted housing programs, namely: assisted living programs (ALPs) and four levels each of residential care facilities (RCFs) and private non-medical institutions (PNMIs). The latter two may offer the same services as ALPs, but provide bedrooms rather than apartment units.

The rules for PNMIs are the same as those for RCFs; they are licensed as a separate type of assisted housing program only because they receive Medicaid funding for the provision of personal care services to their residents and therefore must comply with additional requirements as specified in various sections of the licensing rules. In this profile, the rules listed for each of the four levels of licensing apply to both RCFs and PNMIs.

Multilevel facilities are assisted housing programs that are located on the same contiguous grounds with licensed nursing facilities, adult day services programs, or home health agencies. For such facilities, a single license is issued that identifies each level of service and the facility must meet all of the state rules and regulations with regard to the operation of each type of facility.

An adult family care home (AFCH) is a residential-style home for eight or fewer residents, which is licensed by DHHS as an Assisted Housing Program Residential Care Facility,<sup>67</sup> Level III or IV, and is primarily engaged in providing services to the elderly. MaineCare, the state's Medicaid program, covers services that include personal care, medication management, and supervision. If an AFCH serves only private pay residents, it can be licensed as a Level I or Level II Assisted Housing Program Residential Care Facility.

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<sup>67</sup> This constitutes a conflict of information between the DHHS licensing rules and the MaineCare Benefits Manual chapter on adult family care in that RCFs funded through Medicaid must be licensed as private non-medical institutions, as stated above. We were unable to get clarification of this conflict of information from state staff.

*The information in this profile, unless it specifically references different types of licensed assisted housing programs, applies to all of them. This profile includes summaries of selected regulatory provisions. The complete regulations are online at the links provided at the end.*

## Definitions

**Assisted living services** means the provision by an assisted housing program--either directly by the provider or indirectly through contracts with persons, entities or agencies--of: (1) assisted housing services, which include personal supervision; protection from environmental hazards; assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs); diversional, motivational or recreational activities; dietary services; and care management services; (2) assisted housing services with the addition of medication administration; or (3) assisted housing services with the addition of medication administration and nursing services, which are defined as services provided by licensed professional nurses that include coordination and oversight of resident care services provided by unlicensed health care assistive personnel.<sup>68</sup>

Assisted living services may be provided in four settings--ALPs, independent housing with services programs (IHSPs), RCFs, and PNMIIs.

**Assisted living program** means a program of assisted living services provided to residents in private apartments in buildings that include a common dining area. The types of ALPs are as follows:

- Type I: services include medication administration.
- Type II: services include medication administration and nursing services as defined above.

**Independent housing with services program** means a program of assisted living services provided to residents in private apartments in buildings that include a common dining area, either directly by the provider or indirectly through contracts with persons, entities, or agencies. Like ALPs, they assist residents with ADLs and IADLs. The major difference between the two settings is that IHSP providers do not offer medication administration or nursing services and therefore do not require licensure.

**Residential care facility** means a house or other place that is maintained wholly or partly for the purpose of providing residents with assisted living services. RCFs provide housing and services to residents in private or semi-private bedrooms in buildings with common living areas and dining areas. The four types of RCFs are:

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<sup>68</sup> Unlicensed health care assistive personnel means individuals employed to provide hands-on assistance with ADLs to individuals in homes, ALPs, RCFs, private non-medical institutions, hospitals, and other health care settings. Unlicensed health care assistive personnel does not include certified nursing assistants (CNAs) employed in their capacity as CNAs.

- Level I: licensed capacity of 1-2 residents (licensing is voluntary for this group).
- Level II: licensed capacity of 3-6 residents.
- Level III: licensed capacity of 3-6 residents and employment of three or more persons who are not owners and are not related to the owner.
- Level IV: licensed capacity of more than six residents.

**Private non-medical institution** means a house or other place that is maintained wholly or partly for the purpose of providing residents with assisted living services. PNMI's are a type of RCF that receives Medicaid funds and complies with additional requirements as specified in various sections of the licensing rules. Otherwise, the four levels of PNMI's are the same as the four RCF levels defined above.

**Alzheimer's/dementia care unit** means a unit, facility, or distinct part of a facility that provides care/services in a designated separate area for residents with Alzheimer's disease or other dementias. The unit, facility, or distinct part provides specialized programs, services, and activities and is locked, segregated, or secured to provide or limit access by a resident outside the designated or separated area.

## Resident Agreements

Each provider and each resident, or someone authorized to act on the resident's behalf, must sign a standard contract issued by the Department at admission and when an existing contract is to be modified. All resident contracts must contain provisions regarding services and accommodations to be provided and the rates and charges for such, and any other related charges not covered by the facility's/program's basic rate.

The contract may contain additional provisions that do not conflict with the licensing regulations. The provider may supplement but not replace the standard provisions, as long as they are consistent with the applicable assisted housing program rules. The facility's grievance procedure, tenancy obligations (if applicable), admissions policy, and residents' rights must be appended to the standard contract.

## Disclosure Provisions

In addition to the resident contract, facilities must provide an information packet that includes information about advance directives; the type of facility, its licensing status, and staff qualifications; admission, transfer, and discharge policies and procedures; and the Maine Long-Term Care Ombudsman Program. The packet must also include toll-free telephone numbers for the Adult Protective Services program, the licensing agency, and the Office of Advocacy of the Department of Behavioral and Developmental Services (BDS) if the facility has residents who receive BDS services.

When an assisted housing program operates a unit meeting the requirements of an Alzheimer's/dementia care unit as all or part of its program, it must give residents and family members, or any other authorized representative, the following information:

- A written statement of the provider's service philosophy.
- The process used for resident assessment and the establishment of a residential services plan and its implementation.
- The physical environment and design features that support the functioning of adults with cognitive impairments.
- The frequency and types of group and individual activities the program provides.
- A description of family involvement and the availability of family support programs.
- A description of the facility's security measures.
- A description of in-service training provided for staff.
- Admission and discharge policies and procedures.

Assisted housing programs must list all standard charges and make them available to the public.

## **Admission and Retention Policy**

The rules encourage aging in place through flexible provisions. When applying for licensure, all facilities must describe their admission policies and the types of services, including the scope of nursing services, to be provided.

Residents may be discharged if: (1) the facility cannot meet their needs; (2) their intentional behavior results in substantial physical damage to the property; or (3) they become a direct threat to others' health or safety.

At the time of admission to an Alzheimer's/dementia unit, or within 30 days of admission, a resident's individual record must contain documentation of a physician's diagnosis of Alzheimer's disease or dementia, and documentation of the legal representative's authority to admit the individual to the unit.

## Services

**Assisted living programs** must offer service coordination, housekeeping services, assistance with ADLs and IADLs, chore services, and other services identified in a service plan.

**Residential Care Facilities/Private Non-Medical Institutions.** Levels I, II, and III providers must coordinate appropriate health care services and assist residents to access them. The facility must provide or arrange transportation to medical and other appointments. Nursing services must be provided by professional nurses, including the coordination and oversight of assisted living services that are provided by unlicensed assistive personnel.

Level IV residents are able to receive individualized services to help them age in place, function optimally in the facility and in the community, engage in constructive activity, and manage their health conditions. The facility must ensure, to the extent practicable, that residents' choices and preferences will be accommodated. The licensing rules require the provision of reasonable accommodation in regulations, policies, practices, or services, including permitting reasonable supplementary services to be brought into the facility/program unless it imposes an undue financial burden or results in a fundamental change in the program.

Medicaid covers services provided by PNMI as follows: personal care, housekeeping, laundry, dietary, and other services, including clinical consultant services; interpreter services; licensed practical nurse services; licensed social workers or other social worker services; practical nurses; registered nurse (RN) consultant services; and other qualified medical and remedial staff.

**Alzheimer's/dementia care units** must provide individual and/or group activities covering gross motor skills, self-care, social interaction, crafts, and sensory enhancement, as well as outdoor and spiritual activities.

### **Service Planning**

**Assisted Living Programs.** Residents in ALPs need to be assessed within 30 calendar days of admission and reassessed at least every 6 months thereafter.

**Residential Care Facilities/Private Non-Medical Institutions Levels I and II.** Providers must ensure that each resident's abilities and needs are adequately assessed and that each resident is offered all necessary services.

**Residential Care Facilities/Private Non-Medical Institutions Levels III and IV.** Residents must be assessed<sup>69</sup> within 30 calendar days of admission and reassessed

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<sup>69</sup> PNMI residents must be assessed using the state-approved Resident Assessment Instrument as required by the agency providing Medicaid funding.

annually or when there is a significant change in condition. A service plan must be developed and implemented within 30 calendar days of admission.

### ***Third-Party Providers***

Assisted living services may be provided indirectly through written contracts with persons, entities, or agencies.

## **Medication Provisions**

***All Facilities.*** Upon admission, all residents must be assessed for their ability to self-administer medications and their need for assistance. Unlicensed staff who have successfully completed a training program approved by the licensing agency may administer medications and/or treatments. Administration of medications means reading labels for residents, observing residents taking their medications, checking the dosage, removing the prescribed dosage, filling a syringe and administering insulin and bee sting kits (when permitted), and the maintenance of a medication record for each resident.

With the exception of bee sting kits and insulin, no injectable medications may be administered by an unlicensed person. Unlicensed persons must be trained by a registered professional nurse with regard to safe and proper use of a bee sting kit and insulin administration.

***Assisted living program and Residential Care Facilities/Private Non-Medical Institutions Levels III and IV.*** A person qualified to administer medications must be on site at the ALP whenever a resident has medications prescribed “as-needed” (PRN) if this medication is not self-administered. All unlicensed assistive personnel administering medications and/or treatments must complete a Department-approved 8-hour refresher course every 2 years for recertification within 2 years of the original certification. Whenever the standards or guidelines of the medication administration course are substantially revised, unlicensed personnel must be recertified within 1 year of the revision, using a Department-approved method.

## **Food Service and Dietary Provisions**

***Assisted Living Programs.*** At least one nutritious meal a day must be provided by the ALP.<sup>70</sup> A registered dietician must approve menus annually. Menus must be planned in accordance with residents’ needs and preferences. Therapeutic diets are considered treatments and must be ordered, in writing, by a duly authorized licensed practitioner, and must be planned, in writing, and approved by a registered dietitian.

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<sup>70</sup> The regulations do not address how residents in facilities that provide only one meal can obtain additional meals.

**Residential Care Facilities/Private Non-Medical Institutions.** Levels I-IV require a nourishing, well-balanced diet that meets the daily nutritional and special dietary needs of each resident and that meets the Recommended Dietary Allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences. In addition, Level IV facilities must have a meal plan that provides three meals in a 24-hour period and a dietary coordinator who has experience and/or training in food service suitable to the size of the facility.

## Staffing Requirements

### **Assisted Living Programs**

**Type of Staff.** Each facility must have an *administrator* who holds a current professional license related to residential care, ALPs, or health care.

**Staff Ratios.** *No minimum ratios.*

### **Residential Care Facilities/Private Non-Medical Institutions**

**Type of Staff.** Level I, II, and III *providers* are responsible for the overall operation of the facility and must have a person available to provide supervision in their absence. The provider must coordinate appropriate health care services and assist residents to access them. Nursing services are provided by *professional nurses*.

The Department reserves the right to require: (1) pharmacist consultation if it finds serious or multiple deficiencies in medication administration; (2) licensed nurse consultation if it finds serious or multiple deficiencies in residents' health care; and (3) a qualified consultant dietitian if it finds serious or multiple deficiencies in food service.

Level IV facilities require an on-site *administrator* who is licensed as a multilevel or resident facility administrator<sup>71</sup> and who is responsible for the facility's overall operation. In the absence of the administrator during the normal working day, a competent individual, authorized to act must be designated. Each facility must retain a *registered nurse* (other than the administrator), either on staff or on a contractual basis, to observe residents' signs and symptoms, review residents' records for completeness and accuracy, review medication records, review medication administration practices and procedures, review therapeutic diets, recommend staff training, and undertake other reviews or make other recommendations as necessary.

Each facility of more than ten beds must retain the services of a *pharmacist* consultant no less than quarterly. The Department reserves the right to require the facility to obtain the services of a qualified consultant dietitian if it finds serious or multiple deficiencies in food service.

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<sup>71</sup> Unlicensed administrators must complete an approved training program.

**Staff Ratios.** Staffing in all licensed RCF/PNMI settings must be adequate to implement service plans and provide a safe setting. The Department may require additional staff based on residents' needs and the facility's size and layout.

Level IV facilities with ten or fewer beds are required to have, at a minimum, one responsible adult on-site at all times whenever residents are present, to perform resident care and provide supervision. This person must possess the health and judgment determined necessary by the Department to carry out assigned duties; to determine this, the Department may require an examination and submission of a written report from a duly authorized licensed practitioner or licensed psychologist.

Level IV facilities with more than ten beds are required to have at least two responsible awake adults on duty and readily available at all times. In addition, the following ratios of minimum *resident care* staff-to-residents must be maintained at all times: 1:12 from 7:00 a.m. to 3:00 p.m., 1:18 from 3:00 p.m. to 11:00 p.m., and 1:30 from 11:00 p.m. to 7:00 a.m.

Resident care staffing means the functions of direct care and supervision, activities, housekeeping, laundry, and social services. It does not include the functions of administration, maintenance, and dietary services. If fewer than two resident care staff are required by the minimum staff-to-resident ratio in a facility with more than ten beds (e.g., between 11:00 p.m. to 7:00 a.m.), a staff person serving in another capacity may be considered as the required second responsible on-duty awake person.

## Training Requirements

**Assisted Living Programs.** The licensee must attend any training sessions that the Department determines are necessary to meet licensing standards. The administrator must attend any training sessions mandated by the Department.

**Residential Care Facilities/Private Non-Medical Institutions.** All staff in Levels I, II, and III must attend and show evidence of successful completion of any training that the Department determines is needed.

Level IV staff (other than CNAs and licensed professional staff) whose job responsibilities include direct service to residents for at least 20 hours per week, must successfully complete a Personal Support Specialist certification course within 120 days of hiring. All regular staff must have in-service training, at least annually, in areas related to the specific needs of the residents served. Administrators must complete 12 hours of continuing education per year in areas related to the care of the population the facility serves.

## Provisions for Apartments and Private Units

**Assisted living programs** are multi-unit residential buildings that provide apartments and must meet state and local building codes. A private apartment is a private dwelling unit with an individual bathroom, bedroom, and a food preparation area. The rules require facilities to permit reasonable modifications to the existing premises at the tenants' expense, or other willing payer, to enable persons with disabilities to reside in licensed facilities. Providers may require disabled individuals to return the premises to its prior condition upon their discharge.

**Residential Care Facilities/Private Non-Medical Institutions** provide housing and services to residents in private<sup>72</sup> or semi-private bedrooms in buildings with common living areas and dining areas. Only two residents are allowed per unit. Couples who reside in the facility have the right to share a room.

For all Level I, II, and III facilities licensed on or after 2004,<sup>73</sup> a bathroom equipped with flush toilets and hand-washing facilities must be provided for each six users. Users include residents, as well as staff on duty. *No provisions identified for bathtubs or showers.*

Level IV facilities must provide one toilet and sink for every six users. Users include residents, as well as staff on duty. There must be at least one dedicated staff bathroom and public toilets at specified ratios (e.g., one public bathroom for 1-25 residents). Facilities licensed on or after May 30, 2002, must have one bathing facility for every ten users (one for 15 users for facilities licensed prior to May 30, 2002). Facilities initially licensed after May 29, 1998, must have at least one tub or shower for each floor that has resident bedrooms. Facilities initially licensed on or after May 30, 2002, must have at least one bathroom that includes, at a minimum, a toilet and hand-washing sink on each floor that has resident bedrooms.

## Provisions for Serving Persons with Dementia

**Dementia Care Staff.** *No provisions identified.*

**Dementia Staff Training.** Pre-service training is required for staff who work in Alzheimer's/dementia care units and includes a minimum of 8 hours classroom orientation and 8 hours of clinical orientation. The trainer(s) must be qualified with experience and knowledge in the care of individuals with Alzheimer's' disease and other dementias. In addition to the usual facility orientation, which covers such topics as residents' rights, confidentiality, emergency procedures, infection control, facility

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<sup>72</sup> Private rooms are not required under MaineCare, but if there is a medical necessity for a private room, the facility must make one available.

<sup>73</sup> No provisions were identified for facilities licensed before 2004.

philosophy related to Alzheimer's/dementia care, and wandering/egress control, the 8 hours of classroom orientation must also include the following topics:

- A general overview of Alzheimer's disease and other dementias.
- Basic communication techniques.
- Creating a therapeutic environment.
- Activity-focused care.
- Dealing with difficult behaviors.
- Understanding and addressing family issues.

***Dementia Facility Requirements.*** The unit must be designed to accommodate residents with dementia, enhance their quality of life, and promote their safety. In addition to the physical plant standards required for licensure, an Alzheimer's/dementia care unit must have adequate space for dining, group and individual activities and family visits, and must provide freedom of movement between common areas and residents' rooms. Residents may not be locked inside or outside their rooms.

For facilities licensed after May 29, 1998, the design must include: secured outdoor space and walkways, which allow residents to ambulate but prevent undetected egress; high contrast between floors, walls, and doorways; non-reflective surfaces; and lighting to minimize glare. Facilities must also have policies and procedures to deal with wandering. Electronic locking devices may be used on exterior doors if they release in an emergency.

Residents are encouraged and assisted to decorate their unit with personal items and furnishings and facilities must individually identify each resident's room to help with recognition.

## Background Checks

***All Facilities.*** During the licensure process, a criminal background check is conducted for CNAs, CNAs who have received special training in medication administration (CNA-M), and the administrator. Facilities may not employ a CNA or CNA-M who is not on the CNA Registry, or who has been cited for abuse, neglect, or misappropriation of patient/client/resident funds in a health care setting.

***Assisted Living Programs.*** The facility may not hire as unlicensed assistive personnel any individuals who have been convicted in a court of law of a crime involving abuse, neglect or misappropriation of property in a health care setting; or who have been the subject of a complaint involving abuse or neglect that was substantiated by the Department and that was entered on the Maine Registry of Certified Nursing Assistants; or has been the subject of a complaint involving the misappropriation of property in a health care setting, which was substantiated by the Department and entered on the Maine Registry of Certified Nursing Assistants.

## Inspection and Monitoring

DHHS makes regular and unannounced inspections of all facilities prior to initial licensure, prior to the expiration of a license, in response to complaints, and as often as deemed necessary to determine continued compliance with applicable laws and regulations.

## Public Financing

The state pays for services in assisted housing programs through the Medicaid MaineCare State Plan and the MaineCare 1915(c) Elderly Waiver program. Maine also has several non-Medicaid state-funded affordable assisted living facilities (ALFs) and IHSP facilities.

### ***Room and Board Policy***

The state limits room and board charges for Medicaid-eligible residents in PNMIs, residential care homes, and AFCH s to the current Supplemental Security Income (SSI) payment plus an optional state supplement (OSS). In 2011, the SSI payment was \$674 and the maximum OSS payment was \$234. The amount of a personal needs allowance (PNA) was not stated.<sup>74</sup>

PNMIs may permit payment by a relative of an additional amount to enable a Medicaid-eligible resident to obtain a private room, telephone, television, or other non-covered services. However, the additional charge may not exceed the charge to private pay residents. For example, the supplement for a private room must be no more than the difference between the private pay rate for a semi-private room and a private room rate. This provision does not apply if private rooms are standard in the facility. The resident or relative making the additional payment must sign a statement that he/she was notified and agreed to the payment for the private room or non-covered services before they were provided.

Room and board charges for residents in the non-Medicaid state-funded ALFs and IHSP settings are subject to the U.S. Department of Housing and Urban Development Fair Market Rents for the town in which they live.

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<sup>74</sup> Social Security Administration, *State Assistance Programs for SSI Recipients*, January 2011. [http://www.socialsecurity.gov/policy/docs/progdesc/ssi\\_st\\_asst/2011/me.html](http://www.socialsecurity.gov/policy/docs/progdesc/ssi_st_asst/2011/me.html). Current information about the OSS and the PNA was not available online or through other sources.

## Location of Licensing, Certification, or Other Requirements

*Code of Maine Regulations*, Title 10-144, Chapter 113: Regulations Governing the Licensing and Functioning of Assisted Housing Programs. Department of Health and Human Services, Division of Licensing and Regulatory Services. [August 20, 2008]

<http://www.maine.gov/sos/cec/rules/10/ch113.htm>

*Code of Maine Regulations*, Title 10-144, Chapter 101: MaineCare Benefits Manual, various chapters/sections, including: Chapter 2, Section 2: Adult Family Care Services. [July 1, 2008]; Chapter 2, Section 97: Private Non-Medical Institution Services [October 16, 2013]; and Chapter 3, Section 97: Principles of Reimbursement for Private Non-Medical Institution Services [May 15, 2010]. Department of Health and Human Services.

<http://www.maine.gov/sos/cec/rules/10/ch101.htm>

## Information Sources

Michael Swann  
Division of Licensing and Regulatory Services  
Medical Facilities Unit  
Department of Health and Human Services

David C. Projansky  
Housing Resource Developer  
Office of Aging and Disability Services  
Maine Department of Health and Human Services

## MARYLAND

### Licensure Terms

Assisted Living Programs

### General Approach

The Department of Health and Mental Hygiene licenses three types of assisted living programs (ALPs) based on the level of care provided. The state does not specify a minimum number of residents for ALP licensure.

*Adult Foster Care (AFC).* The state licenses two types of AFC. (1) AFC provides a family setting in the community for an aged adult or an adult with disabilities who requires protective oversight, assistance with the activities of daily living (ADLs), and room and board. AFC is administered by local departments of social services. (2) Certified Adult Residential Environment (CARE) programs licenses individuals to provide--in their own homes--room and board, assistance, and supervision to adults with disabilities who are capable of living in the community but are unable to live alone.

The program, also known as Project Home, is a voluntary program that develops, certifies, and monitors protective CARE housing for individuals with disabilities; provides case management services to residents living in CARE housing; and provides a long-term or permanent housing setting for a stable population of individuals with disabilities using an adult foster family model of care. *Regulatory provisions for these settings are not included in this profile but a link to the provisions can found at the end.*

*This profile includes summaries of selected regulatory provisions for ALPs. The complete regulations are online at the links provided at the end.*

### Definitions

**Assisted living program** means a residential or facility-based program that provides housing and supportive services, supervision, personalized assistance, health-related services, or a combination thereof to meet the needs of residents who are unable to perform, or who need assistance with, ADLs and/or instrumental activities of daily living. Programs can be licensed to provide three levels of care: Level 1 (low), Level 2 (moderate), or Level 3 (high).

## Resident Agreements

Resident agreements must include information about the facility's level of care licensure; a list of services provided and not provided and the services that the resident will receive; rights and responsibilities of the facility and residents; the terms and conditions of continued occupancy/discharge; grievance procedures; occupancy provisions and policies (e.g., regarding room assignment, relocation, and changes in roommates); and the obligations of all parties for arranging for and overseeing medical care and monitoring health status.

Financial information must also be provided in the resident agreement, including rate, payment, and refund policies; policies and procedures for arranging and contracting for services the facility does not provide; and notification requirements for changes. If a residents' needs change significantly, the agreement must be amended. The agreement must also include a recommendation for review by an attorney.

## Disclosure Provisions

Programs must complete a Department-approved Assisted Living Disclosure Form that must be included in all marketing materials and made available to consumers upon request. The form is reviewed during facility surveys, and providers must notify the Office of Health Care Quality if they have changed the services that they will furnish.

Programs with an Alzheimer's special care unit must complete the Department's disclosure form that describes the following:

- A statement of philosophy or mission.
- Staff training and job titles.
- Admission and discharge procedures.
- Assessment and care planning protocols.
- A description of the physical environment and any unique design features appropriate to support the functioning of cognitively impaired individuals.
- A description of activities, including frequency and type, how they meet the needs of residents with dementia, and how the activities differ from those for residents in other parts of the program.
- Fees for services provided.
- Any services, training, or other procedures that are over and above those that are provided by the ALP.

## Admission and Retention Policy

Programs may not admit individuals who require: (1) more than intermittent nursing care; (2) treatment of Stage III or IV skin ulcers; (3) ventilator services; (4) skilled monitoring, testing, and close monitoring and adjustment of medications and treatments where there is the presence of, or risk for, a fluctuating acute condition; (5) monitoring of a chronic medical condition that is not controllable through readily available medications and treatments; (6) treatment for an active reportable communicable disease; or (7) treatment for a disease or condition that requires more than contact isolation.

Individuals may also not be admitted if they are a danger to self or others and the danger cannot be eliminated through appropriate treatment modalities, or if they are at risk for health or safety complications that cannot be adequately managed.

Programs may request a waiver to care for residents whose needs exceed the licensure level. Approval is based on the facility's demonstrated ability to meet the resident's needs without harm to other residents. The number of waivers granted to a facility is limited.

## Services

*Level 1 programs* must provide: (1) assistance in accessing and coordinating health services; (2) supervision or occasional assistance with two or more ADLs; (3) assistance with self-administration of medications; (4) uncomplicated interventions to manage occasional behaviors that might disrupt or harm the resident or others; (5) monitoring and management of occasional psychological or psychiatric episodes or fluctuations that require uncomplicated intervention or support; and (6) occasional assistance in accessing social and recreational services. *The Medicaid waiver program does not cover services in Level 1 programs.*

*Level 2 programs* provide all Level 1 services and also substantial support with two or more ADLs; medication administration, including monitoring the effects of the medication and treatment; monitoring and providing intervention to manage frequent behaviors that are likely to disrupt or harm the resident or others; monitoring and managing frequent psychological or psychiatric episodes that may require prompt intervention or support; and ongoing assistance in accessing social and recreational services.

*Level 3 programs* provide all Level 2 and 3 services and also ongoing access to and coordination of comprehensive health services and interventions; comprehensive and frequent assistance with ADLs; monitoring and providing ongoing therapeutic intervention or intensive supervision to manage chronic behaviors that might disrupt or harm the resident or others; and monitoring and managing a variety of psychological or

psychiatric episodes involving active symptoms, condition changes, or significant risks that may require skilled interpretation or immediate interventions.

### ***Service Planning***

Programs must assess individuals to identify the appropriate level of care needed to meet needs related to medical illnesses/conditions and cognitive and psychiatric conditions; treatment requirements; ability to self-administer medication; ADL needs; risk factor management needs; and problematic behaviors.

The assessment must be reviewed every 6 months. A full assessment is required after a significant change of condition and each non-routine hospitalization. Significant change of condition means a resident has demonstrated major changes in status that are not self-limiting or which cannot be resolved within 30 days; a change in one or more areas of the resident's health condition that could demonstrate an improvement or decline in the resident's status; and the need for interdisciplinary review or revision to the service plan. A significant change of condition does not include any ordinary, day-to-day fluctuations in health status, function, or behavior, or an acute short-term illness such as a cold, unless these fluctuations recur on an ongoing basis.

Evaluation by a health care practitioner is required and changes must be made to the resident's service plan if there is an assessment score change in any of the following areas: cognitive and behavioral status; ability to self-administer medications; and/or behaviors and communication. If the resident's previous assessment did not indicate the need for awake overnight staff, each full assessment or review of the full assessment must document whether awake overnight staff are required due to a change in the resident's condition.

### ***Third-Party Providers***

Home health and hospice agencies may provide services through direct contracts with residents.

## **Medication Provisions**

Programs may provide assistance with self-administration of medications or may administer medications. Assistance with self-administration includes reminders to take medications and/or physical assistance to open and remove medications from a container. Residents' ability to self-administer must be reviewed at least quarterly by a licensed health professional. Staff who have passed a Board of Nursing program may administer medications.

A licensed health professional must review each resident's medication regime within 14 days of admission in order to: (1) verify the resident's current medication profile, including all prescription and non-prescription medications and tube feedings;

(2) identify the potential that current medications have to act as chemical restraints; (3) identify the potential for any adverse drug interactions, including potential side effects from the medications; and (4) identify any medication errors that have occurred since admission.

In addition, programs must arrange for a licensed pharmacist to conduct an on-site review of physician's prescriptions, orders, and residents' records at least every 6 months for any resident receiving nine or more medications, including over-the-counter and as-needed medications. The purpose of the review is described in detail and includes topics such as proper packaging and storage, physicians' orders, whether prescribed medications appear to be effective, errors, adverse effects, inappropriate treatment, overuse, and potential drug interactions. Residents' providers must be informed about negative findings.

## Food Service and Dietary Provisions

Programs must provide three meals a day and snacks that are well-balanced, palatable, varied, properly prepared, and of sufficient quantity and quality to meet daily nutritional needs. A licensed nutritionist or licensed dietician must review menus on a 4-week cycle for nutritional quality. Programs must also provide special diets as ordered by a physician or needed by residents. Residents must have access to snacks or food supplements during the evening hours.

## Staffing Requirements

**Type of Staff.** A *manager* is required to direct daily operations, and an *alternate manager* must be identified when the manager is unavailable. The facility must have a signed agreement with a *registered nurse* (RN) and/or employ an RN to provide required nursing services, including delegation of nursing tasks. The facility must provide on-site nursing when a delegating nurse or physician, based upon the needs of a resident, issues a nursing or clinical order for that service. Staff must include *medication technicians* who have completed required medication administration training and *direct care staff* to assist residents with personal care.

**Staff Ratios.** *No minimum ratios.* Staff sufficient in number and qualifications to meet residents' 24-hour scheduled and unscheduled needs are required. Awake overnight staff may not be required if a physician or nurse determines that residents do not require overnight assistance. The facility must apply to the Department for a waiver to use an electronic monitoring system in place of awake overnight staff.

## Training Requirements

Managers of programs licensed for five or more residents must complete 20 hours of Department-approved continuing education every 2 years.

Staff must receive initial and ongoing training in fire and life safety; infection control, including standard precautions; basic food safety; basic first-aid; emergency disaster plans; and their individual job requirements. Staff must have knowledge in health and psychosocial needs of the population served as appropriate to their job responsibilities; the resident assessment process; the use of service plans; and residents' rights.

Staff whose duties include personal care must complete a state-approved, 5-hour training on cognitive impairment and mental illness within the first 90 days of employment. Staff must demonstrate competence to the delegating nurse before performing personal care services.

## Provisions for Apartments and Private Units

Apartment-style units are not required. A maximum of two residents is allowed per resident unit; however, this limit may be waived by the state agency for existing programs that have previously received a waiver. Programs must have a minimum ratio of one toilet for every four residents. Buildings with nine or more residents must have at least one toilet for four residents on each floor where a resident is located. A minimum of one bathtub or shower is required for every four residents in facilities with 1-8 residents and one for every eight residents in larger facilities.

## Provisions for Serving Persons with Dementia

***Dementia Care Staff and Facility Requirements.*** *No provisions identified.*

***Dementia Staff Training.*** Staff must receive a minimum of 5 hours of training on cognitive impairment and mental illness within 90 days of employment. The training content must be designed to meet specific resident's needs as determined by the manager.

At least 2 hours of ongoing training must be provided annually for staff who provide personal care. Training can be provided through classroom instruction, in-service training, Internet courses, correspondence courses, pre-recorded training, or other methods.

## Background Checks

Before licensure, the applicant must document any convictions and provide the results of a current criminal background check or criminal history records check of the owner, applicant, assisted living manager, alternate assisted living manager, other staff, and any household member (for small owner-occupied homes). The manager must conduct a criminal background check or criminal history records check of all prospective employees.

## Inspection and Monitoring

Inspections occur every 15 months or more often, as needed. The Department of Health and Mental Hygiene may delegate inspection and monitoring of programs to the Department of Aging or to local health departments through an interagency agreement.

## Public Financing

The state covers services in Level II and Level III ALPs for individuals age 50 and older under the Medicaid 1915(c) Home and Community-Based Options Waiver program (formerly the Waiver for Older Adults, now merged with the Living at Home Waiver).<sup>75</sup>

In addition, the state-funded Senior Assisted Living Group Home Subsidy program provides subsidies for services in small assisted living facilities licensed for 4-16 residents. The subsidy supports the cost of services provided, including meals, personal care, and 24-hour supervision for elderly residents who are frail and unable to live independently.

### ***Room and Board Policy***

In 2014, the Department of Aging paid the difference between a resident's income and the monthly facility rate--after deducting \$68 a month for personal needs--up to a maximum of \$650 a month. In 2009, family supplementation was not permitted.<sup>76</sup>

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<sup>75</sup> See <http://aging.maryland.gov/MedicaidWaiverServices.html>.

<sup>76</sup> Mollica, R.L. (2009). *State Medicaid Reimbursement Policies and Practices in Assisted Living*, National Center for Assisted Living, American Health Care Association. <http://www.ahcancal.org/ncal/resources/Documents/MedicaidAssistedLivingReport.pdf>. Current information about family supplementation policy was not available online or from other sources.

## Location of Licensing, Certification, or Other Requirements

*Annotated Code of Maryland*, Title 10, Subtitle 07, Chapter 14: Assisted Living Programs  
Authority: Health-General Article, Title 19, Subtitle 18.

<http://www.dsd.state.md.us/comar/SubtitleSearch.aspx?search=10.07.14>

*Annotated Code of Maryland*, Title 07, Subtitle 02, Chapter 17: Adult Foster Care Authority.

<http://www.dsd.state.md.us/comar/SubtitleSearch.aspx?search=07.02.17>

*Annotated Code of Maryland*, Title 07, Subtitle 02, Chapter 19: Certified Adult Residential Environment (CARE) Program Authority.

<http://www.dsd.state.md.us/comar/SubtitleSearch.aspx?search=07.02.19>

Department of Aging website: Senior Assisted Group Home Subsidy Program, including information and links regarding funding of assisted living.

<http://www.aging.maryland.gov/SeniorGrpHomeSubsidy.html>

## Information Sources

Dakota Burgess  
Maryland Department of Aging

## MASSACHUSETTS

### Licensure Terms

Assisted Living Residences<sup>77</sup>

### General Approach

The state certifies assisted living residences (ALRs) as residential environments with personal care services that support the goal of aging in place. The Executive Office of Elder Affairs (EOEA) is responsible for certification and promulgating regulations.<sup>78</sup> Services are covered under the Medicaid State Plan program and under the Money Follows the Person Residential Supports 1915(c) Waiver program.

*Adult Foster Care (AFC).* Also called adult family care, AFC is a program for frail elderly adults and adults with disabilities who cannot live alone safely but want to live in a family setting rather than in a nursing home or other facility. In addition to room and board, trained caregivers provide 24-hour supervision, companionship, and personal care. Caregivers may be family members (except legally responsible relatives). AFC is covered as a Medicaid State Plan service for up to three individuals. Providers must be authorized to conduct a business that delivers health and human services to elderly or disabled adult populations and must comply with Medicaid policies and procedures. The state does not regulate AFC providers that serve only private pay residents. *The Medicaid provisions for AFC are not included in this profile but a link to them can found at the end.*

*This profile includes summaries of selected regulatory provisions for ALRs. The complete regulations are online at the links provided at the end.*

### Definitions

**Assisted living residence** means any entity that provides room and board and personal care services--directly by its employees or through arrangements with another organization, which the entity may or may not own or control--for three or more adult residents who are not related by blood or marriage to their care provider. Personal care services include assistance with one or more of the activities of daily living (ADLs) and the management of self-administered medications.

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<sup>77</sup> ALRs are certified, not licensed.

<sup>78</sup> Revised regulations were due to be published in early 2015. This profile includes modifications that were in the red-line version of the revised regulations, dated November 21, 2014, that were relevant to the profile headings. The red-line version is no longer available online and the final version was not yet available in February 2015.

**Special care residence** means a residence in its entirety or a separate and distinct section within an ALR that provides an enhanced level of supports and services to one or more individuals to address their specialized needs due to cognitive or other impairments.

## Resident Agreements

Resident agreements are written contracts between an ALR and a resident that include information about: (1) the services covered in any fees, a description of all other bundled services, and an explanation of other services available at an additional charge; (2) any limitations on the services the residence will provide, such as limitations on services to address specific ADLs and behavioral management; (3) payment arrangements, refund policies, and provisions for terminating the agreement; and (4) resident's rights, including the right to privacy and the right to contract with outside providers. Agreements must include the specific unit number in which the resident will reside.

## Disclosure Provisions

Before execution of a residency agreement or transfer of any money, residences must deliver a disclosure statement to prospective residents and their legal representatives that includes information about: (1) the number and type of certified units; (2) current staffing and how staffing is determined; (3) entry and discharge policies and procedures, and the resident assessment process; (4) the cost of services offered and not offered, and payment policies; (5) any limitations on services, including the residence's medication administration policies; (6) eligibility requirements for any subsidy programs, including costs for which the resident would be responsible; and (7) the resident grievance procedure, including the right to contact the state Assisted Living Ombudsman at any time.

Any residence that chooses to advertise, market, or otherwise promote or provide special care for residents must provide a written statement that describes its mission and philosophy, and how it provides care in accordance with same.

## Admission and Retention Policy

An ALR may not admit or retain any resident in need of 24-hour skilled nursing supervision unless: (1) it will be provided by a certified provider of ancillary health

services<sup>79</sup> or by a licensed hospice; (2) the certified provider of health services does not train the ALR staff to provide the skilled nursing care; and (3) the resident requires no more than 90 consecutive days of skilled nursing care, or such care is limited to a periodic scheduled basis.

## Services

The regulations require that ALRs provide assistance with: (1) ADLs, including at a minimum bathing, dressing, ambulation and similar tasks; and (2) instrumental activities of daily living (IADLs), including at a minimum laundry, housekeeping, socialization and similar tasks. Other required services include management of self-administered prescription or over-the-counter medications, and timely assistance with urgent or emergency needs through 24/7 on-site staff and personal emergency or other response systems required by the EOEA to meet residents' service needs.

Skilled nursing services may only be provided by a certified home health agency on a part-time or intermittent basis. Medical conditions requiring nursing services on a periodic, scheduled basis, such as injection of insulin or other drugs used routinely for maintenance therapy of a disease, may be furnished by a certified provider of ancillary health services. Nurses employed or contracted by residences may not direct any non-licensed staff to perform skilled nursing care or administer medications to residents, or to oversee or supervise such practices.

Each special care residence must submit an operating plan to the EOEA that explains how the special care residence will meet its resident populations' specialized needs, including those who may need assistance in directing their own care due to cognitive or other impairments. In addition to providing the services listed above, the special care residence must prepare a planned activity program that addresses residents' needs, on at least a daily basis, in the following areas of resident function, as applicable: gross motor activities, self-care activities, social activities, and sensory and memory enhancement activities.

### ***Service Planning***

Prior to an individual's admission, the residence must conduct an initial screening and assessment to determine the individual's needs and preferences and the residence's ability to meet those needs. If determined able, the residence must develop a service plan based on the assessment and an evaluation--conducted within the previous 3 months by the resident's physician or authorized practitioner--of the individual's physical, cognitive, and psychosocial condition. The service plan must

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<sup>79</sup> A certified provider means a person or legal entity certified to provide home health care services or hospice care services under Title XVIII of the Social Security Act, or a licensed practitioner such as a physician, pharmacist, restorative therapist, podiatrist, and home health aide. Ancillary health service means any nursing or skilled service a resident may need that the ALR is not allowed (under regulation) to provide but that a resident can obtain by hiring an outside provider to come into the residence to provide separately as a private service.

include information regarding the individual's diagnoses; current medications (including dosage, route, and frequency); allergies; dietary needs; need for assistance in emergency situations; history of psychosocial issues; level of personal care needs; and ability to manage medications.

The residence must review the initial resident service plan within 30 days of the individual's admission, and whenever a significant change in condition is identified, but not less than once every 6 months.

### ***Third-Party Providers***

The residence may arrange for the provision of health services by a certified provider of ancillary health services or licensed hospice. Residents may directly engage or contract with licensed or certified health care providers to obtain necessary health care services in the resident's unit or in such other space in the ALR as may be available to residents to the same extent available to persons residing in their own homes.

## **Medication Provisions**

Management of self-administered medications, a required service, includes reminding residents to take medications, opening containers and pre-packaged medications, reading the medication label to residents, and observing them while they take the medication. Management of self-administered medication may only be performed by an individual who has completed personal care service training as described in the training section below.

Limited medication administration is an optional service and ALRs must disclose the availability of this service and its cost in the residency agreement and/or the disclosure of rights and services. Limited medication administration may only be provided in ALRs by a family member or by a practitioner as defined in state law<sup>80</sup> or a nurse registered or licensed under state law. A nurse may only administer medication from an original, pharmacy filled and pharmacy labeled container.

A licensed nurse employed by the residence may administer non-injectable medications, prescribed or ordered by an authorized prescriber, by oral or other methods (e.g., topical, inhalers, eye and ear drops, medicated patches, as-necessary oxygen, suppositories).

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<sup>80</sup> Includes a physician, dentist, podiatrist, or optometrist.

## Food Service and Dietary Provisions

An ALR must provide up to three<sup>81</sup> regularly scheduled meals daily and use daily recommended dietary allowances as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences as a minimum dietary standard. In addition, the residence must provide or arrange for the availability of food selections that would permit a resident to adhere to a diet consistent with the most recent edition of Dietary Guidelines for Americans, and dietary plans that do not require complex calculations of nutrients or preparation of special food items. Dietary plans may include sodium-restricted and sugar-restricted and low-fat diets. The residence must have a qualified dietitian to review residents' dietary needs, and counsel residents regarding therapeutic diets and other dietary issues. The dietitian must review the residence's dietary plans at least every 6 months.

## Staffing Requirements

**Type of Staff.** Each ALR must designate a *manager* who has general administrative charge of the residence and at least one *service coordinator* who is primarily responsible for developing, reviewing and revising each resident's service plan. *Personal care staff* must be *licensed nurses*, *certified nursing assistants (CNAs)*, *certified home health aides*, or qualified *personal care homemakers*; otherwise, they must complete a 54-hour training course, described below.

**Staff Ratios.** *No minimum ratios.* A residence must have sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled resident needs as required by the residents' assessments and service plans on a 24-hour-per-day basis. Staffing must be sufficient to respond promptly and effectively to individual resident emergencies and the residence must have a plan to secure staffing necessary to respond to emergency, safety, and disaster situations affecting residents.

Each residence must develop and implement a process for determining its staffing levels. The plan must include an assessment of the appropriateness of staffing levels, to be conducted at least quarterly but more frequently if the residence so chooses.

## Training Requirements

Prior to active employment, all staff and contracted providers who will have direct contact with residents and all food service personnel must receive an initial 7-hour general orientation that includes the following topics:

- Philosophy of independent living in an ALR.

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<sup>81</sup> The regulations require a minimum of one meal and up to three meals per day, but nearly all ALRs in the state provide three meals per day as part of the service package.

- Resident bill of rights.
- Elder abuse, neglect, and financial exploitation (at least 1 hour).
- Communicable diseases.
- Policies and procedures concerning disaster and emergency preparedness.
- Communication skills.
- Review of the aging process.
- Dementia/cognitive impairment including a basic overview of the disease process, communication skills, and behavior management (at least 2 hours).
- Resident health and related problems.
- Job requirements.
- Management of self-administered medications.
- Sanitation and food safety.

In addition, all personnel providing personal care services must receive at least 1 additional hour of orientation devoted to the topic of management of self-administered medications, and both the manager and service coordinator must receive an additional 2 hours of training devoted to dementia care topics. A residence may include the use of techniques such as the shadowing of more experienced employees during the first 5 days of an employee's tenure.

ALR staff and contracted providers of personal care services (unless they are licensed nurses, CNAs, certified home health aides, or qualified personal care homemakers as stated under type of staff above) must complete an additional 54 hours of training prior to providing personal care services to a resident, 20 hours of which must be specific to the provision of personal care services and conducted by a qualified registered nurse. Topics include personal hygiene; the effects of dehydration; maintaining skin integrity; management of self-administered medication; elimination; nutrition; human growth, development and aging; family dynamics; grief, loss, death and dying; mobility; maintenance of a clean, safe and healthy environment; home safety; and assistance with appliances.

Prior to or within 48 hours after the provision of personal care services to a resident, a qualified nurse must review the resident's service plan with all relevant personal care workers, who must demonstrate competence in the assigned personal care tasks in the resident's service plan. At least twice per year, a nurse must evaluate the personal care services provided by the residence's personal care staff or by contracted providers.

A minimum of 10 hours per year of ongoing education and training is required for all employees, with at least 2 hours on the specialized needs of residents with Alzheimer's disease. Other topics include the causes and prevention of falls and of injuries; behavior management, including prevention of aggressive behavior and de-escalation techniques (mandatory); defining, recognizing and reporting elder abuse (mandatory); and death and dying. Residence managers must complete an additional 5 hours of training that complements the individual's background and experience.

All staff providing assistance with personal care services must be trained in first-aid and the residence's policy on emergency response to acute health issues, and must also complete at least 1 hour of ongoing education and training per year on the management of self-administered medications.

Each residence must conduct an annual training needs assessment to prepare the curriculum for its required training and establish a process by which it will evaluate the efficacy of its training program.

## Provisions for Apartments and Private Units

Apartment-style units are not required. Units must have lockable doors and may be single-occupancy or double-occupancy only. All newly constructed ALRs must provide a private bathroom for each unit, which must be equipped with one sink, one toilet, and one bathtub or shower stall.

All other ALRs must provide, at a minimum, a private half-bathroom (i.e., equipped with one sink and one toilet) for each living unit and provide at least one bathing facility (equipped with either a shower or bathtub) for every three residents.

All facilities must provide, at a minimum, either a kitchenette or access to a refrigerator, sink, and heating element for residents of all living units.

An ALR that serves Medicaid waiver participants must provide apartments with separate living, sleeping, bathing, and cooking areas; lockable entrance and exit doors; and meet other criteria.

## Provisions for Serving Persons with Dementia

***Dementia Care Staff.*** Special care residences must designate a *manager* who will be responsible for the operation of the special care residence, and must have sufficient staff--but never less than two staff members--qualified by training and experience awake and on-duty at all times to meet residents' 24-hour-per-day scheduled and reasonably foreseeable unscheduled needs, based on their assessments and service plans. Staffing must be sufficient to respond promptly and effectively to individual resident emergencies, and the residence must have a plan to secure staffing necessary to respond to emergency, safety, and disaster situations affecting residents.

Each residence must develop and implement a process for determining its staffing levels. The plan must include an assessment, to be conducted at least quarterly but more frequently if the residence so chooses, of the appropriateness of staffing levels.

***Dementia Staff Training.*** In addition to completing requirements for general orientation, all new employees who work within a special care residence and have direct contact with residents must receive 7 hours of additional training on topics related to the specialized care needs of the resident population (e.g., communication skills, creating a therapeutic environment, dealing with difficult behaviors, competency, sexuality, and family issues). A minimum of 10 hours per year of ongoing education and training is required for all employees (as described above), with at least 4 additional hours on the specialized needs of residents with Alzheimer’s disease and other dementias, including the development of communications skills for residents with dementia.

***Dementia Facility Requirements.*** A special care residence must prepare a plan that includes a description of the physical design of the structure and the units, the physical environment, and specialized safety features. Entry and exit doors in common-use areas must be secured.

## **Background Checks**

Applicants for ALR certification must ensure that none of its officers, directors, trustees, limited partners, or shareholders has ever been found in violation of any local, state, or federal statute, regulation, ordinance, or other law by reason of the individual’s relationship to an ALR.

No person working in a residence must have ever been found in violation of any local, state, or federal statute, regulation, ordinance, or other law reasonably related to the safety and well-being of a resident or patient at an ALR or health care facility; and the residence manager must never have been convicted of a felony.

## **Inspection and Monitoring**

The EOEA conducts compliance reviews of ALRs prior to the issuance of initial or renewal certification and at least every 2 years. The reviews include inspections of the common areas, living quarters (by consent of the resident), inspection of resident records (by consent of the resident), including service plans and resident agreements, and a review of the resident satisfaction survey. Inspectors may, at their discretion, interview the person or legal entity named in the certification, as well as the manager, staff and residents. Compliance reviews may be initiated at any time with probable cause. Any duly designated EOEA officer or employee has the right to enter and inspect at any time without prior notice.

## **Public Financing**

The Medicaid State Plan covers services in ALRs, AFC homes, and conventional elderly housing for individuals who are chronically disabled and require 24-hour

supervision, daily assistance with at least one ADL, and assistance with managing medications. Services include assistance with ADLs and IADLs, other personal care as needed, and nursing services and oversight.

Assisted living services are also available under the Money Follows the Person Residential Supports Waiver program. To qualify for the program, an applicant must be eligible for Medicaid and be living in a nursing home or long-stay hospital for at least 90 consecutive days (excluding Medicare rehabilitation days); and need residential support services with staff supervision 24 hours a day, 7 days a week.

### **Room and Board Policy**

The majority of ALRs in Massachusetts are for profit entities that charge fair market rates for rental units; most reserve only a small number of units for lower-income residents who are eligible for Medicaid.

To support residents who do not have sufficient income to pay for room and board in an ALR, the state provides an optional state supplement (OSS) that is added to the federal Supplemental Security Income (SSI) payment. The maximum payment in 2011 for an individual in an ALR was \$1,128, which included the SSI payment of \$674 and the OSS of \$454. A personal needs allowance (PNA) was not reported.<sup>82</sup> The state does not have a policy on family supplementation.

## **Location of Licensing, Certification, or Other Requirements**

*Code of Massachusetts Regulations*, Title 651, Section 12.00: Certification Procedures and Standards for Assisted Living Residences. Executive Office of Elder Affairs. [August 23, 2006] *These regulations were updated in early 2015, but were not yet available online in February 2015. The relevant modifications were included in this profile.*

<http://www.mass.gov/elders/docs/651cmr-1.doc>

*Massachusetts Medicaid Provider Manual Series: Adult Foster Care Manual*. [February 1, 2007] <http://www.mass.gov/eohhs/gov/laws-regs/masshealth/provider-library/provider-manual/adult-foster-care-manual.html>

## **Information Sources**

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<sup>82</sup> Social Security Administration, *State Assistance Programs for SSI Recipients*, January 2011. [http://www.socialsecurity.gov/policy/docs/progdsc/ssi\\_st\\_asst/2011/ma.html](http://www.socialsecurity.gov/policy/docs/progdsc/ssi_st_asst/2011/ma.html). Current information about the OSS and the PNA was not available online or through other sources.

## MICHIGAN

### Licensure Terms

Homes for the Aged, Adult Foster Care

### General Approach

The Department of Human Services licenses and regulates homes for the aged and adult foster care (AFC). In general, a home for the aged provides care to persons who are over the age of 60, while an AFC home can provide care to any adult in need of AFC service. All licensed settings must comply with minimum standards (statutes and administrative rules) that establish an acceptable level of care. The term assisted living is used, but it is not recognized in the rules.

*Adult Foster Care* includes three categories: family homes that serve up to six residents and the licensee resides in the home; small group homes that serve 1-12 residents; and large group homes that serve 13-20 residents. For these last two, the licensee is not required to reside on-site. *Regulatory provisions for AFC settings are not included in this profile but a link to the provisions can found at the end.*

*This profile includes summaries of selected regulatory provisions for homes for the aged. The complete regulations are online at the links provided at the end.*

### Definitions

**Homes for the aged** are personal care facilities, other than hotels, AFC homes, hospitals, nursing homes, or county medical care facilities, that provide supervised personal care to 21 or more individuals who are age 60 or older. Homes that are operated in conjunction with and as a distinct part of a licensed nursing home may serve 20 or fewer adults.

### Resident Agreements

The resident admission contract must specify the services to be provided; monthly fees and rate increase policies; refund policies; admission and discharge policies; and resident rights and responsibilities.

## Disclosure Provisions

Settings that represent to the public that they provide care and services to persons with Alzheimer's disease or other dementias are required to provide prospective residents and/or their representatives with a written description of the following information:

- The program's overall philosophy and mission reflecting the needs of residents with Alzheimer's disease or other dementias.
- Services provided and the type and frequency of activities for residents with Alzheimer's disease or other dementias.
- Additional fees for dementia care services.
- Admission and discharge criteria.
- The assessment and care planning process.
- Staff training and continuing education policies and practices.
- The physical environment and design features appropriate to support the functioning of residents with Alzheimer's disease or other dementias.

## Admission and Retention Policy

A licensee may not admit an individual whose needs cannot be met. A resident who needs continuous nursing care may not remain in the home unless the resident is receiving services from a licensed hospice program or home health agency. Residents may be discharged for medical reasons or if a resident has demonstrated behaviors that pose a risk of serious harm to himself or herself or others, unless the home has the capacity to manage the resident's behavior.

## Services

Homes for the aged must provide supervised personal care, which means guidance (cuing, prompting, reminding) or assistance with eating, toileting, bathing, grooming, dressing, transferring, mobility, medication management, reminding resident of important activities to be carried out, assisting a resident to keep appointments, supporting a resident's personal and social needs, and being aware of a resident's general whereabouts even if the resident is capable of independent travel about the community.

## ***Service Planning***

If an applicant is under a health care professional's care, a written health care statement that describes prescribed treatments and medications must be provided to the facility prior to admission. The home must complete a service plan in cooperation with each resident and/or their representative, if any, that identifies the individual's specific needs for care, services, and activities, taking into account the preferences and competency of the resident. The service plan must be updated annually and following a significant change in health status.

## ***Third-Party Providers***

Residents may receive services from a licensed hospice or home health agency.

## **Medication Provisions**

Facilities must provide medication supervision and administration. Supervision means reminding a resident to maintain his/her medication schedule in accordance with the prescription. If direct care workers supervise residents or administer medications, the home must train them in the proper handling and administration of medications. Residents who are capable may self-administer medications.

## **Food Service and Dietary Provisions**

Three daily meals and snacks must be provided, and medical nutrition therapy prescribed by a licensed health care professional. Food must be prepared in accordance with the recommended daily dietary allowances of the Food and Nutrition Board of the National Academy of Sciences' National Research Council.

## **Staffing Requirements**

***Type of Staff.*** The home must have an *administrator* to operate the home. One staff person on each shift must be designated as the shift *resident care supervisor* whose responsibilities include ensuring that residents are treated with kindness and respect, protecting residents from accidents and injuries, and maintaining residents' safety in an emergency. *Direct care staff* provide personal care and supervision and protection of residents.

***Staff Ratios.*** *No minimum ratios.* The resident care supervisor must be awake and on the premises when on duty. The home must have adequate and sufficient staff on duty at all times, who are trained and capable of providing for resident needs consistent with their service plans.

## **Training Requirements**

The administrator must establish and implement a staff training program based on the home's program statement, the residents' service plans, and employees' needs. Training topics include: reporting requirements and documentation; first-aid; administration of medication; personal care; supervision; residents' rights and responsibilities; safety and fire prevention; containment of infectious disease; and standard precautions. *Requirements for administrator training were not identified.*

## **Provisions for Apartments and Private Units**

Apartment-style units are not required. Resident rooms may be single-occupancy or multiple-occupancy, with no more than four beds in a room. (Homes constructed prior to 1969 may have more than four beds in a room.) A minimum of one toilet and sink is required for every eight resident beds per floor and one bath/shower for every 15 residents.

## **Provisions for Serving Persons with Dementia**

*No provisions identified.*

## **Background Checks**

A criminal background state and Federal Bureau of Investigation fingerprint check is required. Homes may not employ, independently contract with, or grant clinical privileges to an individual who will regularly have direct access or provides direct services to residents if he or she has been convicted of a felony or misdemeanor, unless 15 years have elapsed since the conviction. In case of a felony, all terms of either parole or probation must also have been satisfied.

## **Inspection and Monitoring**

The Bureau of Children and Adult Licensing conducts annual onsite inspections to determine compliance with state law and licensing rules.

## **Public Financing**

The state covers personal care services provided in homes for the aged through the Medicaid State Plan.

## **Room and Board Policy**

The state provides an optional state supplement (OSS) to Supplemental Security Income (SSI) recipients who reside in a home for the aged and limits room and board charges for Medicaid-eligible residents to the combined SSI and OSS payments minus a personal needs allowance (PNA). In 2009, the monthly room and board payment was \$765.30 (SSI \$674 plus OSS \$135.30 less a PNA of \$44).<sup>83</sup>

## **Location of Licensing, Certification, or Other Requirements**

Bureau of Children and Adult Licensing, Department of Human Services: Licensing Rules for Homes for the Aged.

[http://michigan.gov/documents/dhs/BCAL\\_PUB\\_0337\\_253632\\_7.pdf?20140414155325](http://michigan.gov/documents/dhs/BCAL_PUB_0337_253632_7.pdf?20140414155325)

Bureau of Children and Adult Licensing, Department of Human Services: Licensing Rules for Adult Foster Care Large Group Homes (13-20).

[http://michigan.gov/documents/dhs/DHS-BCAL-PUB-334\\_276575\\_7.pdf?20140414155325](http://michigan.gov/documents/dhs/DHS-BCAL-PUB-334_276575_7.pdf?20140414155325)

Bureau of Children and Adult Licensing, Department of Human Services: Licensing Rules for Adult Foster Care Small Group Homes (12 or less).

[http://michigan.gov/documents/dhs/BCAL-PUB-0333\\_241598\\_7.pdf?20140414155325](http://michigan.gov/documents/dhs/BCAL-PUB-0333_241598_7.pdf?20140414155325)

Bureau of Children and Adult Licensing, Department of Human Services: Licensing Rules for Adult Foster Care Family Homes.

[http://michigan.gov/documents/dhs/BCAL-PUB-0332\\_281384\\_7.pdf?20140414155325](http://michigan.gov/documents/dhs/BCAL-PUB-0332_281384_7.pdf?20140414155325)

*Michigan Compiled Laws*, Section 333.20178: Alzheimer's care disclosure requirement.

[https://www.legislature.mi.gov/\(S\(rp2roazw4jr55s45levpuqfr\)\)/mileg.aspx?page=getObject&objectName=mcl-333-20178](https://www.legislature.mi.gov/(S(rp2roazw4jr55s45levpuqfr))/mileg.aspx?page=getObject&objectName=mcl-333-20178)

*Michigan Compiled Laws*, Section 333.20173a. Criminal History Check.

[http://www.legislature.mi.gov/\(S\(t50xwhv22fgh0mei4dxzqgrk\)\)/mileg.aspx?page=GetObject&objectname=mcl-333-20173a](http://www.legislature.mi.gov/(S(t50xwhv22fgh0mei4dxzqgrk))/mileg.aspx?page=GetObject&objectname=mcl-333-20173a)

## **Information Sources**

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<sup>83</sup> Mollica, R.L. (2009). *State Medicaid Reimbursement Policies and Practices in Assisted Living*, National Center for Assisted Living, American Health Care Association.  
<http://www.ahcancal.org/ncal/resources/Documents/MedicaidAssistedLivingReport.pdf>. Current information about Medicaid room and board policies, the OSS, the PNA, and family supplementation policy was not available online or from other sources.

## MINNESOTA

### Licensure Terms

Class A and Class F Home Care Providers

### General Approach

The state does not license assisted living as a distinct category. Instead, the state defines assisted living as comprising two elements: a site that is registered annually with the Department of Health as a housing with services establishment, and a licensed Class A or a Class F home care agency<sup>84</sup> that is either the establishment itself or another entity with which the establishment has an arrangement. Only establishments that comply with the relevant statutes' requirements may use the term assisted living.

*Adult Foster Care (AFC).* Adult foster homes are licensed by the Department of Human Services (DHS) as a residence that provides food and lodging and 24-hour care--including protection, supervision, and household services--to no more than four functionally impaired residents. DHS issues a family adult foster home license if the home is the primary residence of the license holder and the license holder is the primary caregiver, and issues a corporate adult foster home license if the license holder does not live in the home. In addition to holding a DHS family AFC license, a provider may be licensed as a Class A home care provider, which allows the home to offer a higher level of service. The state licenses all corporate homes as Class A providers. A corporate AFC home may also be registered as a housing with services establishment and offer services with a Class F license. *The regulatory provisions for AFC are not included in this profile, but a link to them can found at the end.*

*This profile includes summaries of selected regulatory provisions for housing with services establishments and licensed home care providers. The complete regulations are online at the links provided at the end.*

### Definitions

**Housing with services establishments** provide sleeping accommodations to one or more adult residents, at least 80 percent of whom are 55 years of age or older, and

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<sup>84</sup> Under a new home care law that was passed in the state's 2013 legislative session and updated in the 2014 legislative session, the categories of licensure were changed. The current "Classes" of licenses (i.e., Class A, B, C, and F) will be replaced by two types of home care licenses: either Basic or Comprehensive. Current providers continue to operate under their existing license and current law until their renewal date occurring between July 1, 2014, and June 30, 2015. See link to the new regulations at the end of the profile.

offer or provide one or more regularly scheduled health-related services or two or more regularly scheduled supportive services. Services may be offered or provided directly by the establishment or by another entity arranged for by the establishment.

**Health-related services** include professional nursing services, home health aide tasks, and home care aide tasks as identified in the relevant administrative rules. Health-related services must be provided by a Class A or a Class F home care agency in a manner that complies with applicable home care licensure requirements.

**Supportive services** means help with personal laundry; handling or assisting with residents' personal funds; or arranging for medical services, health-related services, social services, or transportation to medical or social services appointments. Arranging for services does not include making referrals, assisting a resident in contacting a service provider of the resident's choice, or contacting a service provider in an emergency.

**Assisted living** is a service or package of services advertised, marketed, or otherwise described, offered, or promoted using the phrase "assisted living" either alone or in combination with other words, whether orally or in writing, and which is subject to the requirements of Minnesota statutes.

## Resident Agreements

Contracts between the housing with services operator and residents include a statement describing the: (1) establishment's registration and licensure status and any provider furnishing health-related or supportive services under an arrangement with the establishment; (2) services provided in the base rate and fee schedules for any additional services; (3) process for modifying, amending, or terminating the contract, including whether a move to a different room or sharing a room would be required in the event that the resident can no longer pay the current rent; (4) complaint process; and (5) criteria for determining who may reside in the establishment. The contract must also include a statement regarding residents' ability to receive services from providers that do not have an arrangement with the establishment and a statement regarding the availability of public funds to pay for room and board and services.

Home care provider licensing regulations cover the service agreement, which includes a description of the services to be provided and the frequency of each service, the persons or category of persons who will provide the service, the schedule or frequency of sessions of supervision or monitoring, fees for each service, and a plan for contingency action if scheduled services cannot be provided.

## Disclosure Provisions

In addition to the contract, the state requires the provision of a separate Uniform Consumer Information Guide that includes information about services offered by the provider, service costs, and other relevant provider-specific information, which must be made available to all current and prospective residents in a required format.

Housing with services establishments that secure, segregate, or provide a special program or special unit for residents with a diagnosis of probable Alzheimer's disease or another type of dementia, or that advertise, market--or otherwise promote the establishment as providing specialized care for such individuals--are considered "special care units" (SCUs). Before an agreement to provide care is entered into, all SCUs must provide a written disclosure to: (1) the Commissioner of Health, if requested; (2) the Office of Ombudsman for Older Minnesotans; and (3) each person seeking placement within a SCU or the person's authorized representative. Written disclosure must include, but is not limited to, the following:

- A statement of the overall service philosophy and how it reflects the special needs of residents with Alzheimer's disease or other dementias.
- The criteria for determining who may reside in the SCU.
- The process used for assessment and establishment of the service plan or agreement, including how the plan is responsive to changes in the resident's condition.
- Staffing credentials, job descriptions, and staff duties and availability, including any dementia-specific training.
- The physical environment as well as design and security features that specifically address the needs of residents with Alzheimer's disease or other dementias.
- Frequency and type of programs and activities for SCU residents.
- Fee schedules for additional services provided to SCU residents.
- Family involvement in resident care and the availability of family support programs.

## Admission and Retention Policy

A person or entity offering assisted living may determine which services it will provide and may offer assisted living to all or only some of the residents of a housing with services establishment. Housing with services establishments and home care providers are not required to offer or continue to provide services under a service

agreement or service plan to prospective or current residents, if they determine that they cannot meet their needs.

Health care services provided by an arranged home care provider may be terminated without affecting the resident's housing status. Thirty days' notice, with certain exceptions, must be given prior to terminating health care services and assistance must be offered to find another health care provider.

## Services

The state restricts the use of the phrase "assisted living" to housing with services establishments that provide or make available the following services at a minimum:

- Health-related services under a Class A or a Class F home care agency that include assistance with self-administration of medication or medication administration, assistance with at least three activities of daily living (ADLs), and assessments of the residents' physical and cognitive needs by a registered nurse (RN).
- Weekly housekeeping and laundry service.
- Periodic opportunities for socialization and reasonable assistance with arranging transportation to medical and social services appointments and accessing community resources.

The licensed home care agency providing the health care services must provide all services required by the resident's current service agreement or service plan. The housing with services establishment must have a system for RN delegation of health care activities to unlicensed assistive health care personnel, which includes supervision and evaluation of the delegated activities.

### ***Service Planning***

Establishments must offer to arrange an assessment by an RN of a prospective resident's physical and cognitive needs and propose a service agreement or service plan prior to the date on which the prospective resident executes a contract or the date on which he or she moves in, whichever is earlier.<sup>85</sup>

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<sup>85</sup> An arranged home care provider is not obligated to conduct a nursing assessment by a RN when requested by a prospective resident if either the geographic distance between the prospective resident and the provider, or urgent or unexpected circumstances, do not permit the assessment to be conducted prior to the date on which the prospective resident executes a contract or moves in, whichever is earlier. When such circumstances occur, the arranged home care provider may offer to conduct a telephone conference whenever reasonably possible.

### ***Third-Party Providers***

The establishment must have an arrangement with a Minnesota Class A or Class F licensed home care agency or use its own Class A or Class F licensed home care agency to provide home care services. Minnesota Class A home care agencies may provide professional nursing and home health aide tasks; physical, speech, respiratory, and occupational therapy; and medical social services, and may also provide medical supplies and equipment when accompanied by the provision of a home care service. Minnesota Class F home care agencies may provide nursing services, and delegated nursing services or other services performed by unlicensed personnel.

Residents may receive services from providers that do not have an arrangement with the establishment.

### **Medication Provisions**

At a minimum, an establishment representing itself as assisted living must offer to provide or arrange for assistance with self-administration of medications or administration of medications. Staff administering medications must be instructed by an RN, the instructions must be written, and the person must demonstrate competence in following the instructions.

Standards for medication management--which includes medication administration--may vary according to the nature of the services provided, the setting in which the services are provided, and the resident's status.

### **Food Service and Dietary Provisions**

Housing with services establishments that use the term assisted living must provide two meals per day.

### **Staffing Requirements**

***Type of Staff.*** The housing with services establishment must provide staff access to an on call *registered nurse* 24 hours per day, 7 days per week; must maintain a system to check on each assisted living resident at least daily; and must provide a means for residents to request assistance for health and safety needs 24 hours per day, 7 days per week from the establishment or a person or entity with which the establishment has made arrangements.

***Staff Ratios.*** *No minimum ratios.* Housing with services establishments must provide adequate staff to meet residents' needs. Unless they meet the criteria for

exemption for awake staff described in statute,<sup>86</sup> housing with services establishments are required to have a person(s) available 24 hours per day, 7 days per week, who: (1) is responsible for responding to assisted living residents' requests for assistance with health or safety needs; (2) must be awake and located in the same building, in an attached building, or on a contiguous campus with the housing with services establishment in order to respond within a reasonable amount of time; (3) is capable of communicating with assisted living residents and capable of recognizing the need for assistance; and (4) is capable of providing either the assistance required or summoning the appropriate assistance, and capable of following directions.

## Training Requirements

The person primarily responsible for oversight and management of a housing with services establishment must have at least 30 hours of continuing education every 2 years in topics relevant to the operations of the establishment and residents' needs. Continuing education earned to maintain a professional license, such as a nursing home administrator or nursing license, can be used to complete this requirement. In addition, the continuing education must include at least 4 hours of documented training on dementia care topics within 160 working hours of hire, and 2 hours of training on these topics annually.

Each person who provides direct care, supervision of direct care, or who manages services for a licensee, must receive an orientation to home care requirements covering: (1) the general approach of the statute and regulations; (2) handling of emergencies; (3) reporting abuse/neglect; (4) the home care bill of rights; (5) handling and reporting complaints; and (6) ombudsman services.

Training and a competency evaluation are required for unlicensed staff who perform assisted living home care tasks. In addition to the orientation topics listed above, the curriculum includes: (1) observation, reporting, and documentation of resident status and of the care or services provided; (2) basic infection control and maintenance of a clean, safe, and healthy environment; (3) communication skills; (4) basic elements of body functioning and changes in body function that must be reported to an appropriate health care professional; and (5) the residents' physical, emotional, and developmental needs.

Staff who provide medication administration and active assistance with medications must complete the above training program, pass a competency test, and

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<sup>86</sup> A housing with services establishment with a maximum capacity to serve 12 assisted living residents is exempt from the requirement of 24-hour awake staff if the person or persons available and responsible for responding to requests for assistance are physically present within the establishment, and the establishment has a system in place that is compatible with the health, safety, and welfare of the assisted living residents. The establishment's housing with services contract must include a statement disclosing the establishment's qualification for, and intention to rely upon, this exemption.

be instructed by an RN in the procedures for administering medications specific to each resident.

In addition to the above requirements, supervisors of direct care staff in a housing with services establishment must complete at least 4 hours of initial training on dementia care topics within 120 working hours of the employment start date and 2 hours annually. Direct care staff must complete at least 4 hours of initial training on dementia care topics within 160 working hours of the employment start date and 2 hours annually. Until these initial training requirements are completed, an employee must not provide direct care unless there is another employee on-site who has completed the initial 4 hours of training and who can act as a resource and assist if issues arise.

Staff providing home management tasks (housekeeping, meal preparation, and shopping) must receive training on the bill of rights and orientation on the aging process and the needs and concerns of elderly and disabled persons. They must also complete at least 4 hours of initial training on dementia care topics within 160 working hours of the employment start date and 2 hours annually.

Dementia care topics for all staff include: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with ADLs; (3) problem solving with challenging behaviors; and (4) communication skills.

## Provisions for Apartments and Private Units

Apartment-style units are not required. Units may be shared by resident choice.

## Provisions for Serving Persons with Dementia

***Dementia Care Staff and Facility Requirements.*** No provisions identified.

***Dementia Staff Training.*** The *manager* of a SCU and the *direct care staff* must complete double the amount of initial dementia training as staff in all establishments. The areas of required training are the same.

## Background Checks

Owners, managers, employees, contractors, and volunteers of a home care provider are subject to a criminal background check. A license may be denied or suspended for conviction of any of 15 types of crimes listed in the regulations. Each employee with direct contact with residents must sign a statement disclosing convictions of all crimes, except minor traffic violations. Employees may be required to sign a

release statement authorizing local authorities to provide the commissioner a history of criminal convictions.

## **Inspection and Monitoring**

The state evaluates, monitors, and licenses home care providers in accordance with the relevant statutes and administrative rules, which include the right to inspect the office and records of a provider during regular business hours without advance notice, and the right to visit the home where services are being provided, with the consent of the resident. Home care providers are surveyed before a license is approved or renewed.

## **Public Financing**

The state uses several Medicaid 1915(c) Waiver programs (Elderly, Traumatic Brain Injury, Community Alternatives for Disabled Adults, and Community Alternative Care) to pay for one or more of the following three services: AFC, customized living, and 24-hour customized living.

Customized living services (formerly called assisted living services) are a package of component services individually designed to meet the assessed needs of a waiver participant that can include home management tasks, supportive services, home care aide tasks, home health aide tasks, incidental nursing services, and supervision. The same component services are included in 24-hour customized living services (formerly called assisted living plus services) with the addition of 24-hour supervision and oversight.

### ***Room and Board Policy***

The state provides an optional state supplement to Supplemental Security Income (SSI) recipients residing in group residential facilities. The maximum payment in 2014 was \$250 a month. Residents receiving SSI benefits were permitted to retain a personal needs allowance of \$95 per month.

The state does not cap room and board charges for Medicaid participants and family members may supplement the resident's payment.

## **Location of Licensing, Certification, or Other Requirements**

Minnesota Department of Health website: Class A Licensed Home Care Provider. [2014]  
<http://www.health.state.mn.us/divs/fpc/profinfo/lic/licclassa.htm>

Minnesota Department of Health website: Class F Licensed Home Care Provider. [2014]  
<http://www.health.state.mn.us/divs/fpc/profinfo/lic/alhcp.htm>

Minnesota Department of Health website: Comprehensive Home Care Provider Licensing. [2014] *This website is being updated as additions and changes occur.*  
<http://www.health.state.mn.us/divs/fpc/comphomecare/>

Minnesota Department of Health website: Housing with Services Establishments/Assisted Living Designation. [2014]  
<http://www.health.state.mn.us/divs/fpc/profinfo/lic/lichws.htm>

*Minnesota Statutes*, Chapter 144D: Housing with Services Establishments. [2014]  
<https://www.revisor.mn.gov/statutes/?id=144D&view=chapter>

*Minnesota Statutes*, Chapter 144G: Assisted Living Services. [2014]  
<https://www.revisor.mn.gov/statutes/?id=144G&view=chapter>

*Minnesota Statutes*, Chapter 325F.72: Disclosure of Special Care Status. [2014]  
<https://www.revisor.mn.gov/statutes/?id=325F.72>

*Minnesota Administrative Rules*, Rule 203, Parts 9555.5105 to 9555.6265: Administration of Adult Foster Care Services and Licensure of Adult Foster Homes. [October 8, 2007]  
<https://www.revisor.mn.gov/rules/?id=9555>

## Information Sources

Lisa Rotegard  
Manager  
Home and Community-Based Services Policy and Integration for Seniors  
Aging and Adult Services Division  
Department of Human Services

## MISSISSIPPI

### Licensure Terms

Personal Care Home-Assisted Living, Personal Care Home-Residential Living

### General Approach

The Mississippi Department of Health, Health Facilities Licensure and Certification, licenses two types of personal care homes: assisted living and residential living. The primary difference between these two settings is that residential living communities may not admit or retain individuals who cannot ambulate independently.

A licensed personal care home may establish a separate Alzheimer's disease/dementia care unit. The rules and regulations for such units are in addition to the licensure requirements for the facility. Any licensed facility that establishes an Alzheimer's disease/dementia care unit and meets the additional requirements will have the designation printed upon the certificate of licensure issued by the licensing agency.

*Adult Foster Care (AFC).* An AFC home is a setting for vulnerable adults who are unable to live independently due to physical, emotional, developmental, or mental impairments; or who are in need of emergency and continuing protective social services to prevent further abuse or neglect; and to safeguard and enhance the welfare of abused or neglected vulnerable adults. AFC programs provide a variety of health, social, and related support services in a protective setting, enabling participants to live in the community and may be traditional (the foster care provider lives in the residence and is the primary caregiver); corporate (the foster care home is operated by a corporation with staff delivery of services to residents); or shelter (the foster care home accepts residents on an emergency short-term basis for up to 30 days). The definition does not specify the maximum number of beds. *Regulatory provisions for AFC are not included in this profile but a link to the provisions can found at the end.*

*This profile includes summaries of selected regulatory provisions for personal care homes--assisted living and, when they differ, for personal care homes--residential living. The complete regulations are online at the links provided at the end.*

### Definitions

**Personal care home-assisted living** is a licensed facility operating 24 hours a day, 7 days a week, accepting individuals who require assisted living services as defined by the state's regulations. Assisted living means the provision of personal care

and supplemental services, including--but not limited to--the provision of medical services (i.e., medication procedures and medication administration) and emergency response services.

**Personal care home-residential living** is a licensed facility operating 24 hours a day, 7 days a week, accepting individuals who require personal care services or individuals who, due to functional impairments, may require mental health services to compensate for limitations in activities of daily living (ADLs).

## Resident Agreements

An agreement must be signed prior to or on admission and must contain information about the following:

- Basic charges for services agreed upon.
- The period covered by the charges.
- Services that incur additional fees.
- Refunds for any payments made in advance.
- A statement that the operator shall make the resident's responsible party aware, in a timely manner, of any changes in the resident's status, including those that require transfer and discharge.

Facilities must also give written notice to the resident or responsible party when basic charges or facility policies change.

## Disclosure Provisions

*No provisions identified.*

## Admission and Retention Policy

**Personal care homes-assisted living** may only admit residents whose needs it can meet. An appropriate resident is typically an aged ambulatory person who requires personal care and who may require non-medical services, medical services such as medication assistance, emergency response services, and home health services prescribed by a physician. Residents who require a wheelchair must be capable of transferring to the wheelchair and propelling it independently or with prompting. No more than 10 percent of the resident census can require assistance during any staffing shift.

A person may not be admitted or retained if he or she:

- Requires physical restraints.

- Poses a serious threat to self or others.
- Requires certain treatments (nasopharyngeal and/or tracheotomy suctioning; gastric feedings; intravenous (IV) fluids, medications, or feedings; an in-dwelling urinary catheter; sterile wound care); or treatment of decubitus ulcers or exfoliative dermatitis.

Specified exceptions and agency approval permit some residents who do not meet the retention criteria to continue living in a facility. No facility may allow more than two residents, or 10 percent of the total number of residents, whichever is greater, to remain under these circumstances.

Facilities that admit residents requiring mental health services must help arrange transportation to mental health appointments and cooperate with the community mental health center or other provider of mental health services, as-necessary, to ensure access to and the coordination of care.

***Personal Care Homes-Residential Care.*** Provisions are identical to those for assisted living, with the exception that residents who are not ambulatory may not be admitted or retained.

The state has separate regulations for Alzheimer's disease/dementia care units, which are permitted to accept persons with up to Stage II Alzheimer's disease. Before admission, a complete medical examination must be conducted by a physician, nurse practitioner, or physician assistant; and an assessment by a licensed practitioner whose practice includes the assessment of cognitive, functional, and social abilities, must also be conducted. These assessments must demonstrate that the individual is appropriate for placement. Facilities must have policies and procedures to deal with residents who may attempt to wander outside the facility.

## Services

Personal care homes provide laundry, assistance with ADLs, social activities, and referral to social services as needed.

Dementia care units must provide daily therapeutic activities provided by a certified therapeutic recreation specialist. Activities may include those focused on self-care; domestic tasks; life skills; relationships; leisure; holidays; meals; and intellectual, spiritual, creative, and physically active pursuits. Activities may be conducted in structured large and small groups.

### ***Service Planning***

Prospective residents must be given a thorough examination by a licensed physician or certified nurse practitioner, or physician assistant within 30 days prior to

admission to determine the appropriateness of admission. A re-examination by a physician and/or nurse practitioner or physician assistant is required annually.

### **Third-Party Providers**

*No provisions identified for either licensure category.*

## **Medication Provisions**

**Personal Care Homes-Assisted Living.** Medication administration is defined as decisions made by someone other than the person for whom the medication has been prescribed regarding which medication is to be taken, the dosage of the medication, or the time at which the medication is to be taken. Only a licensed nurse may administer medications to residents who do not self-administer.

Medication assistance is any form of delivering prescribed medication that is not defined as “medication administration” including, but not limited to, the physical act of handing an oral prescription medication to the resident along with liquids to assist the resident in swallowing.

**Personal Care Homes-Residential Care.** The provisions do not define medication administration but do describe medication assistance as described above. Facilities may not permit use of Schedule I drugs<sup>87</sup> or the use of intramuscular, subcutaneous, IV, or injectable medications, except for insulin and vitamin B-12. Injections must be self-administered or administered by a licensed nurse.

## **Food Service and Dietary Provisions**

Facilities must provide at least three daily meals that meet the nutritional, social, emotional, and therapeutic needs of residents and that meet current recommended dietary allowances. All special diets must be planned by a licensed dietician who visits the facility at least once every 30 days.

## **Staffing Requirements**

**Type of Staff.** A full-time *operator* is responsible for facility management, and when the operator is not at the facility, a designated employee must be responsible for management. *Direct care staff* provide personal care assistance and a *licensed nurse* must be on the premises 8 hours a day to administer medications.

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<sup>87</sup> Drugs with a high potential for abuse, with no currently accepted medical treatment use in the United States, and/or a lack of accepted safety for use of the drug under medical supervision.

**Staff Ratios.** From 7:00 a.m. to 7:00 p.m., at least one employee per 15 or fewer residents must be present, and from 7:00 p.m. to 7:00 a.m., at least one employee per 25 residents. A licensed nurse.

## Training Requirements

On a quarterly basis, direct care staff must receive appropriate training on topics related to the care of the population being served. New operators must spend 2 concurrent days with the licensing agency for training and mentoring. *A description of the training is not provided.*

## Provisions for Apartments and Private Units

Private units are not required. As many as four residents can share a bedroom. Separate toilet and bathing facilities are required on each floor for each sex: one bathtub or shower must be provide for every 12 residents or fraction thereof for each sex, and one sink and toilet for every six residents or fraction thereof.

## Provisions for Serving Persons with Dementia

**Dementia Care Staff.** Facilities must provide 3 hours of nursing care per resident per 24 hours and a *registered nurse* or *licensed practical nurse* must be present on all shifts. Two staff members must be available at all times. The services of licensed nursing staff and nurse aides are included in the count of nursing care.

If the Alzheimer's/dementia care unit is not freestanding, licensed nursing staff may be shared with the rest of the facility. A licensed social worker, licensed professional counselor, or licensed marriage and family therapist must provide social services to residents and support to family members. The *social service consultant* must work a minimum of 8 hours per month on site.

**Dementia Staff Training.** Dementia care units must provide a staff orientation covering the facility's philosophy, policies, and procedures regarding care and therapy; a description of the disease; treatment modalities; admission, discharge, and transfer criteria; basic services provided; policies regarding restraints, wandering, and egress control; medication management; nutrition management techniques; family activities; and common behavior problems and recommended behavior management techniques.

Quarterly in-service training must provide hands-on training in at least three of the following topics: nature and progression of the disease; common behavior problems and management techniques; positive therapeutic interventions; role of the family; environmental modifications; developing individual and comprehensive care plans and how to implement them across shifts; and new developments in diagnosis and therapy.

***Dementia Facility Requirements.*** Physical design standards for Alzheimer's/dementia units include security controls on all entrances and exits, and a secure, exterior exercise pathway. Resident rooms may be individually identified to assist with recognition.

## **Background Checks**

The administrator and all direct care staff must document that they are not listed on the Nurses' Aide Abuse Registry. A criminal background check, including fingerprinting, must be completed for all new employees who provide direct patient care or services. The regulations list several crimes and offenses that preclude employment.

## **Inspection and Monitoring**

New facilities are inspected prior to licensure and at intervals specified by the Mississippi Department of Health.

## **Public Financing**

Services in personal care homes-assisted living are covered under a Medicaid 1915(c) Assisted Living Waiver program that serves individuals age 65 and older, and those age 21-64 with physical or other disabilities, including acquired brain injury. Services in dementia care units are not covered.

### ***Room and Board Policy***

As of 2015, Medicaid policy does not address room and board and the state does not provide a supplement to help pay for room and board.

## **Location of Licensing, Certification, or Other Requirements**

Mississippi State Department of Health, Health Facilities Licensure and Certification: Minimum Standards for Adult Foster Care Facilities. [October 2012]  
[http://www.msdh.state.ms.us/msdhsite/\\_static/resources/2347.pdf](http://www.msdh.state.ms.us/msdhsite/_static/resources/2347.pdf)

Mississippi State Department of Health, Health Facilities Licensure and Certification: Minimum Standards for Alzheimer's Unit [October 2012], Personal Care Homes-Assisted Living [August 15, 2014], and Personal Care Homes-Residential Living. [August 15, 2014]  
[http://msdh.ms.gov/msdhsite/\\_static/30,0,83,60.html](http://msdh.ms.gov/msdhsite/_static/30,0,83,60.html)

## Information Sources

Wanda Kennedy  
Mississippi Health Care Association

James Horton  
Division Director I  
Long-Term Care  
Office of the Governor  
Division of Medicaid

## MISSOURI

### Licensure Terms

Assisted Living Facilities and Residential Care Facilities

### General Approach

The Missouri Department of Health and Senior Services, Division of Regulation and Licensure, Section for Long-Term Care Regulation, licenses assisted living and residential care facilities (RCFs) with one set of rules; however, some provisions differ for the two facility types. The primary difference between assisted living and RCFs is that assisted living facilities (ALFs) may admit and retain individuals who require a higher level of assistance to evacuate the building than can RCFs, whose residents must be able to evacuate without assistance. In addition, ALFs must adhere to social model of care principles and have a physician available to supervise care.

Under 2006 revised statutes, facilities previously licensed as RCF I are now licensed as RCFs, and facilities previously licensed as RCF II are now licensed as ALFs. However, facilities licensed on or before August 27, 2006, that continue to meet the licensure standards in effect on that date may maintain this designation on behalf of residents receiving supplemental welfare assistance payments allocated immediately prior to August 28, 2006.

The state has no licensure category for adult foster care.

*This profile includes summaries of selected regulatory provisions for ALFs and RCFs. Because the rules do not permit construction of RCFs II after 2006, this profile does not include the regulations for this category. The complete regulations are online at the links provided at the end.*

### Definitions

**Assisted living facility** means any residence, other than a RCF, intermediate care facility, or skilled nursing facility, that provides 24-hour care and services and protective oversight to three or more adults who need assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs); storage, distribution, or administration of medications; and/or supervision of health care under the direction of a licensed physician.

The rules describe assisted living as a social model of care that emphasizes the abilities, desires, and functional needs of the individual, with services delivered in a setting that is more home-like than institutional and which promote the residents' dignity, individuality, privacy, independence, and autonomy.

**Residential care facility** means any residence, other than an ALF, intermediate care facility, or skilled nursing facility, that provides 24-hour care to three or more adults who need or are provided with shelter, board, and with protective oversight, which may include storage and distribution or administration of medications and care during short-term illness or recuperation.

## Resident Agreements

At the time of admission, both facility types are required to provide information about the services they provide or coordinate; service costs; resident's rights; policies related to resident conduct and responsibilities; and community-based services available in the state.

## Disclosure Provisions

Both licensure categories require facilities to disclose to prospective residents, and/or their representative, information regarding the services that will be provided or coordinated, their cost, and discharge policies.

## Admission and Retention Policy

**Assisted Living Facilities.** Facilities may not admit or retain persons who are bedbound; or who: (1) have behaviors that present a reasonable likelihood of serious harm to self and/or others; (2) require the use of physical or chemical restraints; (3) require skilled nursing services, which the facility is not able to provide; or (4) require more than one person to provide physical assistance (excluding bathing and transferring). Facilities may discharge residents who have needs that cannot be met; who no longer need assisted living services; and/or who endanger the health and/or safety of others. Facilities must be able to accommodate residents who require minimal or more than minimal assistance to evacuate the building during an emergency.

Facilities may admit and retain individuals who are receiving hospice care, including those who are bedbound, require skilled nursing care, and need more than one person to provide physical assistance, provided the resident, his or her legally authorized representative or designee, or both, and the facility, physician, and licensed hospice provider all agree that such program of care is appropriate for the resident.

Residents experiencing short periods of incapacity due to illness or injury or who are recuperating from surgery may be allowed to remain or be readmitted from a hospital if the period of incapacity does not exceed 45 days and a physician provides written approval.

Facilities may accept or retain residents with an impairment (physical, cognitive, or other type) that prevents their safe evacuation with minimal assistance only if provisions are met regarding staffing requirements to assist in evacuations, and each resident has an individualized evacuation plan.

**Residential Care Facilities.** To be admitted and retained, individuals must be able to independently get to an area of refuge inside or outside the building during an emergency within 5 minutes of being alerted. Facilities may discharge residents who have needs that cannot be met; who no longer need services; and/or who endanger the health and/or safety of others. Residents who have short periods of incapacity due to illness, injury, or recuperation from surgery may be allowed to remain or be readmitted from a hospital if the period of incapacity does not exceed 45 days and a physician provides written approval.

## Services

**Assisted Living Facilities.** Facilities must provide 24-hour care and protective oversight; nursing services; assistance with ADLs and IADLs; assistance with storage, distribution, and/or administration of medications; and recreational activities.

**Residential Care Facilities.** Facilities must provide 24-hour care and protective oversight; storage, distribution or administration of medications, and care during short-term illness or recuperation. Staff must encourage residents to be active and participate in activities.

### Service Planning

**Assisted Living Facilities.** Facilities must complete screening prior to admission to determine whether an applicant is eligible to be admitted. Within 5 days of admission, a community-based assessment--using a Department-approved assessment tool--must be completed by an authorized staff person and a physician must conduct a physical exam to document the individual's current medical status and write any special orders regarding care and needed procedures. The community-based assessment must be repeated whenever the resident has a significant change in condition and at least semi-annually. An individualized service plan must be developed that describes the services to be provided to meet the resident's goals, needs, and expectations. An individualized evacuation plan must be developed for residents who require more than minimal assistance to evacuate.

**Residential Care Facilities.** Individuals must be examined by a licensed physician in order to document their current medical status and the need for any special orders or procedures. Documentation should be obtained prior to admission but not later than 10 days after admission. The facility must review, on a monthly basis, each resident's general medical condition and needs; medications; weight; referrals for third-party services; and any accidents that potentially could have or did result in injury to the resident.

### **Third-Party Providers**

Both facility types may obtain services from third-party providers, if needed to meet residents' needs.

## **Medication Provisions**

In both facility types, residents may self-administer prescription and non-prescription medications if a licensed health provider approves. A physician, pharmacist, or registered nurse (RN) must review the medication regimen of each resident every other month. At a minimum, staff who administer medications must be certified as level I medication aides or certified medication technicians unless they are a licensed physician, nurse, or pharmacist. Injections may be administered only by a physician or licensed nurse, except that insulin injections may be administered by a certified medication technician or Level I medication aide who has successfully completed the state-approved course for insulin administration.

## **Food Service and Dietary Provisions**

Both licensure categories require at least three meals a day. Modified diets prescribed by a physician can be provided if the resident is monitored by the physician and the diet is reviewed at least quarterly by a consulting nutritionist, dietitian, RN, or physician.

## **Staffing Requirements**

### **Assisted Living Facility**

**Type of Staff.** Facilities must employ a licensed *administrator* (or manager) to oversee daily operations and supervise staff, a *licensed nurse*, and *direct care staff*. A *Level I medication aide* and/or *certified medication technicians* may be employed to administer medications. Each facility must be under the supervision of a *physician* who has been informed of the facility's emergency medical procedures and is kept informed of treatments or medications prescribed by any other professional authorized to prescribe medications. The facility must hire an adequate number and type of personnel

to ensure the proper care of residents, the residents' social well-being, protective oversight of residents, and the facility's upkeep.

**Staff Ratios.** Minimum staff-to-resident ratios are 1:15 during the day shift; 1:20 during the evening shift; and 1:25 during the night shift. The required staff must be in the facility awake, dressed, and prepared to assist residents in case of emergency. The administrator may count toward staffing when physically present in the facility. A licensed nurse must be employed a minimum number of hours per week based on the number of residents: 8 hours a week for 3-30 residents; 16 hours a week for 31-60 residents; 24 hours a week for 61-90 residents; and 40 hours a week for more than 90 residents.

Facilities that provide services to residents with a physical, cognitive, or other impairment that prevents them from safely evacuating the facility with minimal assistance must meet the following minimum staff-to-resident ratios: 1:15 during the day and evening shifts, and 1:20 during the night shift.

### ***Residential Care Facility***

**Type of Staff.** Facilities must employ an *administrator* (or manager) to oversee daily operations and supervise staff and *direct care staff* to provide personal care. A *Level I medication aide* and/or *certified medication technicians* may be employed to administer medications. Facilities are required to provide an adequate number and type of personnel on duty at all times for the proper care of residents and the facility's upkeep.

**Staff Ratios.** At minimum, there must be one staff person for every 40 residents. Facilities operated in conjunction with and contiguous to another licensed facility may not be required to have staff on-site 24 hours daily based on specified exceptions (e.g., a call system or the number of staff in the other building). Facilities with fewer than 12 residents are not required to have overnight awake staff unless any of those residents are blind or use mobility aides, in which case awake staff are required.

## **Training Requirements**

In both facility types, all staff must receive at least 1 hour of fire safety training and orientation appropriate to job function and responsibilities, including information about preservation of resident dignity, abuse/neglect, and working with residents with mental illness.

Any facility that provides care to any resident having Alzheimer's disease or other dementia must provide orientation to all staff. For employees providing direct care to such residents, the orientation training must include at least 3 hours of training, including at a minimum an overview of mentally confused residents; communicating with persons with dementia; behavior management; promoting independence in ADLs;

techniques for creating a safe, secure, and socially oriented environment; provision of structure, stability, and a sense of routine for residents based on their needs; and understanding and dealing with family issues.

For other employees who do not provide direct care but may have daily contact with such residents, the orientation training must include at least 1 hour of training, including at a minimum an overview of mentally confused residents, such as those having dementias, as well as communicating with persons with dementia.

Dementia-specific training must be incorporated into ongoing in-service curricula. Orientation and training must be conducted, presented, or provided by an individual who is qualified by education, experience, or knowledge in the care of individuals with Alzheimer's disease or other dementia.

In addition to the requirements listed above, all staff in an ALF must receive a minimum of 2 hours of initial training on transfer assistance (e.g., wheelchair to bed, bed to dining room chair); instruction regarding person-centered care and the social model of care; and techniques that are effective in enhancing residents' choice and control over their environment; and 24 hours of additional training, approved by the Department, consisting of definition and assessment of ADLs; assessment of cognitive ability; service planning; and interview skills.

## **Provisions for Apartments and Private Units**

Apartment-style units are not required. Both facility types may offer either single or multiple-occupancy rooms, with a maximum of four residents to a room. One tub or shower must be provided for every 20 residents and one toilet and sink for every six residents.

For ALFs, the rules emphasize that facilities must be "home-like," which is defined as "a self-contained long-term care setting that integrates the environmental, psychosocial, and organizational qualities that are associated with being at home." Home-like may include, but is not limited, to the following: (1) a living room and common-use areas for social interactions and activities; (2) a kitchen and family-style eating area for use by the residents; (3) a laundry area for use by residents; (4) a toilet room that contains a toilet, sink, and bathing unit in each resident's room; (5) meeting preferences for residents who wish to share a room and for residents who wish to have private bedrooms; (6) an outdoor area for outdoor activities and recreation; and (7) a place where residents can enjoy privacy, security, familiarity, and a sense of belonging; exercise control over their environment; give and receive affection; explore their interests; and engage in interactions with others.

## Provisions for Serving Persons with Dementia

No provisions identified for either type of facility apart from general training described above.

## Background Checks

Prior to hiring staff or allowing volunteers to work, both facility types must conduct a criminal background check and an employee disqualification list check (maintained by the Department of Health and Senior Services). Individuals who have been convicted of, pled guilty or no contest to, or who have been found guilty of a crime (Class A or B felony violation), cannot have contact with residents unless the facility obtains verification from the Department that a good cause waiver has been granted. Professional services staff (e.g., plumbing or air conditioning repair personnel) who will have contact with any resident must either have a criminal background check or be monitored by staff while in the facility.

## Inspection and Monitoring

Facilities in both licensure categories must be inspected prior to being licensed and then annually.

## Public Financing

The state pays for the provision of personal care services in assisted living and RCFs under the Medicaid State Plan Personal Care authority. The program provides support to residents whose personal care needs exceed those that the facility is typically able to provide. The state does not cover services in either facility type under a Medicaid waiver program.

### ***Room and Board Policy***

The state provides an optional state supplement (OSS) to eligible residents in specified living arrangements. In 2015, the maximum OSS was \$156 per month for RCF residents and \$292 per month for ALF residents, less a personal needs allowance of \$45, which is retained by the resident.

In 2009, family supplementation was allowed.<sup>88</sup>

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<sup>88</sup> Mollica, R.L. (2009). *State Medicaid Reimbursement Policies and Practices in Assisted Living*, National Center for Assisted Living, American Health Care Association. <http://www.ahcancal.org/ncal/resources/Documents/MedicaidAssistedLivingReport.pdf>. Current information about family supplementation policy was not available online or from other sources.

## Location of Licensing, Certification, or Other Requirements

*Code of State Regulations*, Title 19, Division 30, Chapter 86: Licensure and Regulation of Residential Care Facilities and Assisted Living Facilities. [September 30, 2012]

<http://www.sos.mo.gov/adrules/csr/current/19csr/19c30-86.pdf>

*Missouri Revised Statutes*, Title XL, Chapter 660.050: Division of Aging created—dementia-specific training requirements established. [2009]

[http://law.justia.com/codes/missouri/2009/t40/c660/660\\_050.html](http://law.justia.com/codes/missouri/2009/t40/c660/660_050.html)

## Information Sources

Keith Sappington  
Missouri Assisted Living Association

Carmen Grover-Slatery  
Regulation Unit Manager  
Division of Regulation and Licensure  
Section for Long-Term Care Regulation  
Missouri Department of Health and Senior Services

## MONTANA

### Licensure Terms

Assisted Living Facilities

### General Approach

The Montana Department of Public Health and Human Services licenses assisted living facilities (ALFs) as a setting for frail, elderly, or disabled persons, which provides supportive health and service coordination to maintain the resident's independence, individuality, privacy, and dignity. Three categories of facilities provide different levels of care, based on the needs of residents, as follows:

- Category A residents can self-medicate, need assistance with no more than three activities of daily living (ADLs), and are generally in good health.
- Category B residents may be in need of nursing services and be consistently and totally dependent in four or more ADLs.
- Category C residents are those with cognitive impairments who are not capable of expressing needs or making basic care decisions.

All facilities are licensed as meeting the applicable requirements for a Category A facility and may additionally be endorsed to provide Category B or Category C services with the approval of the Department. The Montana Medicaid Big Sky 1915(c) Waiver program provides adult residential living services to elders and people with disabilities in ALFs.

*Adult Foster Care (AFC).* Adult foster homes are private homes licensed by the Department of Public Health and Human Services to offer light personal care, custodial care, and supervision to aged or disabled adults who require assistance in meeting their basic needs and who are not related to the operator by blood or marriage. An adult foster family care home does not provide skilled nursing care. *The licensing provisions for AFC are not included in this profile but a link to them can found at the end.*

*This profile includes summaries of selected regulatory provisions for all categories of ALFs, unless specifically noted as provisions for those endorsed as Category B or C. The complete regulations are online at the links provided at the end.*

## Definitions

**Assisted living facility** means a congregate residential setting that provides or coordinates personal care, health-related services, scheduled and unscheduled 24-hour supervision and assistance, and activities.

## Resident Agreements

An ALF must enter into a written, dated, and signed resident agreement with each prospective resident prior to admission to the facility. The resident agreement lists all charges, refunds, services, and move-out criteria and also includes statements explaining: (1) the availability of skilled nursing or other professional services from a third-party provider to a resident in the facility; and (2) the resident's responsibilities, including but not limited to house rules, the facility grievance policy, facility smoking policy, and policies regarding pets.

## Disclosure Provisions

Each facility endorsed to provide Category C services must make available, in writing, to the prospective resident's guardian or family member, the following:

- The overall philosophy and mission of the facility regarding meeting the needs of residents with severe cognitive impairment, and the form of care or treatment.
- The process and criteria for move-in, transfer, and discharge.
- The process used for resident assessment.
- The process used to establish and implement a health care plan, including how the health care plan will be updated in response to changes in the resident's condition.
- Staff training and continuing education practices.
- The physical environment and design features appropriate to support the functioning of cognitively impaired residents.
- The frequency and type of resident activities.
- The level of involvement expected of families and the availability of support programs.
- Any additional costs of care or fees.

## Admission and Retention Policy

An ALF offers a suitable living arrangement for persons with a range of capabilities, disabilities, frailties, and strengths. Assisted living is not appropriate for individuals who are incapable of responding to their environment, expressing volition, interacting, or demonstrating any independent activity. The facility must determine whether a potential resident meets the facility's admission requirements and that the resident is appropriate to the facility's license endorsement.

Category A facilities may not serve residents who: (1) have Stage III or IV pressure sores; (2) require a gastronomy or jejunostomy tube; (3) require skilled nursing care or other skilled services on a continual basis (except administration of medications); (4) require physical or chemical restraint or confinement in locked quarters; (5) are a danger to self or others; (6) are dependent in four or more ADLs as a result of cognitive or physical impairment; or (7) are incapable of expressing needs or making basic care decisions. Category A residents may receive skilled medical services for no longer than 30 continuous days per occurrence, not to exceed 120 days in a 12-month period.

Facilities with a Category B endorsement may serve individuals who: (1) are consistently and totally dependent in four or more ADLs; (2) require skilled services for more than 30 days per episode and more than 120 days a year if the services are provided or arranged by the facility or the resident; (3) are not a danger to self or others; (4) do not require physical or chemical restraint or confinement in locked quarters; and (5) have a signed health care assessment by a licensed health care professional that is renewed quarterly.

Facilities with a Category C endorsement may serve residents who have severe cognitive impairments that render the individual incapable of expressing needs or of making basic care decisions but who do not require physical or chemical restraint or confinement in locked quarters. The individual may be at risk for leaving the facility without regard for personal safety but is not a danger to self or others.

A resident must have a practitioner's written order for admission and written orders for care to be admitted as a Category B or C resident.

## Services

All facilities must provide, or make provisions for, personal services such as laundry, housekeeping, and local transportation; assistance with ADLs; assistance using mobility and other assistive devices; recreational activities; assistance with self-administration of medications; 24-hour on-site supervision by staff; and assistance in arranging medical appointments.

A Category A facility may provide, make provisions for, or allow a resident to obtain third-party provider services for: (1) administration of medications consistent with applicable laws and regulations; and (2) skilled nursing care or other skilled services related to temporary, short-term acute illnesses, which may not exceed 30 consecutive days for one episode or more than a total of 120 days in 1 year.

A facility with a Category B endorsement may provide skilled nursing care or other skilled services to five or fewer residents, consistent with move-in and move-out criteria specified in law, in addition to serving other residents who do not require Category B level of service.

A facility with a Category C endorsement may provide care to meet the needs of individuals with severe cognitive impairment that renders them incapable of expressing needs or making basic care decisions. Category C facilities may also serve residents who are categorized as A and B.

### ***Service Planning***

Prior to admission to any ALF, an initial assessment must be conducted to determine the prospective resident's needs. Assessment topics include: cognitive patterns; sensory patterns; ADLs abilities; mood and behavior patterns (such as sadness or anxiety, wandering, and verbally/physically abusive and socially inappropriate/disruptive behavior); health problems; weight/nutritional status; skin problems; medication use; and use of restraints, safety, or assistive devices.

Category A facilities must develop an initial service plan based on the initial needs assessment, which must be reviewed or modified within 60 days of admission to ensure the service plan accurately reflects the resident's needs and preferences.

A facility with a Category B or Category C endorsement must also ensure that a resident health care assessment covering specific topics is conducted within 21 days of admission by a licensed health care professional to develop a resident health care plan, which must be reviewed and, if necessary, revised upon change of condition.

Additionally, Category C facilities must conduct a resident certification that includes detailed assessment, therapeutic management, and intervention techniques for the following behaviors and resident needs: memory, judgment, ability to care for oneself, ability to solve problems, mood and character changes, behavioral patterns, wandering, and dietary needs.

### ***Third-Party Providers***

A resident may purchase third-party services provided by an individual or entity, licensed if applicable, to provide health care services under arrangements made directly with the resident or resident's legal representative. Third-party services must not compromise the ALF operation or create a danger to others in the facility.

## Medication Provisions

All Category A facility residents must be capable of self-administering their medication, except as described above under Services, when residents are allowed to obtain third-party services for short-term needs consistent with applicable laws and regulations. Those residents in Category B facilities who are capable of and who wish to self-administer medications are encouraged to do so. Any direct care staff member who is capable of reading medication labels may provide necessary assistance to a resident in taking their medication. Assistance includes the following:

- Removing medication containers from secured storage.
- Providing verbal suggestions, prompting, reminding, gesturing or providing a written guide for self-administrating medications.
- Handing a pre-filled, labeled medication holder, labeled unit dose container, syringe or original marked, labeled container from the pharmacy or a medication organizer to the resident.
- Opening the container lid.
- Guiding the resident's hand to self-administer the medication.
- Assisting the resident in drinking fluid to swallow oral medications.
- Assisting with removal of a medication from a container for residents with a physical disability which prevents independence in the act.

Category B or Category C residents who are unable to self-administer their medications must have the medications administered by a licensed health care professional or by an individual delegated to do so under the Montana Nurse Practice Act, including: a licensed physician, physician's assistant, certified nurse practitioner, advanced practice registered nurse or a registered nurse (RN); a licensed practical nurse (LPN) working under supervision; an unlicensed individual who is either employed by the facility or is working under a third-party contract with a resident or resident's legal representative and has been delegated the task; and a person related to the resident by blood or marriage or who has full guardianship.

Resident medication organizers may be prepared by a family caregiver/guardian up to 4 weeks in advance and injectable medications, such as insulin, may be set up 7 days in advance.

## Food Service and Dietary Provisions

Foods must be served in amounts and a variety sufficient to meet the nutritional needs of each resident. Facilities must prepare modified diets when ordered by a resident's health care provider. If a facility accepts residents who require a physician-recommended therapeutic or special diet, it must consult with a dietician to ensure that meals are appropriately prepared.

At least three meals must be offered daily and at regular times, with not more than a 14-hour span between an evening meal and breakfast unless a nutritious snack is available in the evening, then up to 16 hours may lapse between a substantial evening meal and breakfast. Meals must offer an alternative food or drink to give residents a choice.

## Staffing Requirements

**Type of Staff.** ALFs must employ a qualified *administrator*<sup>89</sup> who is responsible for the daily operation of the facility at all times and must ensure 24-hour supervision of the residents. In the absence of the administrator, a staff member must be designated to oversee the operation of the facility. The administrator or designee must ensure there are sufficient, qualified staff so that the care, well-being, health, and safety needs of the residents are met at all times. If the facility offers cardiopulmonary resuscitation (CPR), at least one person per shift must hold a current CPR certificate.

Category B facilities must employ or contract with a *registered nurse* to provide or supervise nursing services, which include: (1) general health monitoring for each resident; (2) performing a nursing assessment on residents when and as required; (3) assistance with the development of the resident health care plan and, as appropriate, the development of the resident service plan; and (4) routine nursing tasks, including those that may be delegated to LPNs and unlicensed assistive personnel in accordance with the Montana Nurse Practice Act.

**Staff Ratios.** *No minimum ratio.* At least one staff member must be present 24 hours a day. Facilities must have a sufficient number of qualified staff on-duty 24 hours a day to meet the scheduled and unscheduled needs of each resident, provide all related services, and respond in emergency situations. Category C facilities require 24-hour awake staff.

Volunteers can be used to provide direct care, but may not be considered part of the required staff and may not assist with medication administration, delegated nursing tasks, bathing, toileting, or transferring. Volunteers must be adequately supervised and

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<sup>89</sup> Administrators must be licensed as a nursing home administrator in Montana or another state; or have successfully completed all of the self-study modules of "The Management Library for Administrators and Executive Directors", a component of the assisted living training system published by the Assisted Living University; or be enrolled in and complete the self-study course within 6 months of employment.

be familiar with resident rights and the facility's policy and procedures that apply to their duties as a volunteer.

## Training Requirements

New employees must receive orientation and training in areas relevant to their duties and responsibilities, including: (1) an overview of the facility's policies and procedures manual; (2) services provided by the facility; and (3) the Montana Elder and Persons with Developmental Disabilities Abuse Prevention Act and the Montana Long-Term Care Resident Bill of Rights Act.

In addition, direct care staff must be trained to perform the services established in each resident service plan and must be trained in the use of the abdominal thrust maneuver and basic first-aid. Administrators must show evidence of at least 16 contact hours of annual continuing education relevant to the individual's duties and responsibilities.

## Provisions for Apartments and Private Units

Apartment-style units are not required. In a facility licensed prior to 2004, no more than four residents may reside in a single bedroom. In facilities licensed after 2004 and those serving residents with severe cognitive impairment, occupancy must be limited to no more than two residents per room. Each resident must have access to a toilet room without entering another resident's room or the kitchen, dining, or living areas. There must be one toilet room for every four residents and one bathing facility for every 12 residents.

Kitchens or kitchenettes in resident rooms are permitted if the resident's service plan permits unrestricted use and the cooking appliance can be removed or disconnected if the service or health care plan indicates the resident is not capable of unrestricted use.

## Provisions for Serving Persons with Dementia

***Dementia Care Staff.*** Staff in Category C facilities must remain awake, fully dressed and be available in the facility or on the unit at all times to provide supervision and care to the residents as well as to assist the residents in evacuation of the facility if a disaster occurs.

***Dementia Staff Training.*** In addition to meeting all other requirements for direct care staff in Category A and Category B facilities, Category C direct care staff must receive additional documented training in:

- The facility's or unit's philosophy and approaches to providing care and supervision for persons with severe cognitive impairment.
- The skills necessary to care for and direct residents who are unable to perform ADLs.
- Techniques for minimizing challenging behavior, including wandering, hallucinations, illusions and delusions, and impairment of senses.
- Therapeutic programming to support the highest possible level of resident function, including large motor activity, small motor activity, appropriate level cognitive tasks, and social/emotional stimulation.
- Promoting residents' dignity, independence, individuality, privacy, and choice.
- Identifying and alleviating safety risks to residents.
- Identifying common side effects of and untoward reactions to medications.
- Techniques for dealing with bowel and bladder aberrant behaviors.

At least 8 of the 16 hours of the annual training requirement for administrators must pertain to caring for persons with severe cognitive impairments.

***Dementia Facility Requirements.*** In addition to meeting all other requirements for ALFs stated in the rules, if a secured distinct part or locked unit within a Category C ALF is designated for the exclusive use of residents with severe cognitive impairment, the facility must provide a separate dining area and a common day or activities area on the unit.

## Background Checks

The administrator must develop policies and procedures for screening, hiring, and assessing staff--which include practices that assist the employer in identifying employees that may pose risk or threat to the health, safety or welfare of any resident--and provide written documentation of findings and the outcome in the employee's file. The employer must have evidence to verify that each certified nursing assistant has no adverse findings entered on the Nurse Aid Registry maintained by the Department in the certification bureau.

## Inspection and Monitoring

The Licensure Bureau conducts a full survey of each facility once every 1-3 years, near the renewal date of the current operating license, depending on whether the facility has been granted an extended license.

## Public Financing

The Montana Medicaid Big Sky 1915(c) Waiver program provides adult residential living services to persons 65 and older and younger adults with disabilities who reside in ALFs.

### **Room and Board Policy**

Charges for assisted living room and board are set at the medically needy income standard, which was \$768 per month in 2011. This amount included the federal Supplemental Security Income (SSI) payment of \$674 plus an optional state supplement (OSS) of \$94 a month. Depending on the facility, residents retained a personal needs allowance (PNA) of up to \$100 a month.<sup>90</sup> In 2009, family supplementation was not permitted.<sup>91</sup>

## Location of Licensing, Certification, or Other Requirements

*Administrative Rules of Montana*, 37.106, Subchapter 28: Assisted Living Facilities. [May 7, 2004]

<http://www.mtrules.org/gateway/Subchapterhome.asp?scn=37.106.28>

*Montana Code Annotated*, 50-5-227. Licensing Assisted Living Facilities. [2014]

<http://leg.mt.gov/bills/mca/50/5/50-5-227.htm>

*Montana Code Annotated*, 50-5-226. Placement in Assisted Living Facilities. [2014]

<http://leg.mt.gov/bills/mca/50/5/50-5-226.htm>

*Administrative Rules of Montana*, 37.100, Subchapter 1: Licensure of Adult Foster Care Homes. [May 23, 2014]

<http://www.mtrules.org/gateway/Subchapterhome.asp?scn=37.100.1>

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<sup>90</sup> Social Security Administration, *State Assistance Programs for SSI Recipients*, January 2011.

[http://www.socialsecurity.gov/policy/docs/progdesc/ssi\\_st\\_asst/2011/mt.html](http://www.socialsecurity.gov/policy/docs/progdesc/ssi_st_asst/2011/mt.html). Current information about Medicaid room and board policies, the OSS, and the PNA, was not available online or from other sources.

<sup>91</sup> Mollica, R.L. (2009). *State Medicaid Reimbursement Policies and Practices in Assisted Living*, National Center for Assisted Living, American Health Care Association.

<http://www.ahcanal.org/ncal/resources/Documents/MedicaidAssistedLivingReport.pdf>. Current information about family supplementation policy was not available online or from other sources.

*Montana Code Annotated*, 50-5-216: Limitation on care provided in adult foster care home.  
[2014]

<http://leg.mt.gov/bills/mca/50/5/50-5-216.htm>

## Information Sources

Leigh Ann Holmes  
Program Manager  
Health Care Facility Licensing  
Licensure Bureau, Quality Assurance Division  
Department of Public Health and Human Services

LaDawn Whiteside  
Program Manager  
Home and Community-Based Services Senior and Long-Term Care Division  
Department of Public Health and Human Services

## NEBRASKA

### Licensure Terms

Assisted Living Facility

### General Approach

Assisted living facilities (ALFs) are licensed by the Nebraska Division of Public Health, Department of Health and Human Services, Department of Licensure and Regulation. The definition of ALF does not include a home, apartment, or facility where casual care is provided at irregular intervals, or where less than 25 percent of the residents contract for their own personal or professional services.

The Alzheimer's Special Care Disclosure Act established regulations applicable to facilities that market themselves as providing special care for persons with Alzheimer's disease or other dementias.

*Adult Foster Care.* Adult family homes provide a home-like living arrangement to meet the needs of individuals who are unable to live independently but who can function adequately with minimal supervision and protection. Adult family homes are certified by the Nebraska Department of Social Services to provide services to not more than three adults age 19 or older; services include room and board, equipment, household supplies, laundry service, and facilities to ensure residents' comfort. *Regulatory provisions for these settings are not included in this profile but a link to the provisions can found at the end.*

*This profile includes summaries of selected regulatory provisions for ALFs. The complete regulations can be viewed online using the links provided at the end.*

### Definitions

**Assisted living facilities** provide daily shelter, food, and care to four or more residents not related to the owner, operator, manager, or administrator who require or request services due to age, illness, or physical disability. Care includes a minimum amount of supervision and assistance with personal care, activities of daily living (ADLs), health maintenance activities, or other supportive services.

## **Resident Agreements**

Facilities must develop a resident service agreement based on an assessment. In addition to listing any specialized care services (for dementia) that will be provided, the agreement must specify the rights and responsibilities of the facility and residents, the costs of services and terms of payment, and the terms and conditions of continued occupancy.

## **Disclosure Provisions**

Facilities must provide a written document that contains the following information: a description of the services provided and the staff available to provide them; charges; whether Medicaid payment is accepted and, if applicable, policies or limitations regarding Medicaid payment; move-out criteria; and updates to the resident services agreement.

ALFs that market themselves as having a special care unit for people with dementia must file with the licensing agency a written statement of the facility's mission and philosophy; admission, discharge, and transfer criteria; resident assessment policies and practices; staffing; physical features that support dementia care; activities; and policies for involving families.

## **Admission and Retention Policy**

To be admitted to an ALF, a person must be in need of, or wish to have, available shelter; food; assistance with ADLs or health maintenance activities; assistance with or provision of personal care; or supervision due to age, illness, or physical disability. Individuals who require complex nursing interventions or whose conditions are not stable and predictable may not be admitted, retained, or readmitted unless all of the following conditions are met:

- The resident (or resident designee or physician) or the facility registered nurse (RN) agree that admission or retention is appropriate.
- The resident (or designee) assumes responsibility for arranging care through private duty personnel, a licensed home health agency, or a licensed hospice agency.
- The resident's care does not compromise the facility operations or create a danger to others in the facility.

## Services

Facilities may provide assistance with personal care, ADLs and instrumental activities of daily living, self-administration of medications, and health maintenance activities (i.e., non-complex nursing interventions). All health maintenance activities must be performed in accordance with the Nurse Practice Act. A facility may also provide supportive services, including transportation, laundry, housekeeping, financial assistance/management, behavioral management, case management, shopping, beauty/barber, and spiritual services.

### ***Service Planning***

A service agreement describes the services that will be provided to meet the resident's needs as identified during an assessment. The agreement specifies whether the services are provided by the facility and/or other sources; how often, when, and by whom they will be delivered; and services for residents with special needs. The agreement must be reviewed and updated as the resident's needs change.

### ***Third-Party Providers***

Residents may assume the responsibility for arranging their own care through a licensed home health or hospice agency or appropriate private duty personnel.

## Medication Provisions

Residents may receive medications in any of three ways:

- Residents who are capable of doing so may self-administer, with or without staff supervision.
- Licensed health care professionals, whose scope of practice includes medication administration, may administer medications.
- Medication aides who are trained, have demonstrated minimum competency standards, and are appropriately directed and monitored may administer medications.

An RN must review and document medication administration policies and procedures at least annually and provide or oversee medication aide training. The rules include extensive provisions that address the administration of medications by unlicensed medication aides in accordance with the Medication Aide Act, and include training in the following:

- Procedures for storing, handling, and providing medications.

- Procedures for documentation of medications.
- Procedures for documentation and reporting medication errors and adverse reactions.
- Information about the person(s) responsible for direction and monitoring of medication aides.
- Resident-specific training on providing medications.

## Food Service and Dietary Provisions

Facilities must provide food services and may provide special diets requested by residents. Written menus must be based on federal nutrition standards. Residents must be monitored for potential nutritional problems based on specified weight changes.

## Staffing Requirements

**Type of Staff.** An *administrator* is responsible for the facility's overall operation, including planning, organizing, and directing day-to-day operations, and must designate a substitute to act in his or her absence who must be responsible and accountable for management of the facility. *Direct care staff* (also called nursing assistants) assist residents with personal care. Trained *medication aides* may administer medications. The facility must provide for a *registered nurse* to review medication administration policies and procedures and to provide or oversee medication aide training.

**Staff Ratios.** *No minimum ratios.* Facilities must maintain a sufficient number of staff with the required training and skills necessary to meet the residents' specified needs. At least one staff person must be on site and awake at all times to meet residents' needs as required in the resident service agreements.

## Training Requirements

The administrator of an ALF must meet the initial training requirements specified in rule within the first 6 months of employment as the administrator. Initial training consists of at least 30 hours total covering the following topics: resident care and services; social services; financial management; administration; gerontology; and rules, regulations, and standards relating to the operation of an ALF. In addition, administrators must complete 12 hours of ongoing training in areas related to care and facility management of the populations served. Administrators with an active hospital or nursing home administrator's license are exempt from initial and ongoing training requirements.

Direct care staff must complete an orientation and ongoing training on topics appropriate to their job duties, including meeting the physical and mental special care needs of current residents. All staff must complete at least 12 hours of continuing education per year.

## Provisions for Apartments and Private Units

A resident unit may be a bedroom or apartment. Apartments are not required, but if they are provided, they must include a private bathroom and kitchen area in addition to the sleeping area. For facilities constructed prior to April 3, 2007, a maximum of four residents are allowed per resident unit, one toilet and sink fixture per six licensed beds is required, and at least one bathing facility is required for every 16 residents.

After that date, a maximum of two residents are allowed per resident unit. One toilet and sink fixture per four licensed beds is required and at least one bathing facility must be provided for every eight residents. In new construction, one toilet room adjoining each resident's bedroom is required.

## Provisions for Serving Persons with Dementia

***Dementia Care Staff.*** A sufficient number of appropriately skilled staff must be available to meet resident needs.

***Dementia Staff Training.*** The administrator and direct care staff must be trained in the following topics: the facility's philosophy of dementia care and supervision; the Alzheimer's disease process; and the skills necessary to care for residents who are unable to perform personal care or health maintenance, who may have behavior problems, and who wander. Staff must receive annually at least 4 hours of continuing education on dementia care.

***Dementia Facility Requirements.*** *No provisions identified.*

## Background Checks

Criminal background and sex offender registry checks must be completed on all direct care staff. Providers must contact the nurse aide registry, the adult central registry of abuse and neglect, and the child central registry of abuse and neglect to determine whether potential employees are listed there for abuse, neglect, or misappropriation of resident property. Facilities determine how to use the information in making hiring decisions except that a person with adverse findings on the nurse aide registry may not be employed as direct care staff. The facility must document the reasons for hiring a person with adverse findings in the background or registry checks by documenting the

basis for the decision and how it will not pose a threat to resident safety or resident property.

## Inspection and Monitoring

To determine compliance with operational, care, treatment, and physical plant standards, the Department inspects an ALF prior to and following licensure. The Department may conduct an on-site inspection at any time. The state annually inspects 25 percent of all licensed facilities chosen through a random sample. Inspections may also be conducted for cause or if the facility has not been inspected during a 5-year period.

## Public Financing

Medicaid covers assisted living services through two 1915(c) waiver programs, one for adults with physical disabilities and persons over age 65 and one for persons with traumatic brain injury.

### **Room and Board Policy**

In 2009, room and board charges for Medicaid-eligible residents were capped at \$614 a month (i.e., the federal Supplemental Security Income (SSI) benefit (\$674) minus a \$60 personal needs allowance (PNA). Family supplementation was not allowed.<sup>92</sup>

In 2011, the state provided an optional state supplement (OSS) of \$438 to aged, blind, or disabled residents in ALFs who qualified under state guidelines. Federal SSI resource limitations and income exclusions applied.<sup>93</sup>

## Location of Licensing, Certification, or Other Requirements

*Nebraska Administrative Code*, Title 473, Chapter 6: Adult Family Homes. [October 1, 1983]  
[http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health\\_and\\_Human\\_Services\\_System/Title-473/Chapter-6.pdf](http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-473/Chapter-6.pdf)

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<sup>92</sup> Mollica, R.L. (2009). *State Medicaid Reimbursement Policies and Practices in Assisted Living*, National Center for Assisted Living, American Health Care Association.  
<http://www.ahcancal.org/ncal/resources/Documents/MedicaidAssistedLivingReport.pdf>. Current information about Medicaid room and board policies, the PNA, and family supplementation policy was not available online or from other sources.

<sup>93</sup> Social Security Administration, *State Assistance Programs for SSI Recipients*, January 2011.  
[http://www.socialsecurity.gov/policy/docs/progdesc/ssi\\_st\\_asst/2011/ne.html](http://www.socialsecurity.gov/policy/docs/progdesc/ssi_st_asst/2011/ne.html). Current information about the OSS was not available online or from other sources.

*Nebraska Administrative Code*, Title 175, Chapter 4: Assisted Living Facilities. [April 3, 2007]  
[http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health\\_and\\_Human\\_Services\\_System/Title-175/Chapter-04.pdf](http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-175/Chapter-04.pdf)

*Statutes related to Health Care Facilities*, Alzheimer's Special Care Disclosure Act.  
<http://dhhs.ne.gov/publichealth/Licensure/Documents/Facilities-HealthCareFacilities.pdf>

*Nebraska Administrative Code*, Title 172, Chapter 95: Administration of Medications by Medication Aides and Medication Staff. [May 6, 2008]  
[http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health\\_and\\_Human\\_Services\\_System/Title-172/Chapter-095.pdf](http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-172/Chapter-095.pdf)

## Information Sources

Tracy Rathe  
Nebraska Healthcare Association

## NEVADA

### Licensure Terms

Residential Facilities for Groups

### General Approach

The Division of Health, Bureau of Health Care Quality and Compliance, licenses residential facilities for groups, which generally care for elderly persons or persons with physical disabilities. Some facilities may wish to care for special populations, such as persons with Alzheimer's disease or other dementia, mental illness, or intellectual disability; or persons with chronic illnesses, such as Hepatitis C and HIV; or to provide assisted living services. To do so, they need to apply for special endorsements to their license and meet additional requirements, including submitting evidence that they have received relevant training in caring for the population they wish to serve.

A facility may have more than one endorsement if it provides satisfactory evidence that it complies with the requirements for each type of endorsement and can demonstrate that the residents will be protected and receive necessary care and services.

*Adult Foster Care.* Homes for individual residential care are licensed to provide food, shelter, assistance, and supervision for no more than two persons who are aged, infirm, physically disabled, or intellectually disabled. No public funding is available for services in these homes. *Regulatory provisions for these settings are not included in this profile but a link to the provisions can found at the end.*

*This profile includes summaries of selected regulatory provisions for residential facilities for groups. The complete regulations can be viewed online using the links provided at the end.*

### Definitions

**Residential facilities for groups** means an establishment that furnishes food, shelter, assistance, and limited supervision to persons who are aged or infirm, have physical or other disabilities, or have chronic illnesses. The term includes, without limitation, an assisted living facility.

Residential facilities for groups that provide assisted living services must be operated in a manner that minimizes the need for its residents to move out of the facility

as their respective physical and mental conditions change over time; and supports, to the maximum extent possible, each resident's need for autonomy and the right to make decisions regarding his or her own life.

## **Resident Agreements**

Facilities must provide in writing, information about basic rates and included services, charges for optional services, and refund policies.

## **Disclosure Provisions**

Facilities must make a full written disclosure to prospective residents regarding the type of personal care services available and their cost.

Facilities that want to serve persons with dementia must obtain an endorsement on their licenses to do so. The facility's policies and procedures must include a description of basic services and activities, the manner in which behavioral problems will be addressed, medication management, steps to encourage family involvement, admission and discharge criteria, and actions that will be taken to prevent and respond to wandering.

Facilities endorsed to provide assisted living services must maintain a list of resources for financial assistance and other social services that may decrease the need for a resident of the residential facility whose physical or mental condition is declining over time to move out of the residential facility.

## **Admission and Retention Policy**

Residents are assessed as either Care Category 1 (ambulatory) or Care Category 2 (non-ambulatory). Ambulatory status is defined based on the residents' ability to move from an unsafe area to an area of safety without assistance from another person within four minutes. To admit or retain non-ambulatory individuals, a facility must meet specific fire and life safety building standards.

Facilities may not admit individuals who are bedfast or require 24-hour skilled nursing or medical supervision unless they are in a hospice program and have an approved exemption request from the Bureau. Facilities may not admit individuals who require restraints.

The rules do not allow facilities to admit or retain residents with specified health conditions, such as contractures, pressure ulcers, diabetes, and unmanageable incontinence. In addition, persons who require certain treatments, such as catheters, colostomies/ileostomies, enemas/suppositories, oxygen, or wound care may not be

admitted or retained unless the resident is physically and mentally capable of performing the required care or if the care is provided or supervised by a medical professional.

The facility may retain a resident who is suffering from an illness or injury from which the resident is expected to recover within 14 days after its onset or occurrence.

Residents may not be retained if the Bureau determines that the facility is unable to provide necessary care.

## **Services**

Services provided include personal care; at least 10 hours of social/recreational activities a week; protective supervision; laundry; and assistance with access to dental, optical, social, and related services needed by residents.

Facilities endorsed to provide assisted living services must include, without limitation, services that will enable the facility to retain residents who are otherwise prohibited from being admitted to the facility because they have specified health conditions or require certain treatments as described above under Admission and Retention criteria.

Facilities that are endorsed to provide dementia care must offer activities related to gross motor skills, social activities, sensory enhancement activities, and outdoor activities.

### ***Service Planning***

The administrator must assess whether residents' needs are changing and arrange for assessment and monitoring by a health professional when a resident's health declines. Services must be arranged based on the health professional's assessment.

### ***Third-Party Providers***

Residents may directly contract with licensed home health and hospice agencies to provide services.

## **Medication Provisions**

Residents who are capable may self-administer medications. Unlicensed staff may administer medications after completing a 16-hour medication course from an approved medication training provider. Four of these hours must be hands-on training with a Bureau-approved provider. These staff must complete 8 hours of continuing education

annually and pass an approved examination. Because they manage unlicensed staff, administrators are also required to take the same 16-hour medication course and the annual 8 hours of continuing education.

Facilities must not admit or retain an individual who requires regular intramuscular, subcutaneous, or intradermal injections unless the injections are administered by: (1) the individual; or (2) a medical professional, or licensed practical nurse (LPN), acting within his or her authorized scope of practice and in accordance with all applicable statutes and regulations, who has been trained to administer those injections. Owners who are nurses and nurses employed by a facility are prohibited from administering medications by injections according to the rules for residential facilities for groups.<sup>94</sup>

Caregivers may bring equipment to a resident who self-administers insulin injections. If the resident is unable to draw their own insulin, insulin syringes may be pre-filled, labeled, and dated by a nurse or pre-filled insulin pens may be used.

Facilities that do not assist residents with medication administration or that store resident's medications but allow the resident to independently self-administer medications without direction are not bound by the requirements related to medication administration.

## Food Service and Dietary Provisions

Facilities must provide three meals a day that meet the recommended dietary allowance of the Food and Nutrition Board of the National Academy of Sciences. Meals must be nutritious, served in an appropriate manner, suitable for the residents and prepared with regard for individual preferences and religious requirements. Snacks must be made available between meals for residents who are not prohibited by their physicians from eating between meals. Special diets may be provided if ordered by a physician or dietician.

The facility may serve meals to residents in their rooms upon request for no more than 14 consecutive days if the resident is unable to eat in the dining room because of an injury or illness. Facilities with more than ten residents must consult at least quarterly with a registered dietician concerning development and review of weekly menus, training for kitchen employees, and compliance with the facility's nutritional program.

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<sup>94</sup> Nevada Revised Statute 449.037(6)(d). <http://law.justia.com/codes/nevada/2010/title40/chapter449/nrs449-037.html>. The rules do not explain the reason for the prohibition on facility-employed nurses giving injections given that state law allows them to do so.

## Staffing Requirements

**Type of Staff.** The *administrator* provides oversight and direction for facility staff to ensure that residents receive needed services and protective supervision and that the facility is in compliance with the rules. Administrators must be licensed by the Nevada State Board of Examiners for Administrators of Facilities for Long Term Care and must designate one or more employees to be in charge of the facility during those times when the administrator is absent. *Caregivers* provide personal care services and may assist with medication services after completing required training.

Facilities licensed for 20-49 residents must have one staff member designated to organize, conduct, and evaluate activities. Facilities with 50 or more residents must have a full-time person to assist with activities. Volunteers may be used to supplement the services and programs of a residential facility, but may not be used to replace staff members.

**Staff Ratios.** *No minimum ratios.* Facilities must maintain staffing patterns that are sufficient to meet residents' care needs and enable them to achieve and maintain their functioning, self-care, and independence. There must be at least one caregiver on the premises of the facility if one or more residents are present at the facility. Facilities with more than 20 residents must ensure that at least one employee is awake and on duty at all times. An additional employee must be available to provide care within 10 minutes after being informed that his or her services are needed.

## Training Requirements

Within 60 days of employment, caregivers must receive at least 4 hours of training related to the care that is specific to the facility's resident population, for example, the elderly, persons with mental illness, or persons with chronic illness and debilitating diseases; and must receive 8 hours of annual continuing education and training related to the care of such residents.

Within 30 days after an administrator or caregiver is employed at the facility, they must be trained in first-aid and cardiopulmonary resuscitation (CPR) and maintain a current certification based on the requirements of the certification agency. The advanced certificate in first-aid and adult CPR issued by the American Red Cross or an equivalent certification will be accepted as proof of that training.

A registered nurse (RN) is exempt from first-aid training due to his or her body of knowledge, but must maintain current CPR certification. LPNs are exempt from first-aid training only if they are under direct supervision of an RN.

## Provisions for Apartments and Private Units

Apartment-style units are not required.<sup>95</sup> Facilities may provide private or shared rooms. No more than three residents may share a room. One toilet and sink is required for every four residents, and a bathtub or shower is required for every six residents.

Residents of facilities that provide assisted living services reside in their own units, which must contain a sleeping area/bedroom and toilet facilities.<sup>96</sup> Units may be shared by two occupants only by mutual consent.

## Provisions for Serving Persons with Dementia

**Dementia Care Staff.** A residential facility that provides care to persons with Alzheimer's disease must be administered by a person who has not less than 3 years of experience in caring for residents with Alzheimer's disease or other dementias in a licensed facility; or has a combination of education and training that the Bureau determines is equivalent to the experience required. The *administrator* is required to be responsible for facility policies and services and must ensure that at least one member of the staff is awake and on duty at the facility at all times.

**Dementia Staff Training.** Within a week of employment, all staff must receive at least 2 hours of training in providing care, including emergency care, to residents with any form of dementia, including Alzheimer's disease; and providing support for the members of the resident's family. Within 3 months of employment and then annually, caregivers must complete 8 hours of training in providing care to a resident with any form of dementia, including Alzheimer's disease.

If an employee is licensed or certified by an occupational licensing board, at least 3 hours of required continuing education must address the provision of care to residents with dementia. Continuing education must be completed on or before the first anniversary date of employment.

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<sup>95</sup> In 2009, facilities that had an endorsement to provide assisted living services under the Medicaid Assisted Living Waiver program had to provide apartment-style units, which could be shared by residents' choice. Mollica, R.L. (2009). *State Medicaid Reimbursement Policies and Practices in Assisted Living*, National Center for Assisted Living, American Health Care Association.

<http://www.ahcancal.org/ncal/resources/Documents/MedicaidAssistedLivingReport.pdf>. The Assisted Living Waiver program was terminated in 2014 and current information about Medicaid policy regarding apartments and private units was not available online or from other sources.

<sup>96</sup> The Health Division may grant an exception from the requirement for toilet facilities to a facility with ten or fewer beds that was licensed on or before July 1, 2005 and was originally constructed as a single-family dwelling if the Health Division finds that strict application of that requirement would result in economic hardship to the facility, and the exception, if granted, would not: (1) cause substantial detriment to the health or welfare of any resident of the facility; (2) result in more than two residents sharing a toilet facility; or (3) otherwise impair substantially the purpose of that requirement.

***Dementia Facility Requirements.*** Locked quarters are allowed in Alzheimer's/dementia units. Exits must have warning devices such as alarms, buzzers, horns, or other audible devices that are activated when a door is opened, or time-delay locks. Facilities must have a secure yard, completely fenced and gated with locking devices.

## **Background Checks**

Within 10 days of hire, all employees must undergo a fingerprint criminal background check. Facilities may not accept the results of background checks conducted in other states or by companies other than the Department of Public Safety and the Federal Bureau of Investigation. Caregivers must have no prior convictions or findings of abuse, neglect, or exploitation or other serious convictions relating to the ability to care for dependent persons. All other staff must not have any convictions or history of abuse, neglect, or exploitation.

## **Inspection and Monitoring**

The Health Division conducts a pre-licensure investigation of the premises, personnel qualifications, and the licensing applicants' policies. Facilities are subject to on-site inspections and complaint investigations. The licensing agency provides on-site education during the survey process.

## **Public Financing**

The Nevada Aging and Disability Services Division covers augmented personal care for older persons (65+ years) in a licensed residential facility for groups under the Medicaid Frail Elderly 1915(c) Waiver program. Augmented personal care includes homemaker services, chore services, social and recreational programming, personal care services, companion services, medication oversight, and services that will ensure that residents of the facility are safe, secure, and adequately supervised. Assisted living is covered under the Home and Community-Based Services for Persons with Physical Disabilities 1915(c) Waiver program that serves all age groups.

### ***Room and Board Policy***

In 2009, the state did not limit what providers could charge Medicaid-eligible residents for room and board but allowed residents to retain \$110 from their income as

a personal needs allowance (PNA). Family supplementation for room and board charges was allowed.<sup>97</sup>

The state provides an optional state supplement (OSS) to aged and blind recipients who live in residential facilities that provide personal care and services to 16 or fewer persons. In 2011, the maximum amount of the OSS was \$391.<sup>98</sup>

## Location of Licensing, Certification, or Other Requirements

*Nebraska Administrative Code*, Chapter 443.15511 to 15529: Homes for Residential Care.  
<http://leg.state.nv.us/nac/NAC-449.html#NAC449Sec15511>

*Nebraska Administrative Code*, Chapter 449.156 to 27706: Residential Group Homes.  
<http://leg.state.nv.us/nac/NAC-449.html#NAC449Sec156>

*Nebraska Administrative Code*, Regulations and Interpretive Guidelines for Residential Facilities for Groups.  
[http://www.health.nv.gov/HCQC/AGC\\_InterpretiveGuidelines.pdf](http://www.health.nv.gov/HCQC/AGC_InterpretiveGuidelines.pdf)

Frequently Asked Questions: New Medication Regulations for Residential Facilities for Groups.  
<http://www.health.nv.gov/HCQC/NAC449-FAQ-NewMedRegulations.pdf>

Nevada Aging and Disability Services Division website: Home and Community-Based Waiver Program information. [2014]  
[http://adsd.nv.gov/Programs/Seniors/HCBW/HCBW\\_Prog/](http://adsd.nv.gov/Programs/Seniors/HCBW/HCBW_Prog/)

## Information Sources

Nevada Health Care Association

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<sup>97</sup> Mollica, R.L. (2009). *State Medicaid Reimbursement Policies and Practices in Assisted Living*, National Center for Assisted Living, American Health Care Association.  
<http://www.ahcancal.org/ncal/resources/Documents/MedicaidAssistedLivingReport.pdf>. Current information about Medicaid room and board policies, the PNA, and family supplementation policy was not available online or from other sources.

<sup>98</sup> Social Security Administration. *State Assistance Programs for SSI Recipients*, January 2011.  
[http://www.socialsecurity.gov/policy/docs/progdesc/ssi\\_st\\_asst/2011/nv.html](http://www.socialsecurity.gov/policy/docs/progdesc/ssi_st_asst/2011/nv.html). Current information about the OSS was not available online or from other sources.

## NEW HAMPSHIRE

### Licensure Terms

Assisted Living Residence-Supported Residential Health Care, Assisted Living Residence-Residential Care Facilities

### General Approach

The New Hampshire Department of Health and Human Services, Bureau of Health Facilities Administration, licenses two categories of assisted living residences (ALRs): (1) supported residential health care facilities that may retain nursing home-eligible residents if appropriate care and services are provided; and (2) residential care facilities (RCFs) that provide a lower level of care. Some licensing provisions differ based on facility size--17 or more residents or 4-16 residents. In smaller settings, the licensee might be the home owner.

*Adult Foster Care.* Adult family care residences are certified to provide social or health services to one or two residents in a home-like environment. Such services may include, but are not limited to, supervision, medical monitoring, supervision of medications, and assistance with daily living activities. *Regulatory provisions for adult family care residences are not included in this profile but a link to the provisions can found at the end.*

*This profile includes summaries of selected regulatory provisions for ALR-supported residential health care and ALR-RCFs. The complete regulations are online at the links provided at the end.*

### Definitions

***Assisted Living Residences-Supported Residential Health Care.*** Facilities provide social or health services by appropriately trained or licensed individuals to three or more residents. Facilities may not serve those who require nursing services complex enough to require 24-hour nursing supervision. Facilities may provide short-term medical care for residents who may be convalescing from an illness and these residents must be capable of self-evacuation.

***Assisted Living Residences-Residential Care.*** Facilities offer assistance with personal and social activities that require a minimum of supervision, or health care that can be provided in a home or home-like setting.

## Resident Agreements

**Assisted Living Residences-Supported Residential Health Care.** Agreements must list the fees and core services; house rules; responsibility for discharge planning; information about nursing and other health care services and supplies that are not core services--their availability, the facility's responsibility for arranging them, and their cost (if known); policies and procedures regarding arranging/providing transportation and arranging for third-party services; and medication management services.

**Assisted Living Residences-Residential Care.** In addition to the topics listed above, agreements must state the resident acuity level that the facility can accommodate.

## Disclosure Provisions

**Both licensure categories** must use a Department-required disclosure summary form to provide information to applicants prior to admission, including the facility's base rate and the services included in that rate; staff coverage; transportation; and other services offered.

## Admission and Retention Policy

**Assisted Living Residences-Supported Residential Health Care.** Facilities may only admit and retain individuals whose needs they can meet and who can evacuate in accordance with the state fire code. Facilities with appropriate staff may admit or retain individuals who require mechanical assistance to transfer or who have a Stage III or higher pressure ulcer. Facilities may admit and retain those who require 24-hour licensed nursing care or monitoring for less than 21 days and those receiving hospice care.

**Assisted Living Residences-Residential Care.** Facilities may only admit and retain individuals whose needs they can meet. Residents must be capable of self-evacuation without assistance. Residents who require rehabilitative or nursing care longer than 21 days must be discharged, with the exception of those receiving hospice services.

## Services

**Assisted Living Residences-Supported Residential Health Care.** Core services include supervision of residents with cognitive deficits; health and safety services; personal care; emergency response and crisis intervention; medication services; social and recreational activities; and assistance with arranging medical and

dental appointments. Facilities must also provide access to nursing services, including supervision and instruction of direct care, rehabilitation, and behavioral health care as needed by residents.

***Assisted Living Residences-Residential Care.*** Services include supervision of residents with cognitive deficits; arrangement of appointments; crisis intervention; supervision of activities of daily living; medication services; provision of or arrangement for transient medical care with licensed home health care providers; and assistance accessing community services.

### ***Service Planning***

***Both licensure categories*** require that residents be assessed by a trained assessor using a Department-approved resident assessment tool. The assessment must be repeated twice yearly and following a change in condition. If indicated by the resident assessment, a nursing assessment must be completed that addresses medication use, clinical services, pain, vital signs, and physical, cognitive, mental, and behavioral status. Assessments are used to develop the resident's care plan.

### ***Third-Party Providers***

***Both licensure categories*** permit residents to contract with home health and hospice services.

## **Medication Provisions**

***Assisted Living Residences-Supported Residential Health Care.*** Residents may self-direct administration of medications if their physical condition prevents them from self-administration and they can verbally direct personnel to assist in the process. Facility staff may supervise self-administration in the following ways: remind residents to take medications; place containers within reach; and observe, record and document observed or reported side effects. Staff may not physically handle the medication. Unlicensed staff may administer oral medications if they have been delegated to do so by a licensed nurse. A licensed nursing assistant working under the direction of a licensed nurse may administer medicinal shampoos and baths; glycerin suppositories and enemas; and topical products to intact skin.

Unlicensed staff who supervise and/or administer medications must first receive a 4-hour training on the following topics: infection control and proper hand-washing techniques; the five rights (right resident; right medication; right dose; right time; and right route); general categories of medications such as antihypertensives or antibiotics; documentation; desired effects and potential side effects of medications; and medication precautions and interactions. *The rules include extensive provisions regarding assisting with self-administration and administering medications.*

**Assisted Living Residences-Residential Care.** Residents may self-administer medications with or without staff supervision or may self-direct medication administration as described above. Medications must be administered by a licensed nurse, a medication nursing assistant, or any other individuals authorized by law. [*Nurse delegation is not described.*]

## Food Service and Dietary Provisions

**Assisted Living Residences-Supported Residential Health Care.** Facilities must provide three or more meals a day--and snacks between meals and before retiring--that meet the recommended dietary allowances of the National Academy of Science's Food and Nutrition Board. Staff responsible for food service must have knowledge of nutritional requirements and planning and preparation of prescribed diets.

**Assisted Living Residences-Residential Care.** Facilities must provide three meals and snacks daily that meet the U.S. Department of Agriculture recommended dietary allowance specified in the 2005 Dietary Guidelines for Americans. Therapeutic diets must be provided to residents as directed by a licensed practitioner or other professional with prescriptive authority.

## Staffing Requirements

### **Assisted Living Residences-Supported Residential Health Care**

**Type of Staff.** Facilities must employ a full-time *administrator* who is responsible for day-to-day operations; *direct care personnel* to provide personal care assistance; and a *licensed nurse* to provide or delegate medication administration, assist with resident assessment, and oversee health services. A certified *medication nursing assistant* may be employed to administer medications.

**Staff Ratios.** *No minimum ratios.* Personnel levels are determined by the administrator based on the facility's size and residents' service needs. At least one awake staff must be on-duty at all times except for facilities with eight or fewer beds that have an electronic communication system, an installed wandering prevention system for facilities serving residents with dementia, and the ability to meet residents' needs at all times.

### **Assisted Living Residences-Residential Care**

**Type of Staff.** Facilities must employ an *administrator* who is responsible for day-to-day operations, *direct care personnel* to provide personal care assistance, and a *licensed nurse* (or other licensed practitioner) to administer medications. The administrator must be employed at least 35 hours per week.

**Staff Ratios.** *No minimum ratios.* Personnel levels must be sufficient to meet residents' needs. In facilities with 16 or fewer beds, an awake personnel member is not required during the night if: (1) there is a communication system that allows a resident to contact and awaken the sleeping personnel member via an intercom or other communication system; (2) the licensee has, for residents with dementia, installed a wandering prevention system that will awaken the sleeping personnel member; (3) residents require nothing more than occasional reminding, cueing, or verbal prompting for mobility and evacuation; (4) residents have no acute medical needs or ongoing nursing needs and no history of being verbally or physically abusive; and (5) the facility meets the needs of the residents at all times as described in resident care plans.

## Training Requirements

**Both licensure categories** require that administrators complete 12 hours of continuing education each year that includes topics such as the resident plan of care; characteristics of residents' disabilities; nutrition, basic hygiene, and dental care; first-aid; medication management; dementia; resident assessment; aging; and residents' rights. Personnel must receive orientation and training within a week of hire that includes residents' rights; complaint procedures; duties and responsibilities; emergency and evacuation procedures; infection control; mandatory reporting requirements; and limitations on and the correct use of restraints. Continuing education must be provided annually on residents' rights, infection control, and the emergency plan.

## Provisions for Apartments and Private Units

**Both Licensure Categories.** Private apartments are not required. Resident units may be single-occupancy or double-occupancy. There must be at least one toilet and one sink, and one shower/bathtub for every six residents.

## Provisions for Serving Persons with Dementia

**Dementia Care Staff.** *No provisions identified for either licensure category.*

**Dementia Staff Training.** *No provisions identified for either licensure category.* Legislation adopted in 2014 requires the Department to develop dementia care training and education programs for staff of health facilities, which include both types of ALRs.

### **Dementia Facility Requirements**

**Assisted Living Residences-Supported Residential Health Care.** Facilities may install a wandering prevention system and/or install locked, secured, or alarmed systems that automatically lock when approached by a resident wearing an electronic sensor.

**Assisted Living Residences-Residential Care.** Mechanical constraints are prohibited. Facilities with fewer than 16 residents must install a wandering prevention system if awake staff are not available overnight.

## Background Checks

**Both licensure types** must obtain and review a criminal records check from the New Hampshire Department of Safety for all applicants for employment, and for household members 18 years of age or older, and verify their qualifications prior to employment. Unless a waiver is granted, licensees may not offer employment for any position or allow a household member to continue to reside in the residence if the individual has been convicted of sexual assault, another violent crime, assault, fraud, abuse, neglect, or exploitation; has been found guilty by the Department or any administrative agency in any state of assault, fraud, abuse, neglect or exploitation of any person; or otherwise poses a threat to residents' health, safety, or well-being.

## Inspection and Monitoring

**Both licensure categories** are inspected prior to licensure and before annual license renewals.

## Public Financing

The New Hampshire Department of Health and Human Services, Bureau of Elderly and Adult Services, administers the Medicaid Choices for Independence 1915(c) Waiver program that pays for assisted living services. The state has applied for an 1115 waiver, which, if received, will cover assisted living services.

### **Room and Board Policy**

The state provides an optional state supplement (OSS) to Supplemental Security Income recipients who reside in a RCF for adults. In 2011, the OSS was \$207.<sup>99</sup> In 2009, the personal needs allowance (PNA) was \$56, and family supplementation was allowed on a case-by-case basis.<sup>100</sup>

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<sup>99</sup> Social Security Administration. *State Assistance Programs for SSI Recipients*, January 2011. [http://www.socialsecurity.gov/policy/docs/progdsc/ssi\\_st\\_asst/2011.nh.html](http://www.socialsecurity.gov/policy/docs/progdsc/ssi_st_asst/2011.nh.html). Current information about the amount of OSS was not available online or from other sources.

<sup>100</sup> Mollica, R.L. (2009). *State Medicaid Reimbursement Policies and Practices in Assisted Living*, National Center for Assisted Living, American Health Care Association. <http://www.ahcanal.org/ncal/resources/Documents/MedicaidAssistedLivingReport.pdf>. Current information about the PNA and family supplementation policy was not available online or from other sources.

## Location of Licensing, Certification, or Other Requirements

*New Hampshire Code of Administrative Rules*, Chapter He-P 800, PART He-P 804: Assisted Living Residence-Residential Care Licensing. [April 3, 2008]

<http://www.dhhs.nh.gov/oos/bhfa/documents/he-p804.pdf>

*New Hampshire Code of Administrative Rules*, Chapter He-P 800, PART He-P 805: Assisted Living Residence-Supported Residential Health Care Licensing. [October 25, 2006]

<http://www.dhhs.nh.gov/oos/bhfa/documents/he-p805.pdf>

*New Hampshire Code of Administrative Rules*, Chapter He-P 800, Part He-P 813: Adult Family Care Residence. [March 29, 2011]

<http://www.dhhs.nh.gov/oos/bhfa/documents/he-p813.pdf>

*Revised Statutes Annotated*, Title XI, Chapter 151: Residential Care and Health Facility Licensing.

<http://www.gencourt.state.nh.us/rsa/html/xi/151/151-mrq.htm>

## Information Sources

Jeffrey A. Meyers  
Director, Intergovernmental Affairs  
Department of Health and Human Services

## NEW JERSEY

### Licensure Terms

Assisted Living Services, which are provided in Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs

### General Approach

The Department of Health and Senior Services licenses three types of assisted living services under one set of rules: assisted living residences (ALRs), which are purpose-built residences; comprehensive personal care homes (CPCHs), which are converted residential boarding homes that may or may not meet new building code requirements; and assisted living programs (ALPs)--service agencies--that provide services to tenants of publicly subsidized housing. The licensing rules refer to all three types as facilities, with specific provisions for ALPs. Assisted living services require a certificate of need to be licensed. The rules do not specify a minimum or maximum number of residents that can be served in any of the three types of assisted living services.

All purpose-built ALRs have apartment-style units with a kitchenette. Only facilities licensed prior to December 1993, the effective date of the assisted living regulations, can convert to CPCHs and offer bedrooms rather than apartment-style units.

The licensing rules were reviewed in 2014 by New Jersey's Assisted Living Licensing Workgroup and were re-adopted with technical changes only.

*Adult Foster Care.* Adult family care is a 24-hour living arrangement for no more than three persons who, because of age or physical disability, need assistance with activities of daily living, and for whom services designed to meet their individual needs are provided by licensed caregivers in approved adult family care homes. Providers must own or rent and live in the home. The adult family care program is operated by sponsor agencies who recruit, assess, and match residents and caregivers; train caregivers; develop a care plan for each resident; perform regular and ongoing assessments of each resident's health status and care plan implementation; and provide care management. In 2009, about 30 providers served 34 residents. *Regulatory provisions for adult family care are not included in this profile.*

*This profile includes summaries of selected regulatory provisions for all three types of assisted living services, unless otherwise specified. The complete regulations are online at the links provided at the end.*

## Definitions

**Assisted living** means a coordinated array of supportive personal and health services, available 24 hours per day and provided in home-like surroundings to residents who have been assessed to need these services, including those who need formal long-term care. Assisted living promotes resident self-direction and participation in decisions that emphasize independence, individuality, privacy, and dignity.

**Assisted living residence** means a facility licensed to provide apartment-style housing and congregate dining that ensures the availability of assisted living services when needed, for four or more adult persons unrelated to the proprietor. Apartment units offer, at a minimum, one unfurnished room, a private bathroom, a kitchenette, and a lockable door on the unit entrance.

**Comprehensive personal care home** means a facility licensed to provide room and board to four or more adults unrelated to the proprietor that ensures the availability of assisted living services when needed. Residential units may house no more than two residents and must have a lockable door on the unit entrance.

**Assisted living program** means providing or arranging for the provision of meals and assisted living services, when needed, to the tenants of publicly subsidized housing, which because of federal, state, or local housing laws, regulations, or requirements cannot become licensed as an ALR. An ALP may also provide staff resources and other services to licensed ALRs and CPCHs; in these instances, ALPs must comply with the licensing standards applicable to the setting.

## Resident Agreements

Prior to, or at the time of admission, the facility administrator must conduct an interview with the prospective resident and, if the individual agrees, the resident's family, guardian, or interested agency. The interview must cover at least an orientation to the facility's or program's policies, business hours, fee schedule, services provided, resident rights, and admission and discharge criteria.

Admission agreements must provide information about the services the facility will provide, the public programs or benefits that it accepts or delivers, the policies that affect a resident's ability to remain in the residence, and any waivers that have been granted of the regulations regarding physical plant requirements for ALRs and CPCHs.

## Disclosure Provisions

In addition to the disclosure requirements for admission agreements above, facilities that advertise or hold themselves out as having an Alzheimer's unit must make available to all staff, residents, and members of the public: (1) its program policies and

procedures, including admission and discharge criteria to identify individuals whose needs the facility cannot meet, based upon a registered nurse (RN) assessment of their cognitive and functional status; (2) the number of licensed and unlicensed staff providing direct care to residents; (3) the specialized activities available for residents with dementia; and (4) safety policies and procedures and any security monitoring system specific to residents with dementia.

## Admission and Retention Policy

Facilities offer a suitable living arrangement for persons with a range of capabilities, disabilities, frailties, and strengths but not generally for individuals who are incapable of responding to their environment, expressing volition, interacting, or demonstrating any independent activity (e.g., individuals in a persistent vegetative state must not be placed or cared for any of the three types of assisted living). ALRs and CPCHs may serve terminally ill persons who lack adequate caregiving support to meet their needs while residing at home.

No notice is required to discharge a resident who poses a threat to the life and safety of the resident or others.

## Services

At a minimum, ***assisted living residences*** and ***comprehensive personal care homes*** must provide or arrange for assistance with personal care; health care, nursing, pharmacy, and social work services; activities; recreation; and transportation to meet residents' individual needs. Supervision of and assistance with self-administration of medications, and administration of medications by trained and supervised personnel are also required services.

***Assisted living programs*** must have contracts between service providers and the housing entity. The programs must be able to provide or arrange for assistance with personal care; nursing, pharmaceutical, dietary, and social work services; recreational activities; and transportation.

### ***Service Planning***

Within 30 days prior to admission, facilities must obtain assessments from individuals' health care practitioner stating that they are appropriate for the level of care the facility provides. Facilities must also obtain information about individuals' nursing needs, and routines and preferences from their regular caregivers, if any. Upon admission, an RN conducts an initial assessment and, if services are needed, develops a general service plan within 14 days of admission.

If the assessment indicates that the individual requires health care services, a health care assessment must be completed within 14 days of admission by an RN using a Department-provided or approved assessment instrument. The assessment must be updated as required in accordance with professional standards of practice. A service plan must be developed based on the assessment.

The general and health service plan must be reviewed, and if necessary, revised quarterly and as needed based on changes in the residents' physical or cognitive status.

When the resident assessment process indicates a high probability that a choice or action of the resident has resulted or will result in placing the resident or others at risk, lead to adverse outcome and/or violate the norms of the facility or program or the majority of the residents, the facility must seek to negotiate a managed risk agreement with the resident (or legal guardian), that will minimize the possible risk and adverse consequences while still respecting the resident's preferences.

### ***Third-Party Providers***

Facilities and residents who are not Medicaid-eligible may contract with outside health care professionals.

## **Medication Provisions**

Facilities are allowed to provide supervision of and assistance with self-administration of medications, and administration of medications by trained and supervised personnel. Employees who have been designated to provide supervision of residents' self-administration of medications must be trained by the facility's RN or the licensed pharmacist.

The state has extensive rules regarding medication administration. Certified nurse aides, certified home health aides, or staff members with other equivalent training approved by the Department of Health (DOH) and who have completed a medication aide course and passed a certifying exam are permitted to administer medications to residents under the delegation of an RN.

The facility must use a unit-of-use/unit dose drug distribution system whenever the administration of medication is delegated by an RN to a certified medication aide.

## **Food Service and Dietary Provisions**

***Assisted living residences and comprehensive personal care homes*** must provide three meals a day, snacks, and beverages based on the current recommended dietary allowances of the Food and Nutrition Board. Menus must reflect nutritional and

therapeutic needs, cultural backgrounds, food habits, and personal preferences. Facilities must designate a food service coordinator who is either a dietician or who consults with a dietician. If indicated by resident needs, a dietician must assess and reassess nutritional needs, provide dietary services, and revise the dietary portion of the health plan as needed.

**Assisted living programs** must make available dining services and/or meal preparation assistance to meet residents' daily nutritional needs; have a mechanism to assist residents with shopping and/or preparation of meals in accordance with their needs and plans of care; and ensure that meals are planned, prepared and served in accordance with, but not limited to, residents' nutritional needs.

## Staffing Requirements

**Type of Staff.** All three licensed settings must have a full-time *administrator* or designated alternate on-site at all times in facilities with 60 or more beds, and half-time in facilities with fewer than 60 beds. A *registered nurse* must be available on staff or on call 24 hours a day. ALPs must have policies that ensure that at least one staff member of the ALP or the housing program is on-site 24 hours a day.

Facilities must designate a *food service coordinator* who, if not a dietitian, receives scheduled consultation from a dietitian. They must also designate a *pharmacist* to direct pharmaceutical services and provide consultation to the physician, facility, or program staff, and residents, as needed.

Facilities must employ *personal care assistants* who are certified nurse aides, certified homemaker-home health aides, or have passed a personal care assistant training course.

**Staff Ratios.** *No minimum ratios.* At least one awake personal care assistant and one additional staff person must be on site 24 hours a day. Facilities must employ both professional and unlicensed staff in sufficient numbers and with sufficient abilities and training to provide the basic resident care, assistance, and supervision required, based on an assessment of the acuity of residents' needs.

## Training Requirements

Administrators must complete a minimum of 30 hours of continuing education every 3 years covering assisted living concepts and related topics, as specified and approved by the Department of Health and Senior Services.

Each personal care aide (PCA) must receive orientation prior to or upon employment on the following topics: assisted living concepts, emergency plans and procedures, infection control and prevention, the care of residents with physical

impairment, resident rights, abuse and neglect, pain management, and the care of residents with Alzheimer's and other dementia conditions.

PCAs must complete 20 hours of continuing education every 2 years in assisted living concepts and related topics, including cognitive and physical impairment and dementia. Medication aides must complete an additional 10 hours of continuing education related to medication administration and elderly drug use every 2 years.

## Provisions for Apartments and Private Units

**Assisted living residences** must offer apartment-style units with a private bathroom, a kitchenette, and a lockable door on the unit entrance. No more than two people may occupy a unit. Additional toilet facilities must be provided in areas other than the residential units to meet the needs of residents, staff, and visitors to the facility.

**Comprehensive personal care homes** provide single-occupancy and double-occupancy units with a lockable door. Private baths and kitchenettes are not required.

**Assisted living programs** are licensed as a service. Requirements for the apartments in subsidized housing projects are specified by the source of financing and the building code.

## Provisions for Serving Persons with Dementia

Facilities may establish programs to meet the needs of residents with Alzheimer's disease or other dementias. Such programs must provide individualized care based upon assessment of the cognitive and functional abilities of its residents with dementia. All licensed and unlicensed staff who provide direct care to residents must have training in specialized care of residents with dementia. *No other provisions identified.*

## Background Checks

The state revised its rules regarding criminal background checks in 2014. The new rules are extensive. The assisted living licensing regulations require that staff be certified or licensed, as applicable, and the certification processes for nurse aides and personal care assistants, and the licensing and certification processes for assisted living administrators require fingerprint criminal background checks.

Assisted living facilities and programs may not employ individuals as certified nurse aides or personal care assistants without making inquiries to the New Jersey Certified Personal Care Assistant Registry, the New Jersey Certified Nurse Aide Registry, or to any other state agency registry in which the facility has a good faith belief the individual is registered.

## Inspection and Monitoring

ALRs and CPCHs are inspected prior to licensure, every 2 years thereafter, and at any time deemed necessary by the licensing agency. The DOH has a voluntary quality-focused program titled Advanced Standing, which is open to all licensed ALRs and CPCHs. Facilities that participate in the program do not receive a routine survey. However, any time a facility falls below DOH standards, such as poor performance on a complaint investigation, that facility can be removed for cause from the program. In addition, DOH provides follow-up surveys based on a random sample of facilities that participate in the program.

## Public Financing

New Jersey consolidated its home and community-based waiver programs into one 1115 Demonstration Waiver program--Managed Long-Term Services and Supports--which covers assisted living services.

Assisted living service settings licensed after September 2001 must set aside 10 percent of their units to serve Medicaid residents within 3 years of licensing. The requirement is waived if there is a waiting list for Medicaid waiver services.

### ***Room and Board Policy***

***Assisted Living Residences and Comprehensive Personal Care Homes.*** In 2014, the state provided an optional state supplement (OSS) of \$150.05 per month to Supplemental Security Income (SSI) recipients and capped room and board for Medicaid-eligible residents at \$764.05 per month (federal SSI benefit of \$721 plus the OSS benefit of \$150.05, minus a personal needs allowance of \$107 retained by the resident).

Family supplementation is permitted for an upgraded living unit (i.e., a private room).

***Assisted living program*** participants who live in subsidized housing are charged a percentage of their income for rent. Those eligible for SSI benefits are eligible for an OSS payment--\$31.25 in 2014--as are SSI recipients who live in adult family homes.

## Location of Licensing, Certification, or Other Requirements

*New Jersey Administrative Code*, Title 8, Chapter 36: Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs; and Title 8,

Chapter 43-I: Criminal Background Investigations of Nurse Aides, Personal Care Assistants, and Assisted Living Administrators.

The New Jersey Administrative Code is accessible at Lexus Nexus.  
<http://www.lexisnexis.com/hottopics/njcode/>

## Information Sources

Kathy Fiery  
Health Care Association of New Jersey

## NEW MEXICO

### Licensure Terms

Assisted Living Facilities for Adults

### General Approach

The New Mexico Department of Health, Division of Health Improvement, Health Facility Licensing and Certification Bureau, licenses and regulates assisted living facilities (ALFs), previously called adult residential care facilities. Facilities that provide a memory care unit must meet additional requirements relating to care coordination; staffing; employee training; individualized service plans (ISPs); assessments and re-evaluations; documentation; security; and resident rights.

The state does not have licensing provisions for the traditional adult foster care (AFC) model; the ALF regulations cover AFC homes serving two or more persons unrelated to the caregiver.

*This profile includes summaries of selected regulatory provisions for ALFs. The complete regulations are online at the links provided at the end.*

### Definitions

**Assisted living facilities** provide programmatic services and assistance with one or more activities of daily living (ADLs) to two or more individuals.

### Resident Agreements

Agreements cover the scope of services to be provided--and their cost--and admission and discharge criteria.

### Disclosure Provisions

Facilities that provide memory care must disclose to prospective residents information about staff training and qualifications; types of resident diagnosis or behaviors for which the facility provides services and which the staff are trained to address; and information about the care, services, and the type of secured environment provided.

## **Admission and Retention Policy**

Facilities may not admit or retain individuals requiring 24-hour continuous nursing care,<sup>101</sup> which includes but is not limited to those who: (1) are ventilator dependent; (2) have Stage III or IV pressure sores; (3) have any condition requiring either chemical or physical restraints; and (4) require intravenous therapy or injections. Exceptions may be made for residents receiving hospice care.

Facilities that provide a memory care unit must conduct a pre-admission assessment of a prospective resident to evaluate whether less restrictive alternatives are available and the basis for the admission to the secured environment, including a physician diagnosis of Alzheimer's disease or other dementia.

Residents may be discharged if the facility cannot meet their needs or if they endanger the safety or health of individuals in the facility.

## **Services**

Facilities must supervise and/or assist residents as necessary with specified nursing services; medication administration or self-administration; ADLs; recreation/social activities; laundry and housekeeping; and transportation services.

### ***Service Planning***

An interdisciplinary team assesses prospective residents to determine whether the facility can meet their needs, and reassesses current residents to determine if the facility can continue to meet their needs. An ISP is developed based on the assessment and reviewed by a licensed nurse at least every 6 months, or following a significant change in health status. The service plan must describe the services to be provided, as well as when, how, and by whom.

### ***Third-Party Providers***

Residents may contract with hospice agencies and other third-party agencies. The facility must coordinate care provided within the building by outside agencies.

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<sup>101</sup> Defined as services which are provided to a resident whose condition requires 24-hour monitoring of vital signs and the assessment of cognitive or physical status on a daily basis.

## Medication Provisions

Medications may be self-administered by residents if their physician approves. If not, they may be self-administered with assistance by an individual who has completed a state-approved program in medication assistance, or administered by a physician, physician extender, licensed nurse, or the resident's relatives. Staff who assist in the self-administration of medications must recognize interactions or possible side effects that might occur.

Facilities must have a consulting pharmacist who reviews medications at least quarterly to determine that all medication orders and records are accurate and current. Consultation consists of all aspects of facility pharmacy services, including providing reference information regarding side effects and, when needed, physician consultation in cases involving the use of psychotropic medications. The consulting pharmacist is responsible for ensuring that the facility meets storage, labeling, destruction, and documentation requirements of the State Board of Pharmacy.

## Food Service and Dietary Provisions

Facilities must provide three nutritionally balanced meals and evening snacks in accordance with the recommended daily dietary allowance of the National Academy of Sciences Food and Nutrition Board. Therapeutic diets and prescribed vitamin and mineral supplements may be given according to a physician's orders. Staff who assist with food preparation or serving must complete training in safe food handling practices.

## Staffing Requirements

**Type of Staff.** Facilities must employ an *administrator* who is responsible for daily operations; *direct care staff* to provide personal care assistance and supervision; and a *licensed nurse* if the facility provides medication administration. In addition, a licensed nurse or *physician extender* must be available to review health evaluations and ISPs.

**Staff Ratios.** The minimum staff-to-resident ratio is one direct care worker for 15 or fewer residents; one direct care worker and one staff person for 16-60 residents; two direct care workers and one staff person for 61-120 residents; and at least three direct care workers and one staff person for 120 or more residents.

## Training Requirements

Direct care staff must complete 16 hours of supervised training prior to providing unsupervised care and 12 hours of training annually. Training must include fire safety; first-aid; resident confidentiality; residents' rights; reporting requirements for abuse, neglect, and exploitation; infection control; transportation safety for assisting residents

and operating vehicles to transport residents; and methods for providing quality resident care. For facilities offering hospice services, all staff must receive 6 hours of hospice training plus 1 additional hour for each hospice resident's ISP.

## Provisions for Apartments and Private Units

Apartment-style units are not required. Resident units may be single-occupancy or double-occupancy. A minimum of one toilet, sink, and bathing unit must be provided for every eight residents.

## Provisions for Serving Persons with Dementia

***Dementia Care Staff.*** Facilities must provide a sufficient number of trained staff members to meet residents' needs, and at least one staff member must be awake and in attendance in the secured environment at all times.

***Dementia Staff Training.*** In addition to training requirements for staff of all ALFs, employees who provide care to memory unit residents must have a minimum of 12 hours of annual training related to dementia, Alzheimer's disease, or other pertinent information relating to current residents.

***Dementia Facility Requirements.*** A secured environment is described as any locked (secured/monitored) area in which doors and fences restrict access through the use of double alarm systems, gates connected to the fire alarm, and tab alarms for residents at risk for elopement. Facilities must provide a fenced and secured outdoor area for residents' use throughout the year.

## Background Checks

Facilities must meet the state's criminal history screening requirements. Applicants for the administrator position and all care staff positions must consent to a national and statewide criminal history screening. Prior to hiring, facilities must also check the State's Employee Abuse Registry.

## Inspection and Monitoring

The Licensing Authority conducts on-site survey/monitoring visits. Up to three residents may be admitted under a temporary license; the licensing authority then conducts an initial health survey. Following a determination of compliance, an annual license is issued. Renewal applications must be submitted annually.

## Public Financing

The state's 1115 waiver managed care demonstration program, Centennial Care, pays for services in ALFs.

### **Room and Board Policy**

Room and board charges are negotiated between the facility and the prospective resident. The state does not specify a personal needs allowance. The state provides an optional state supplement (OSS) to Supplemental Security Income (SSI) recipients who reside in an ALF. In 2014, the federal SSI benefit was \$721 and the OSS payment was \$100. In 2009, family supplementation was permitted.<sup>102</sup>

## Location of Licensing, Certification, or Other Requirements

*New Mexico Administrative Code*, Title 7, Chapter 8, Part 2: Assisted Living Facilities for Adults. [January 15, 2010]

<http://164.64.110.239/nmac/parts/title07/07.008.0002.pdf>

## Information Sources

Tracy M. Alter  
Director, Member Services  
New Mexico Health Care Association

Crystal A. Hodges  
Long-Term Care Manager  
Centennial Care Bureau  
Human Services Department  
Medical Assistance Division

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<sup>102</sup> Mollica, R.L. (2009). *State Medicaid Reimbursement Policies and Practices in Assisted Living*, National Center for Assisted Living, American Health Care Association.  
<http://www.ahcancal.org/ncal/resources/Documents/MedicaidAssistedLivingReport.pdf>. Current information about family supplementation policy was not available online or from other sources.

## NEW YORK

### Licensure Terms

Adult Care Facilities, including Adult Homes, Enriched Housing Programs, and Assisted Living Residences

### General Approach

New York's Department of Health licenses three types of adult care facilities that offer different levels of supervision and personal care to five or more adults who have functional and/or cognitive impairments: adult homes (lowest level of care),<sup>103</sup> enriched housing programs, and assisted living residences (ALRs) (highest level of care).<sup>104</sup> Licensed adult homes and enriched housing programs have similar provisions except that enriched housing programs require private resident units and do not have to offer more than one meal per day.

Both settings form the foundation of the state's Assisted Living Residence Program. When residents reach a level of frailty that can no longer be addressed through the care and services of an enriched housing program or an adult home, an operator may apply for certification to provide a higher level of care as an ALR;<sup>105</sup> operators may also be certified as *special needs assisted living* to provide dementia care, or as *enhanced assisted living* to support aging in place.

Adult homes and enriched housing programs may be licensed by the Department of Health to participate in the assisted living program (ALP) for Medicaid clients, which has additional requirements for admission and retention, staffing, and resident services.

*Adult Foster Care.* The Department of Social Services, Office of Children and Family Services, licenses another type of adult care facility called family-type homes for adults that provide long-term residential care, room, board, housekeeping, supervision and/or personal care to four or fewer adults unrelated to the operator. The Division of Adult Protective Services monitors these homes. *Regulatory provisions for family-type*

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<sup>103</sup> An adult home, with a capacity of 80 beds or more and in which at least 25 percent of the residents have a serious mental illness may be certified as a Transitional Adult Home. This profile does not include information about these homes.

<sup>104</sup> Another adult care facility category, Residences for Adults, are not required to provide personal care and are intended primarily for persons with mental health conditions served by the Office of Mental Health.

<sup>105</sup> In order to operate an ALR, an operator must be licensed as an adult home or enriched housing program. Applications for ALR licensure may be filed simultaneously with an application for licensure as an adult home or enriched housing program.

*homes for adults are not included in this profile but a link to the provisions can found at the end.*

*This profile includes summaries of selected regulatory provisions for adult homes, enriched housing programs, and ALRs. The complete regulations are online at the links provided at the end.*

## Definitions

**Adult homes** provide residential care, meals, housekeeping, personal care, and supervision to five or more adults unrelated to the operator. These settings may accommodate up to 200 residents in one building, with some licensed before 1984 permitted to accommodate more.

**Enriched housing programs** provide long-term residential care to five or more adults, primarily persons 65 years of age or older (no more than 25 percent of residents may be under 65 and all must be 55 or older), in community-integrated settings resembling independent housing units. An enriched housing operator is required to provide only one meal a day, which must be a hot meal provided in a group setting.

**Assisted living residences** provide or arrange 24-hour on-site monitoring, case management, food services, and personal care and/or home care services (either directly or indirectly) to five or more adults. The rules specify that an assisted living operator must provide each resident with considerate and respectful care and promote the resident's dignity, autonomy, independence, and privacy in the least restrictive and most home-like setting consistent with the resident's preferences and physical and mental status.

**Enhanced Assisted Living.** Department certification authorizes an ALR to allow "aging in place" for residents who choose to continue living in the residence and who are chronically chairfast and unable to transfer; or chronically require the physical assistance of another person to transfer, walk, or climb or descend stairs; are dependent on medical equipment and require more than intermittent or occasional assistance from medical personnel; and/or have chronic unmanaged urinary or bowel incontinence.

**Special Needs Assisted Living.** Department certification allows an ALR to serve residents with special needs, including those related to cognitive impairment. The operator must demonstrate to the Department how resident needs will be safely and appropriately met and must meet specified staffing and training guidelines.

## Resident Agreements

**Adult Homes and Enriched Housing Programs.** Admission agreements must include a description of all services required by law to be provided; a list of additional available services; the basic payment rate and all financial policies; Supplemental Security Income (SSI) or Home Relief resident policies; a statement that the resident will provide a signed medical statement and inform the operator of changes in health conditions, status, or medications; and a statement that the resident will comply with all reasonable rules.

**Assisted Living Residences.** The resident agreement must include the facility's certification, if any; the agreement period; basic services; additional services available for a fee; a rate or fee schedule; payment and refund policies; information about how to amend or terminate the agreement; the complaint resolution process; and admission and discharge criteria.

## Disclosure Provisions

**Adult Homes and Enriched Housing Programs.** *No provisions identified.*

**Assisted Living Residences.** The assisted living operator must provide the following to prospective residents and/or their representatives: (1) a consumer information guide developed by the Commissioner of the Department of Health; (2) the residence's licensure type, including enhanced assisted living and/or special needs enhanced assisted living certificates, if applicable; (3) policies regarding resident use of third-party providers, including a statement that residents have the right to choose their health care providers; (4) information about the availability of public funding for residential, supportive, or home health services, including the availability of Medicare for coverage of home health services; and (6) contact information for the Department and for ombudsman services.

## Admission and Retention Policy

All three facility types may not accept or retain anyone who: (1) needs continual medical or nursing care or supervision as provided by an acute care facility or a residential health care facility; (2) suffers from a serious and persistent mental disability sufficient to warrant placement in an acute care setting or residential treatment facility; (3) requires health or mental health services that are not available or cannot be provided; (4) repeatedly behaves in a manner that directly impairs the well-being, care or safety of residents; (5) has an unstable medical condition that requires continual skilled observation of symptoms; (6) refuses or is unable to comply with a prescribed treatment program; (7) is chronically bedfast or chairfast and requires assistance from another person to transfer; (8) regularly needs assistance from another person to walk or climb and descend stairs; (9) has chronic unmanaged urinary or bowel incontinence;

(10) is dependent on medical equipment (with some exceptions); (11) has a communicable disease; (12) has chronic personal care needs that staff cannot meet; (13) is not self-directing; or (14) engages in drug or alcohol use that results in aggressive or destructive behavior.

***Assisted Living Residences Certified to Provide Enhanced Assisted Living.***

A resident in need of 24-hour skilled nursing care or medical care may be retained when all of the following conditions are met: (1) the resident hires appropriate nursing, medical, or hospice staff; (2) the resident's physician and home care services agency determine that the resident can be safely cared for in the residence; (3) the facility agrees to retain the resident and coordinate his/her care; and (4) the resident is otherwise eligible to reside at the residence in accordance with the definition.

## Services

***Adult homes and enriched housing programs*** provide supervision, personal care, housekeeping, case management, activities, and assistance with medication. To operate as an ALP that serves Medicaid clients, additional nursing and therapeutic services must be provided based upon the recipient's initial assessment and periodic reassessments.

***Assisted Living Residences.*** Facilities must offer case management, personal care, coordination of health care services provided by an outside agency, and medication services. Residences certified to provide enhanced assisted living must provide or arrange for nursing services, including assessment and evaluations; monitoring and supervision; nursing care and treatments; and medication administration and management.

### ***Service Planning***

***Adult Homes and Enriched Housing Programs.*** Facilities must determine whether the program can support the physical and social needs of an applicant based on the following: (1) a medical evaluation by a physician, physician assistant, or nurse practitioner that describes significant medical history and current conditions; known allergies; the prescribed medication regimen, including information on the applicant's ability to self-administer medications; and recommendations for diet, exercise, recreation, frequency of medical examinations and assistance with activities of daily living (ADLs); (2) an interview with the applicant and designated program staff; (3) a mental health evaluation by a psychiatrist, physician, registered nurse (RN), certified psychologist, or certified social worker if the applicant has a history of a chronic mental disability, or if the interview suggests the existence of such a disability; and (4) a functional assessment by the program coordinator, case manager, or a consultant RN for the following: sensory impairments; limitations in ADLs and instrumental activities of daily living; behavioral characteristics; personality characteristics; and daily habits. Residents must be reassessed annually and following a change in condition.

**Assisted Living Residences.** An individualized service plan must be developed jointly by the resident, the resident's representative if applicable, a home care agency if needed (as determined by the resident's physician), and in consultation with the resident's physician. The service plan must address the resident's medical, nutritional, rehabilitation, functional, and cognitive needs, and must be reviewed and revised at least every 6 months or when required by the resident's changing care needs.

### **Third-Party Providers**

**Adult Homes and Enriched Housing Programs.** Facilities must access and cooperate with external service providers on behalf of residents who need services not provided by the home or program.

**Assisted Living Residences.** Unless the facility is certified to provide enhanced or special needs care, it must arrange for any needed health care services to be provided by a home care services agency. Residents may contract with a home health agency or a long-term home health care program of their choice.

## **Medication Provisions**

All three types of facilities may provide assistance with self-administration of medications, described as prompting, identifying the medication for the resident, bringing the medication to the resident, opening containers, positioning the resident, disposing of used supplies, and storing the medication. Medication administration may only be provided by a licensed nurse or medication technician.

## **Food Service and Dietary Provisions**

**Adult homes** must provide three meals a day and an evening snack that meet the recommended dietary allowances of the National Academy of Science's Food and Nutrition Board.

**Enriched housing programs** must serve, at a minimum, one hot mid-day or evening meal that meets one-third of the recommended dietary allowances of the National Academy of Science's Food and Nutrition Board.

**Assisted living residences** must follow the provisions specified in either the adult home or enriched housing program, depending on the residence's licensure type.

## Staffing Requirements

### **Adult Homes**

**Type of Staff.** Facilities must employ an *administrator* to oversee daily operations; a *case manager* to evaluate resident needs and perform other case management duties; *personal services staff* to provide resident services; and an *activities director* to organize and coordinate an activities program. At least one person qualified to provide first-aid must be on-duty at all times.

**Staff Ratios.** A minimum of 3.75 hours of personal services staff time is required per week per resident. In facilities with 25 or more beds, the administrator must be on site 40 hours per week, and for 20 hours per week in facilities with 24 or fewer beds. Facilities with 50 or more beds must staff both a case manager and an activities director on a PRN basis for 0.5 hour per week per each additional bed, up to 40 hours per week.

### **Enriched Housing Programs**

**Type of Staff.** The facility must have a *program coordinator* responsible for operating and maintaining the program in compliance with applicable requirements; a *case manager* to evaluate residents' needs and perform other case management duties, including investigating and reporting reportable incidents to the Department; and *personal care staff* to assist residents.

**Staff Ratios.** Personal care staff must be provided at a rate of 6 hours per resident per week. The program coordinator must be employed on the basis of 1.5 hours per resident per week for the first 16 residents and 1 hour per resident per week for each additional resident until the equivalent of a full-time employee is attained. A case manager must be on staff and on duty for 0.5 hour per week per resident.

### **Assisted Living Residences**

**Type of Staff.** The facility must have an *administrator* who is responsible for daily operations and compliance with applicable rules; a *case manager* to assist residents with housing issues, information about local services and activities, and contacting appropriate responders in urgent and emergency situations; and *resident aides* to provide personal care assistance. Facilities certified to provide enhanced assisted living must, in addition, have *licensed practical nurses (LPNs)*, *registered nurses*, and *home health aides*.

**Staff Ratios.** *No minimum ratios.* Resident aides must be present in sufficient numbers 24 hours a day to meet residents' needs. Facilities must employ a case manager based on the number of residents as follows: facilities with 1-24 residents must employ a case manager for 20 hours per week; facilities with 25-44 residents require 20 hours per week plus 1 additional hour per week per bed over 24 up to 40

hours; and facilities with 45 or more residents require 40 hours of case manager staffing.

Facilities certified to provide enhanced assisted living must, in addition, provide (either directly or through contract) sufficient nursing staff to meet residents' health care needs, as determined by a medical evaluation or by the resident's attending physician and/or the service plan. A sufficient number of home health aides (directly or through contract) must be on-duty when a licensed nurse is not on-duty or on-site. [**NOTE:** *the nursing coverage requirements described in the rules (e.g., an RN on staff 8 hours daily at least 5 days per week) were annulled in 2010; see Dear Administrator Letter at the end.*]

## Training Requirements

**Adult Homes and Enriched Housing Programs.** Facilities must provide orientation and in-service training about the characteristics and needs of the population served; residents' rights; program rules and regulations; staff duties and responsibilities; general and specific responsibilities of the individual being trained; and emergency procedures. Adult homes must, in addition, train staff in the identification and reporting of reportable incidents.

**Assisted Living Residences.** All personnel must receive orientation to facility policies and procedures; resident characteristics; and emergency evacuation and disaster plans. Administrators not holding a current New York license as a nursing home administrator must complete at least 60 hours of continuing education every 2 years. Resident aides must receive 40 hours of initial training and 12 hours of annual in-service education on topics relevant to their duties.

## Provisions for Apartments and Private Units

**Adult homes** may provide single-occupancy or double-occupancy bedrooms, and must have at least one toilet and one sink for every six residents and one bathtub/shower for every ten residents.

**Enriched housing programs** must provide single-occupancy units, unless shared by agreement, and each unit must include a full bathroom, living and dining space, sleeping area, and equipment for storing and preparing food.

**Assisted Living Residences.** Resident rooms may be single-occupancy or double-occupancy depending on the residence's licensure as an adult home or enriched housing program.

## Provisions for Serving Persons with Dementia

The following provisions apply to ALRs certified to provide special needs assisted living to individuals with dementia or cognitive impairments.

**Dementia Care Staff.** In addition to the staffing requirements for ALRs described above, facilities must have *licensed practical nurses, registered nurses, and home health aides*. Sufficient nursing staff must be on-duty to meet residents' health care needs, as determined by a medical evaluation or by the resident's attending physician and/or the service plan. A sufficient number of home health aides (directly or through contract) must be on-duty when a licensed nurse is not on-duty or on-site. [**NOTE:** *the nursing coverage requirements described in the rules (e.g., an RN on staff 8 hours daily at least 5 days per week) were annulled in 2010; see Dear Administrator Letter at the end.*]

**Dementia Staff Training.** Facilities must train staff on the following topics: characteristics and needs of persons with dementia, including behavioral symptoms, and mental and emotional changes; and methods for meeting residents' needs on an individual basis.

**Dementia Facility Requirements.** Dementia units must be designed as self-contained units. Fully locked facilities are prohibited, but units must have a delayed-egress system on all external doors as well as window stops and enclosed courtyards. Facilities must meet additional fire safety rules.

## Background Checks

All adult care facilities must conduct a criminal history records check of prospective non-licensed, direct care employees through the Division of Criminal Justice Services. Fingerprinting is required. Applicants must provide a sworn statement to the facility administrator indicating any prior finding of patient abuse.

Staff of licensed home care agencies who work in adult care facilities must have undergone a criminal history background check.

## Inspection and Monitoring

**All Licensure Categories.** The Department inspects all licensed facilities every 18 months.

**Assisted Living Residences.** Applicants for a new facility license are inspected by the Department to assess compliance with applicable regulations.

## Public Financing

The New York State Department of Health regulates the ALP, a Medicaid State Plan service that operates in facilities that are licensed as either an adult home or enriched housing program. The additional licensure as an ALP enables providers to serve individuals who require services above and beyond what is typically provided in those basic settings and who have been assessed as eligible for nursing home level of care.

ALPs must also be a licensed home care services agency or certified home health agency. If a facility is licensed as a home care services agency, it must contract with a certified home health agency to provide skilled services. ALPs provide personal care, housekeeping, supervision, home health aides, personal emergency response services, nursing, physical therapy, occupational therapy, speech therapy, medical supplies and equipment, adult day health care, a range of home health services, and the case management services of a registered professional nurse.

In addition to the ALP, services provided by adult care facilities may be covered for eligible residents through the state's Long-Term Home Health Program 1915(c) Waiver program.

The state does not provide public subsidization of services for low-income residents of ALRs. However, it is possible to receive Medicaid personal care services, which are provided independently to individuals in community settings, including an ALR.

### **Room and Board Policy**

The state provides an optional state supplement (OSS) to SSI recipients who reside in specified living arrangements. The amount of the OSS varies by type of group living facility and geographic area. The 2015 minimum OSS is \$228.48 for residents of family-type homes for adults, and the maximum is \$694 for residents of adult homes or enriched housing programs. The monthly personal needs allowance varies by facility type, from \$141 to \$193.

In 2009, family supplementation was not allowed.<sup>106</sup>

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<sup>106</sup> Mollica, R.L. (2009). *State Medicaid Reimbursement Policies and Practices in Assisted Living*, National Center for Assisted Living, American Health Care Association. <http://www.ahcancal.org/ncal/resources/Documents/MedicaidAssistedLivingReport.pdf>. Current information about family supplementation policy was not available online or from other sources.

## Location of Licensing, Certification, or Other Requirements

*New York Codes, Rules and Regulations*, Title 18, Part 485: Adult Care Facilities, General Provisions.

<http://w3.health.state.ny.us/dbspace/NYCRR18.nsf/56cf2e25d626f9f785256538006c3ed7/f23f2715415f71688525672200769025?OpenDocument&Highlight=0,485>

*New York Codes, Rules and Regulations*, Title 18, Part 487: Adult Care Facilities, Standards for Adult Homes.

<http://w3.health.state.ny.us/dbspace/NYCRR18.nsf/56cf2e25d626f9f785256538006c3ed7/cf61bf0d8ac1b0fa852567220076903f?OpenDocument&Highlight=0,487>

*New York Codes, Rules and Regulations*, Title 10, Chapter X, Part 1001: Adult Care Facilities, Assisted Living Residences.

[https://www.health.ny.gov/facilities/assisted\\_living/adopted\\_regulations/docs/assisted\\_living\\_residences\\_laws\\_and\\_regulations.pdf](https://www.health.ny.gov/facilities/assisted_living/adopted_regulations/docs/assisted_living_residences_laws_and_regulations.pdf)

*New York Codes, Rules and Regulations*, Title 18: Part 488: Adult Care Facilities, Standards for Enriched Housing.

<http://w3.health.state.ny.us/dbspace/NYCRR18.nsf/56cf2e25d626f9f785256538006c3ed7/9dfd107afc3034c1852567220076904c?OpenDocument&Highlight=0,488>

*New York Codes, Rules and Regulations*, Title 18, Part 490: Adult Care Facilities, Standards for Residences for Adults.

<http://w3.health.state.ny.us/dbspace/NYCRR18.nsf/56cf2e25d626f9f785256538006c3ed7/3781a985de53df04852567220076906a?OpenDocument&Highlight=0,490>

*New York Codes, Rules and Regulations*, Title 18, Part 494: Adult Care Facilities, Standards for Assisted Living Programs.

<http://w3.health.state.ny.us/dbspace/NYCRR18.nsf/56cf2e25d626f9f785256538006c3ed7/61b8768b073faef285256722007690a0?OpenDocument&Highlight=0,494>

*New York Codes, Rules and Regulations*, Title 18, Part 489: Adult Care Facilities, Standards for Family-type Homes.

<http://w3.health.state.ny.us/dbspace/NYCRR18.nsf/56cf2e25d626f9f785256538006c3ed7/7bce5cfbc6da307a8525672200769059?OpenDocument&Highlight=0,Part,489>

New York Department of Health website: Dear Administrator Letter regarding changes to regulations in ALRs.

[https://www.health.ny.gov/facilities/assisted\\_living/dal/dal\\_10-10\\_alr\\_lawsuit.htm](https://www.health.ny.gov/facilities/assisted_living/dal/dal_10-10_alr_lawsuit.htm)

## Information Sources

Valerie A. Deetz

Director

Divisions of Assisted Living and Community Transitions Program

Center for Health Care Provider Services and Oversight

New York State Department of Health

## NORTH CAROLINA

### Licensure Terms

Assisted Living Residences

### General Approach

The term assisted living residences (ALRs) covers two types of long-term residential care settings: (1) adult care homes (ACHs); and (2) multi-unit assisted housing with services facilities.

The North Carolina Division of Health Service Regulation licenses ACHs based on size--family care homes for 2-6 residents and ACHs for seven or more residents. Both can choose to serve only elderly persons (55 years or older or any adult who has a primary diagnosis of Alzheimer's disease or other form of dementia) and the license indicates that this is the population to be served. Facilities may provide respite services, but provision of this service is not a condition for licensure.

Multi-unit assisted housing with services settings are not licensed. They are only required to register with the Division of Health Service Regulation and to provide a disclosure statement.

*Adult Foster Care.* The state licenses ACHs located in private residences serving 2-6 residents--called family care homes. With the exception of building and staff requirements, the regulations for family care homes with fewer than seven residents and ACHs with seven or more residents are materially the same. *Distinct regulatory provisions for family care homes are not included in this profile but a link to the provisions can found at the end.*

*The information in this profile, unless it specifically references multi-unit assisted housing with services facilities, applies to licensed ACHs with seven or more residents. This profile includes summaries of selected regulatory provisions. The complete regulations are online at the links provided at the end.*

### Definitions

**Assisted living residence** means any group housing and services program for two or more adults, by whatever name it is called, which makes available, at a minimum, one meal per day and housekeeping services, and provides personal care services directly or through a formal written agreement with one or more licensed home

care or hospice agencies. The Department may allow the provision of nursing services to be provided on a case-by-case basis. Settings in which services are delivered may include self-contained apartment units or single or shared room units with private or shared bathrooms.

**Adult care home** means a type of ALR in which the housing management provides 24-hour scheduled and unscheduled personal care services to seven or more residents, either directly or through formal written agreement with licensed home care or hospice agencies. Some licensed ACHs provide supervision to persons with cognitive impairments whose decisions, if made independently, may jeopardize the safety or well-being of themselves or others and therefore require supervision. Medication in an ACH may be administered by designated, trained staff.

**Multi-unit assisted housing with services** means an ALR in which hands-on personal care services and nursing services, which are arranged by housing management, are provided by a licensed home care or hospice agency through an individualized written care plan. The housing management has a financial interest or financial affiliation or formal written agreement that makes personal care services accessible and available through at least one licensed home care or hospice agency. The resident may choose any provider for personal care and nursing services and the housing management may not combine charges for housing and personal care services.

## Resident Agreements

ACHs must provide specific information in writing to a resident upon move-in, including house rules and facility policies, discharge criteria, residents' rights, and grievance procedures; and specific information in the resident contract, including accommodation and service rates, and rate change and refund policies.

An ACH with a special care unit (SCU) for individuals with Alzheimer's disease or other dementias must provide information about the unit's policies and procedures for caring for the residents and the special services that are provided.

## Disclosure Provisions

**Adult care homes** that market themselves as providing an SCU for persons with dementia must have a license indicating the number of SCU beds in the home, and provide written disclosure statements, which must be approved by the state. The content of the written disclosure statements must include, but is not limited to: the process and criteria for admission and discharge; the assessment and service planning and implementation process; staffing ratios; dementia-specific staff training; physical environment and design features that specifically address the needs of residents with dementia; frequency and type of programs and activities; involvement of families in

resident care, and availability of family support programs; and additional costs and fees for special care.

**Multi-unit assisted housing with services** programs are required to provide a disclosure statement as part of the annual rental contract. The statement must be approved by the state and include a description of the following: emergency response system, service charges, service and tenancy limitations, resident responsibilities, the financial/legal relationship between housing management and home care or hospice agencies, a listing of all home care or hospice agencies and other community services in the area, an appeals process, and procedures for required initial and annual resident screening and referrals for services.

## Admission and Retention Policy

**Adult care homes** may not admit or retain residents who meet the state's eligibility criteria for nursing home care, or individuals with the following conditions or treatment needs: mental illness or alcohol or drug abuse, maternity care, the absence of a need for personal assistance and supervision, posing a direct threat to the health or safety of others, and individuals whose physician certifies placement as no longer appropriate.

Except when a physician certifies that appropriate care can be provided on a temporary basis to meet the resident's needs and prevent unnecessary relocation, ACHs must not care for individuals with any of the following conditions or care needs: (1) ventilator dependency; (2) a need for continuous licensed nursing care; (3) health needs that cannot be met in the specific ACH as determined by the residence; and (4) other medical and functional care that cannot be properly met in an ACH.

Residents may be discharged only for the following reasons: for their welfare, the facility determines that it cannot meet the resident's needs, the resident no longer needs the services provided by the facility, the health or safety of other individuals in the facility is endangered, or discharge is mandated under other rules. All health reasons for discharge must be documented by a physician, physician's assistant, or nurse practitioner.

**Multi-Unit Assisted Housing with Services.** All residents, or their representatives, must be capable, through informed consent, of entering into a contract and must not be in need of 24-hour supervision. Except when a physician certifies that appropriate care can be provided on a temporary basis to meet the resident's needs and prevent unnecessary relocation, providers must not admit or retain individuals with major medical conditions or needs, including: (1) ventilator dependency; (2) Stage III and IV dermal ulcers (except Stage III ulcers that are healing); (3) intravenous therapy or injections; (4) communicable airborne disease requiring isolation or special precautions; (5) continuous licensed nursing care; or (6) total dependency in four or more of the seven activities of daily living (ADLs).

## Services

**Adult care homes** must provide 24-hour staff monitoring and supervision, and assistance with scheduled and unscheduled personal needs, as well as transportation, activities, and housekeeping services. ACHs may provide personal care directly or through contracts, and may provide some specified health care services while licensed home care agencies provide other health care services that unlicensed staff cannot perform.

Nursing services may be provided by the ACH on a case-by-case exception basis approved by the Department of Health and Human Services (DHHS), or through licensed home care agencies. Residents have the right to obtain services from providers other than the housing management, at their own cost.

**Multi-unit assisted housing with services** facilities coordinate personal and health care services through licensed home care agencies.

### Service Planning

**Adult care homes** must assess each resident within 72 hours of admission using a state-provided or approved form, and complete a functional assessment of each resident within 30 days after admission, and at least annually thereafter, using a state-provided or approved assessment instrument. The assessment is used to determine residents' functional level, and includes measures of psychosocial well-being, cognitive status, and ADLs. Reassessments must be completed within 10 days following a significant change in a resident's condition.

The person or persons designated by the administrator to perform resident assessments must successfully complete resident assessment training established by the DHHS before performing the required assessments. Registered nurses (RNs) are exempt from the assessment training requirement.

The facility must complete a care plan based upon the resident's assessment within 30 days following admission. The care plan is an individualized written program of personal care for each resident and must include a statement of the care or service to be provided based on the assessment or reassessment, as well as the frequency of service provision.

Assessments and care plans are reviewed during oversight visits to determine whether residents are appropriate for the facility, whether the assessment was appropriately done, whether the plan of care is appropriate, and whether the facility has the capacity to meet the residents' needs.

Prior to admission, facilities must evaluate the appropriateness of an individual's placement in an SCU. Within 30 days of admission to the SCU and quarterly thereafter, the facility must develop a written resident profile containing assessment data that describes the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment.

**Multi-unit assisted housing with services** facilities must screen prospective residents to determine if they need an in-depth assessment by a licensed home care agency, and if the facility has the capacity and legal authority to meet the prospective resident's needs.

### **Third-Party Providers**

In all licensed settings, a resident may request hospice and home health care, provided with appropriate physician orders.

In **multi-unit assisted housing with services** facilities, personal care and nursing services are provided through licensed agencies. Facilities must have an arrangement with at least one licensed agency to meet the scheduled needs of residents, but residents may choose any agency to provide services.

## **Medication Provisions**

**Adult Care Homes.** The facility must provide orientation to medication policies and procedures for staff responsible for medication administration prior to their administering or supervising the administration of medications.

Residents are permitted to self-administer medications as long as they are competent, physically able to do so, and have a physician's order to do so. In addition, specific instructions for administering medications must be written on the medication label.

Competency validation by an RN is required for unlicensed staff who perform any tasks related to medication administration. ACH staff who administer medications--called medication aides--and staff who directly supervise medication administration must successfully complete the clinical skills validation portion of the state's competency evaluation prior to providing medication administration or supervision of same.

Medication aides and their direct supervisors, except persons authorized by state occupational licensure laws to administer medications, must score at least 90 percent on the written standardized state examination within 90 days after successful completion of the clinical skills validation portion of the competency evaluation, and

must complete 6 hours of continuing education related to medication administration annually.

A licensed pharmacist, prescribing practitioner, or RN must review at least quarterly each resident's medications and the facility's medication policies and procedures, or more frequently as required by the Department based on documentation of specific medication problems in the facility.

ACHs must ensure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin. The training must be provided by an RN, registered pharmacist, or prescribing practitioner and must cover a number of topics, including blood glucose monitoring; sliding scale insulin administration; insulin action; and mixing, measuring, and injection techniques for insulin administration.

***Multi-Unit Assisted Housing with Services.*** Assistance with self-administration of medications may be provided by appropriately trained staff when delegated by a licensed nurse according to the home care agency's established plan of care.

## Food Service and Dietary Provisions

ACHs must provide three meals and three snacks a day (with at least 10 hours between the breakfast and evening meals), and modified or therapeutic diets when ordered by a physician. Menus for modified and therapeutic diets must be planned or reviewed by a registered dietician. Sufficient staff must be available for individual feeding assistance as needed.

## Staffing Requirements

***Type of Staff.*** At all times there must be one *administrator* or *supervisor/administrator-in-charge* who is directly responsible for ensuring that all required duties are carried out and that residents are never left alone. ACHs must also have a designated *activity director*.

On first and second shifts in facilities with a capacity or census of 31 or more residents and on the third shift in facilities with a capacity or census of 91 or more residents, the facility must have at least one *supervisor of personal care aides (PCAs)*. This supervisor must not serve simultaneously as the administrator but may serve simultaneously as the administrator-in-charge in the absence of the administrator.

Facilities must ensure that an appropriate *licensed health professional* participates in the on-site review and evaluation of residents' health status, care plan, and care provided for health or health-related tasks, such as bowel and bladder training and feeding techniques for residents with swallowing problems.

Each ACH must have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardiopulmonary resuscitation and choking management, including the Heimlich maneuver.

**Staff Ratios.** The regulations include very detailed staffing requirements that vary by facility size and shift. Facilities serving 20-30 residents must have 16 hours of PCA time on the first and second shifts, and 8 hours on the third shift. The amount of PCA hours increases with the size of the facility and reaches 96 hours for facilities with 131-140 residents.

## Training Requirements

ACH administrators must complete 30 hours of continuing education every 2 years. Administrators-in-charge and supervisors-in-charge must complete 12 hours of continuing education per year.

Staff who directly provide personal care or who directly supervise those who do, must complete an 80-hour personal care training and competency evaluation program established by the state. Licensed health professionals, staff listed on the Nurse Aide Registry, or staff who document completion of a 40-45 hour or 75-80 hour training program or competency evaluation program are exempt from this training requirement.

The 80-hour training program includes at least 34 hours of classroom instruction and 34 hours of supervised practical experience. The competency evaluation includes observation and documentation; basic nursing skills, including special health-related tasks; personal care skills; cognitive and behavioral skills, including interventions for individuals with mental disabilities; basic restorative services; and resident's rights. Experienced staff may take the competency exam without undergoing training.

Facilities must ensure that non-licensed and licensed personnel not practicing in their licensed capacity complete a one-time competency evaluation for specific personal care tasks (specified in regulation) before performing these tasks. The regulations have additional training requirements for ACHs that serve residents with specific conditions, such as diabetes and the need for restraints.

## Provisions for Apartments and Private Units

Apartment-style units and private rooms are not required. In ACHs licensed after July 1, 2004, a bedroom may not be occupied by more than two residents. If licensed prior to that date, a bedroom may not be occupied by more than four residents. Bathroom and toilet facilities are shared with a minimum of one toilet and sink for every five residents and a tub or shower for every ten residents.

## Provisions for Serving Persons with Dementia

***Dementia Care Staff.*** At least one staff person is required for every eight residents on the first and second shift, plus 1 hour of staff time for each additional resident; and one staff person for every ten residents on the third shift, plus 0.8 hour of staff time for each additional resident. A care coordinator must be on-duty in the SCU at least 8 hours a day, 5 days a week. The care coordinator may be counted in the minimal staffing requirements. In SCUs with more than 16 units, the care coordinator is not counted in determining the minimal staffing requirement.

***Dementia Staff Training.*** Prior to establishing an SCU, the administrator must document receipt of at least 20 hours of training specific to the population to be served for each SCU to be operated, and must have in place a plan to train other staff assigned to the unit.

Within the first week of employment, each employee assigned to perform duties in the SCU must complete 6 hours of orientation about residents' needs. Within 6 months of employment, staff responsible for personal care and supervision within the unit must complete 20 hours of training specific to the population being served, in addition to other specified orientation and training requirements.

***Dementia Facility Requirements.*** Private units are not required. A toilet and sink must be provided within the SCU for every five residents and a tub and shower for bathing must be in the unit. Facilities must provide direct access to a secured outside area and avoid or minimize the use of potentially distracting mechanical noises. Unit exit doors may be locked only if the locking devices meet the requirements outlined in the state building code for special locking devices. If exit doors are not locked, facilities must have a system of security monitoring.

## Background Checks

All employees in all licensed facilities must have a criminal background check and must also have no findings of abuse or neglect listed on the North Carolina Health Care Personnel Registry. Administrators of ACHs must have a criminal background fingerprint check. A criminal background check is not required for licensees.

## Inspection and Monitoring

All licensed facilities are subject to inspections at all times and are inspected on an annual basis. County Departments of Social Services monitor ACHs at least quarterly, investigate complaints, and accompany the state inspection teams for annual surveys. State staff provide consultation, technical assistance, and training to the county monitors; oversee monitoring by county staff; and perform annual surveys and licensing

surveys of all ACHs, including follow-up surveys as needed. County staff are included on these surveys.

Every county with at least one licensed ACH has a community advisory committee that works with each home to ensure residents' best interests. The committee's purpose is to promote community involvement and cooperation with ACHs to ensure quality care for the elderly and disabled adults residing there. The state has a Star Rating program that was designed to be a tool to assist consumers in making informed decisions regarding care options for themselves or a loved one. The program provides consumers with information based on facility inspections by the licensing agency.

## Public Financing

The Medicaid State Plan pays for personal care provided to eligible residents in ACHs.

### ***Room and Board Policy***

In 2014, the maximum state/county special assistance payment for room and board in ACHs was \$1,162 a month, including a \$46 personal needs allowance and a \$20 income disregard. The maximum payment for a resident in a SCU was \$1,575 a month. The state/county assistance payment is a supplemental benefit standard that is based on the federal Supplemental Security Income payment and any other sources of income according to established eligibility requirements.

Family supplementation to pay for a private room is permitted when the resident or family members request one.

## Location of Licensing, Certification, or Other Requirements

*North Carolina Administrative Code*, Chapter 10A, Subchapter 13F: Licensing of Homes for the Aged and Infirm.

<http://reports.oah.state.nc.us/ncac/title%2010a%20-%20health%20and%20human%20services/chapter%2013%20-%20nc%20medical%20care%20commission/subchapter%20f/subchapter%20f%20rules.html>

*North Carolina Division of Health Service Regulation, Adult Care Licensure Section: Legal Requirements for Registration and Disclosure for Multi-unit Assisted Housing with Services.*

<http://www.ncdhs.gov/dhsr/acls/multiunitlegal.html>

*North Carolina Administrative Code*, Chapter 10A, Subchapter 13G: Licensing of Family Care Homes.

<http://reports.oah.state.nc.us/ncac/title%2010a%20-%20health%20and%20human%20services/chapter%2013%20-%20nc%20medical%20care%20commission/subchapter%20g/subchapter%20g%20rules.html>

## **Information Sources**

Doug Barrick  
Department of Health and Human Services  
Division of Health Service Regulation

## NORTH DAKOTA

### Licensure Terms

Assisted Living Facility and Basic Care Facility

### General Approach

The Department of Health establishes rules for basic care facilities and the Department of Human Services oversees licensing and rules for assisted living facilities (ALFs), which must also meet some Department of Health rules. The primary differences between these licensure categories are: (1) the extent to which they are regulated--the ALF regulations are very brief; and (2) only basic care facilities are required to provide meals.

*Adult Foster Care.* Family foster homes for adults are licensed by the Department of Human Services and defined as an occupied private residence in which care is regularly provided to four or fewer adults who are not related by blood or marriage to the owner or lessee. Care includes the provision of personal, non-medical services to assist a resident with activities of daily living (ADLs). *Regulatory provisions for these settings are not included in this profile but a link to the provisions can found at the end.*

*This profile includes summaries of selected regulatory provisions for ALFs and basic care facilities. The complete regulations are online at the links provided at the end.*

*The state will be making major changes to the assisted living regulations during Spring 2015.*

### Definitions

**Assisted living facility** means a building comprising at least five living units in which individualized support services are provided to five or more adults. An ALF is not a congregate housing facility or a basic care facility.

**Basic care facility** means a facility that provides room and board, and health, social, and personal care to assist five or more residents to attain or maintain their highest level of functioning.

## Resident Agreements

**Assisted Living Facilities.** The resident agreement must include the rates for rent and services; payment, refund, and rate change policies; resident criteria; discharge criteria; and living unit inspection policies.

**Basic Care Facilities.** *No provisions identified.* However, all agreements and contracts must be included in the resident's record.

## Disclosure Provisions

*No provisions identified for either licensure category.*

## Admission and Retention Policy

**Assisted Living Facilities.** Each facility must develop residency criteria.

**Basic Care Facilities.** Residents must be capable of self-preservation, and may not have a condition that requires continuous, 24-hour on-site availability of nursing or medical care. Facilities may develop residency criteria.

## Services

**Assisted Living Facilities.** Facilities must provide or coordinate individualized support services, including assistance with ADLs. Facilities may provide health services, described as services provided to an individual for the purpose of preventing disease and promoting, maintaining, or restoring health or minimizing the effects of illness or disability. Residents pay for individual services, not a service package.

**Basic Care Facilities.** Facilities provide personal care (assistance with ADLs and instrumental activities of daily living); observation and documentation of changes in physical, mental, and emotional functioning; arrangements for health care when needed; arrangements for transfer and transportation; assistance with functional aids; housekeeping and laundry; medication services; and social and recreational activities. Nursing services must be available if needed. Residents purchase a package of services.

### **Service Planning**

**Assisted living facilities** must evaluate applicants to make certain they meet residency criteria, and must keep an individual record of services provided to each resident.

**Basic Care Facilities.** Residents must be assessed within 14 days of move-in and at least quarterly, thereafter. Assessment areas include health, psychosocial, functional, nutritional, and activity status; personal care needs; capacity for self-preservation; and social interests and activities. A care plan is developed based on the assessment and resident input.

### **Third-Party Providers**

**Both licensure categories** permit residents to contract with home health agencies.

## **Medication Provisions**

**Both Licensure Categories.** Facilities must meet state requirements and regulations for medication administration, including those in the Nurse Practice Act. Unlicensed staff may provide assistance with medications. Staff who are certified by the Department of Health as a Medication Assistant--Level I, II, or III--may administer medications when supervised by a registered nurse (RN). Only Medication Assistant Level III staff may administer medications by injection, and under provisions defined by the state Board of Nursing.

**Basic Care Facilities.** In addition to the above, basic care facilities must have a health professional or consulting pharmacist review each resident's medication regimen as needed, and at least annually.

## **Food Service and Dietary Provisions**

**Assisted Living Facilities.** Facilities are not required to provide meals.

**Basic Care Facilities.** Facilities must serve a minimum of three meals and snacks per day that meet the recommended dietary allowances of the National Academy of Science's Food and Nutrition Board. If the facility accepts individuals who require prescribed diets, the diets must be planned and reviewed by a professional as described by the Dietetic Practice Board.

## **Staffing Requirements**

### **Assisted Living Facilities**

**Type of Staff.** A *manager* (who may be the licensee) and *direct care staff* are required. If the facility provides medication administration, a *registered nurse* must be available to administer medications and/or to train and supervise certified *medication assistants*.

**Staff Ratios.** *No minimum ratios.* Staff must be available 24 hours a day and able to provide resident care.

### **Basic Care Facilities**

**Type of Staff.** An *administrator* is required to be in charge of the general administration of the facility. A *licensed nurse* must be employed or contracted with to provide nursing services, including supervision of any *medication assistants*. Staff are required to provide personal care and other services to residents.

**Staff Ratios.** *No minimum ratios.* Staff must be awake and available 24 hours a day.

## **Training Requirements**

**Assisted Living Facilities.** All staff must receive annual training on resident rights; fire and accident prevention and response; mental and physical health; behavior problems and preventions; and infection control, including universal precautions. Managers must complete 12 hours of annual continuing education.

**Basic Care Facilities.** Annually, all employees must receive in-service training in at least the following: (1) fire and accident prevention and safety; (2) residents' mental and physical health needs, including behavior problems; (3) prevention and control of infections, including universal precautions; and (4) residents' rights. Staff responsible for activities must attend a minimum of two activity-related educational programs per year. Administrators must attend at least 12 hours of continuing education annually.

## **Provisions for Apartments and Private Units**

**Assisted Living Facilities.** Apartment-style units are not required. A resident living unit must include a sleeping area, an entry door that can be locked, and a private bath with a toilet, sink, and a bathtub/shower. Units may be single-occupancy or double-occupancy.

**Basic Care Facilities.** Resident rooms may be single-occupancy or multiple-occupancy (three or more). At least one toilet and sink is required for every four residents, and one bathtub/shower for every 15 residents.

## **Provisions for Serving Persons with Dementia**

**Assisted Living Facilities.** *No provisions identified.*

**Basic Care Facilities.** Facilities may provide memory care but there are no specific provisions.

## Background Checks

**Assisted Living Facilities.** *No provisions identified.*

**Basic Care Facilities.** Before employing a new staff person, facilities must check state registries and licensure boards to identify any findings of inappropriate conduct, employment, disciplinary actions, and termination.

## Inspection and Monitoring

**Assisted Living Facilities.** The Department receives complaints by and on behalf of residents and must forward the complaints to the appropriate agency, entity, or program for investigation. The state contracts with the Ombudsman Program to provide oversight and monitoring.

**Basic Care Facilities.** The Department may inspect a new applicant before granting a license, and may, at any time, inspect a facility to determine compliance with regulations. On-site scheduled and unscheduled surveys are conducted, and licenses must be issued on a calendar year basis and expire on December 31st of each year.

## Public Financing

The state's Medicaid 1915(c) Waiver for Home and Community-Based Services (HCBS) program pays for residential care provided to eligible residents in basic care facilities (not ALFs). Services are provided in conjunction with shelter and include personal care; therapeutic, social, and recreational programming; and 24-hour on-site response staff to meet scheduled and unpredictable needs and to provide supervision, safety, and security. The Waiver program also pays for adult family foster care.

The state has a Medicaid State Plan program--Basic Care Assistance Program--that supplements the income of Medicaid-eligible residents in participating licensed basic care facilities who, after applying all available income to the cost of care at a basic care facility, requires further assistance.

### **Room and Board Policy**

In 2015, the room and board paid by HCBS waiver clients in a basic care facility is capped at \$683 with a personal needs allowance (PNA) of \$144. Family supplementation is allowed.

The Basic Care Assistance Program limits the room and board rate that facilities charge to Medicaid-eligible residents to the Supplemental Security Income (SSI) federal benefit of \$733 minus a PNA of \$100 in 2015. The state does not provide SSI payment.

## Location of Licensing, Certification, or Other Requirements

*North Dakota Legislative Branch*, Chapter 75-03-34: Licensing of Assisted Living Facilities.  
<http://www.legis.nd.gov/information/acdata/pdf/75-03-34.pdf?20150112162529>

*North Dakota Legislative Branch*, Chapter 23-09: Lodging Establishments and Assisted Living Facilities.  
<http://www.legis.nd.gov/cencode/t23c09.pdf?20150112163253>

*North Dakota Legislative Branch*, Chapter 33-03-24.1: Basic Care Facilities.  
<http://www.legis.nd.gov/information/acdata/pdf/33-03-24.1.pdf?20150112162840>

*North Dakota Legislative Branch*, Chapter 23-09.3: Basic Care Facilities.  
<http://www.legis.nd.gov/cencode/t23c09-3.pdf?20150112163011>

*North Dakota Legislative Branch*, Chapter 75-03-21: Licensing of Family Foster Homes for Adults.  
<http://www.legis.nd.gov/information/acdata/pdf/75-03-21.pdf?20150112154207>

## Information Sources

Shelly Peterson  
President  
North Dakota Long Term Care Association

Bruce Pritsch  
Director  
Division of Health Facilities  
Department of Health

## OHIO

### Licensure Terms

Residential Care Facilities

### General Approach

The Ohio Department of Health licenses residential care facilities (RCFs). The term assisted living is used interchangeably with residential care.

*Adult Foster Care.* Adult foster homes are regulated by the Department on Aging to provide personal care services to 1-2 adults who are unrelated to the residence owner. *Regulatory provisions for adult foster homes are not included in this profile but a link to the provisions can found at the end.*

*This profile includes summaries of selected regulatory provisions for RCFs. The complete regulations are online at the links provided at the end.*

### Definitions

**Residential care facility** means a setting that provides either of the following: (1) accommodations for 17 or more unrelated residents, and supervision and personal care services for three or more residents who need assistance; or (2) accommodations, supervision, and personal care services for three or more unrelated residents who are dependent on the services of others, and skilled nursing care to at least one resident.

### Resident Agreements

Resident agreements must describe monthly charges, fees, and payment policies; residents' rights; facility policies; services offered and the type of skilled nursing care allowed and provided; care for persons with cognitive impairment; accommodations of residents with disabilities; advance directives; and discharge criteria.

### Disclosure Provisions

Facilities that use managed risk agreements must provide a written explanation of their policies and provisions to prospective residents. Facilities that serve special populations must disclose a statement that includes the following information:

- The facility's service mission or philosophy that reflects the needs of the special population.
- Admission and discharge criteria.
- Staffing plan.
- Description of activities offered, including frequency and type, and how the activities meet the needs of the type of residents.
- Specialized staff training and continuing education practices.
- The assessment and service planning process.
- Behavioral health services.
- The physical environment and design features to support resident functioning.
- Services and policies for residents' families.

The Department must approve the disclosure statement.

## **Admission and Retention Policy**

Facilities may admit or retain individuals who require skilled nursing care if the care is on a part-time/intermittent basis for not more than 120 days in any 12-month period, except for hospice clients and those whose skilled nursing care is determined to be routine by a physician. Facilities may not admit or retain individuals who are bedridden with limited potential for improvement; have Stage III or IV pressure ulcers; or have a medically complex condition. Exceptions may be made for persons receiving hospice care.

## **Services**

Services include supervision and personal care, activities, assistance with self-administration of medication, medication administration, and part-time/intermittent skilled nursing services.

### ***Service Planning***

A resident health assessment must be completed on or before admission, annually, and when the resident has a significant change in condition. Domains assessed include medical diagnoses, psychological history, health and physical history, cognitive status, medications, functional status, and the need for skilled nursing services. A licensed health professional must assess the individual's ability to self-administer medication with or without assistance, or the need for medication administration.

If needed, facilities may enter into a risk agreement with a resident or responsible person. A risk agreement is a process through which the resident or sponsor and the facility agree to share responsibility for making and implementing decisions affecting the

scope and quantity of services provided by the facility to the resident. The facility also agrees to identify the risks inherent in a decision made by a resident or sponsor not to receive a service provided by the facility.

### ***Third-Party Providers***

Residents may contract with a licensed hospice agency, certified home health agency, or mental health agency to provide necessary services.

## **Medication Provisions**

Medications must be administered by persons authorized by law to do so, including physicians, registered nurses (RNs), licensed practical nurses (LPNs), or certified medication aides who have completed an approved Board of Nursing training program and are under RN direction. Trained non-licensed staff may assist with self-administration when the resident is mentally alert and able to participate in the medication process. Assistance includes reminders; observing; handing medications to the resident; verifying the resident's name on the label; and, for physically impaired residents, removing oral or topical medications from containers; applying medication upon request; and placing a medication container to the resident's mouth. Assistance also includes helping a resident organize medications in a weekly pill organizer if the resident is able to differentiate between pills and actively participates in the organization.

Medications may also be administered by staff of a licensed hospice agency or certified home health agency.

## **Food Service and Dietary Provisions**

Facilities may choose not to provide meals; or to provide 1-3 meals. Facilities that do not provide meals must ensure that each resident unit is appropriately and safely equipped with facility-maintained food storage and preparation appliances. Facility-prepared meals must provide the recommended daily allowances of the National Academy of Sciences Food and Nutrition Board and be based on a standard meal planning guide approved by a dietician. Facilities providing special diets must monitor staff that prepare or serve the food. A dietician working as consultant or employee is required for facilities that provide and supervise complex therapeutic diets.

## **Staffing Requirements**

***Type of Staff.*** Facilities must have an *administrator* responsible for daily operations who is employed not less than 20 hours per week during the hours of 8:00 a.m. to 6:00 p.m. and who must be accessible at all other times when not present at the

facility; *direct care staff* to provide personal care services; and, if skilled nursing services are provided, a *registered nurse* either on staff or under contract. For facilities that provide personal care services, at least one staff member must have first-aid training.

Facilities that administer medication must have one of the following individuals on duty: an RN; a physician; an LPN who has successfully completed a state-approved course in medication administration and administers medication only at the direction of an RN or physician; or another person authorized by law to administer medication.

Facilities must employ or contract with a *psychologist* or *physician* if any residents have late-stage cognitive impairment with significant ongoing daily living assistance needs; cognitive impairments with increased emotional needs; behaviors that cause problems for the resident or other residents, or both; or serious mental illness.

**Staff Ratios.** *No minimum ratios.* Sufficient numbers of staff must be present to meet residents' total care needs. Facilities that provide skilled nursing care must have sufficient nursing staff and have a licensed nurse on call when one is not present in the facility. At night, a staff member may be on call if the facility meets certain call signal requirements, but another person must also be on call in such cases.

## Training Requirements

All staff must receive orientation and training in their job responsibilities, facility procedures, securing emergency assistance, and residents' rights. Staff must receive 8 hours of continuing education annually in personal care techniques, observational skills, and communication skills. Training must be provided by a licensed nurse. All direct care staff must have first-aid training within 60 days of hire. Administrators must receive 9 hours of continuing education annually in gerontology, health care, business administration, and RCF operation.

Staff members employed by a RCF, or part thereof, that admits or retains residents with: (1) late-stage cognitive impairment with significant ongoing daily living assistance needs; (2) cognitive impairments with increased emotional needs or presenting behaviors that cause problems for the resident or other residents, or both; or (3) diagnoses of serious mental illness must have, within 14 days of the first day of work, 2 hours of training in the care of such residents and 4 hours of continuing education in the care of such residents annually. These hours may count towards the general staff training requirements described above.

## Provisions for Apartments and Private Units

The licensing rules do not require apartment-style units. The maximum occupancy for a resident unit is four persons. One toilet, sink, and tub or shower are required for every eight residents. If more than four persons of one gender are to be accommodated

in one bathroom on a floor, a bathroom must be provided for each gender residing on that floor.

The Medicaid waiver program does require apartment-style units and shared units are allowed only by resident choice.

## **Provisions for Serving Persons with Dementia**

*No provisions identified apart from staff training described above.*

## **Background Checks**

Criminal background checks conducted by the Bureau of Criminal Identification and Investigation and fingerprint impressions are required for all staff who have contact with residents. An Federal Bureau of Investigation check is required for individuals who have resided in Ohio for less than 5 years.

## **Inspection and Monitoring**

RCFs must be inspected at least once prior to the issuance of a license and must have one unannounced visit every 15 months by the Department of Health and the fire marshal.

## **Public Financing**

Two Medicaid waivers cover assisted living services in licensed RCFs. The 1915(c) Assisted Living Program and the 1915(b)(c) Managed Care Demonstration Waiver called MyCare (also known as the Ohio Integrated Care Delivery System) that was launched in March 2014.

In addition, Ohio's Residential State Supplement program is a state-funded cash assistance program for certain Medicaid-eligible aged, blind, or disabled adults who have been determined to be at risk of needing institutional care. A monthly supplement, in combination with the recipient's regular monthly income, is used to pay for accommodations, supervision, and personal care services in approved community-based living arrangements, including adult foster homes and RCFs. In 2014, the maximum fee a RCF was allowed to charge a recipient was \$877. Residents may contract and pay for additional services.

## ***Room and Board Policy***

In 2014, room and board for Medicaid waiver participants was capped at the Supplemental Security Income federal benefit level--\$721--minus a \$50 personal needs allowance. State policy does not address family supplementation.

## **Location of Licensing, Certification, or Other Requirements**

*Ohio Administrative Code*, Chapter 3701-17: Nursing Homes and Residential Care Facilities.  
<http://www.odh.ohio.gov/en/rules/final/3701-10-19/f3701-17.aspx>

*Ohio Administrative Code*, Chapter 5122-35: Adult Foster Homes.  
<http://codes.ohio.gov/oac/5122-35>

Direction Home Akron Canton Area Agency on Aging website: Assisted Living Medicaid Waiver Program, includes information and links to resources for consumers and providers.  
<http://www.services4aging.org/services/need-help-staying-home/assisted-living/assisted-living-medicaid-waver-program.aspx>

## **Information Sources**

Mandy Smith  
Regulatory Director  
Ohio Health Care Association

Jayson Rogers  
Ohio Department of Health

## OKLAHOMA

### Licensure Terms

Assisted Living Center and Residential Care Home

### General Approach

The Department of Health, Protective Health Services, Long-term Care Services, licenses assisted living centers and residential care homes (RCHs). A subchapter of the RCH rules includes provisions for facilities that serve three or fewer residents; this profile includes provisions for assisted living centers and RCHs for four or more residents.

The state does not have a licensure category for adult foster care. Homes that serve two or more residents may be licensed as assisted living centers or RCHs.

*This profile includes summaries of selected regulatory provisions for assisted living centers and RCHs. The complete regulations can be viewed online using the links provided at the end.*

### Definitions

**Assisted living center** means a home or establishment coordinating or providing services to two or more persons who by choice or because of functional impairment need assistance with personal care or nursing supervision, and may need intermittent or unscheduled nursing care, medication assistance, and assistance with transfer and/or ambulation.

**Residential care home** means a facility that provides accommodations and supportive assistance. Residents must be ambulatory and essentially capable of managing their own affairs and may not routinely require skilled nursing care or intermediate care.

### Resident Agreements

**Assisted living centers** must provide a complete and understandable contract to each resident that includes information about admission and discharge criteria; services provided; dispute resolution and grievance procedures; the contract's term, renewal,

and cancellation provisions; and conformity with state law. All rights, privileges, and assurances in the regulations are considered part of the contract.

**Residential Care Homes.** A written contract must be signed within 120 days of admission, or when the source of resident funds changes from private to public or from public to private, or when the terms of the contract have changed. The contract must specify its terms; the services that may be provided to supplement those in the contract and the charges for those services; sources liable for payment; and the rights, duties and obligations of the resident.

## Disclosure Provisions

**Assisted living centers** that provide care to persons with Alzheimer's disease or other dementias must use the Department's required disclosure form to provide specific information about the type of services provided and any additional cost associated with these services; admission, transfer, and discharge policies and procedures; service planning and implementation of care, including specific structured activities that are offered; staffing and staff training to address residents' needs; and safety features of the physical environment.

A facility with only one awake direct care staff member on duty during the night shift must disclose this fact to the resident or the resident's representative prior to move in and must have in place a plan that is approved by the Department of Health for dealing with urgent or emergency situations, including resident falls.

**Residential Care Homes.** *No provisions identified.*

## Admission and Retention Policy

**Assisted living centers** may not admit or retain individuals whose need for care or services exceeds what the facility can provide; who require physical or chemical restraints as determined by a physician; who pose a threat to self or others; or if the facility is unable to meet their needs for privacy and dignity.

If a resident develops a disability or a condition consistent with the facility's discharge criteria, the resident's physician, facility staff, and the resident or his/her representative must determine through consensus any reasonable and necessary accommodations and additional services required to permit the resident to remain in the facility. All accommodations or additional services must be described in a written plan that is reviewed at least quarterly by a licensed health care professional. If the parties fail to reach a consensus on a plan of accommodation, the facility may terminate residency.

**Residential care homes** may not admit or retain individuals who need services provided in a licensed nursing facility or who are not ambulatory and essentially capable of managing their own affairs. A home may not involuntarily transfer or discharge a resident except for medical reasons or for the resident's or other residents' safety.

## Services

**Assisted living centers** provide assistance with personal care; nursing supervision; intermittent or unscheduled nursing care; medication administration; assistance with cognitive orientation and care or services for persons with Alzheimer's disease and other dementias; assistance with transfer or ambulation; social activities, and housekeeping and laundry.

**Residential care homes** provide assistance with personal care; housekeeping; and storage, distribution, and assistance with medications. Facilities may also provide supportive assistance to residents receiving habilitation or rehabilitation services.

### Service Planning

Assisted living centers must have a health professional trained in the state's assessment process assess each applicant using a Department-required form. The assessment is used to determine the appropriateness of the individual's placement in the facility and to prepare a care plan in consultation with the individual.

**Residential Care Homes.** *No provisions identified.*

### Third-Party Providers

**Assisted living centers** and/or residents may contract with licensed home health agencies as defined in the facility's description of services. Residents may receive home health care, hospice care, and intermittent, periodic, or recurrent nursing care. Facilities must monitor and ensure the delivery of third-party services.

The resident or resident's representative may privately contract with or arrange for private nursing services under the orders and supervision of the resident's physician. All nursing services must be in accordance with the written orders of the resident's physician.

**Residential Care Homes.** *No provisions identified.*

## Medication Provisions

**Assisted living centers** must provide medication administration, which may only be administered on a physician's order. The employee responsible for administering

medications prepares the dose, observes the swallowing of oral medications, and records the medication. Unlicensed personnel administering medications must complete a training program approved by the relevant state entity. Medications must be reviewed monthly by a registered nurse (RN) or pharmacist, and quarterly by a pharmacist.

The provisions include very detailed provisions regarding the administration of bulk medications, including staff who may dispense from bulk medication containers (e.g., licensed nurse, physician, pharmacist, certified medication aide, or medication aide technician); storage (e.g., maximum container size); and permitted types of bulk medications (e.g., oral analgesics, antacids, and laxatives).

**Residential care homes** may administer medications and assist with self-administration of medications. Self-administration of all medications--prescription and over-the-counter--is permitted only after the resident has been monitored and documentation shows the resident capable of self-administration of medications. Only persons who have completed an approved course in medication administration may administer or monitor medications. Monitoring includes observation of the resident taking the proper medication, in the proper dosage, at the correct time; documenting medication taken; and storing the medication in a safe manner. The RCH staff must conduct at least a monthly documented review of a resident's self-administration program.

## Food Service and Dietary Provisions

**Assisted living centers** provide three daily meals and must use a licensed dietician or qualified nutritionist to develop the center's diet plan and address the needs of residents who require special diets. Staff who prepare food must complete a food service training program offered or approved by the Department.

**Residential care homes** must provide three nutritionally adequate meals per day. Homes with residents requiring special diets prescribed by a physician must contract with a consulting licensed/registered dietician, who must approve all special diet menus.

## Staffing Requirements

### **Assisted Living Center**

**Type of Staff.** An *administrator* is required who is responsible for facility operations. *Nursing staff* must be employed or arranged for to supervise skilled interventions and other nursing services. Facilities must have a *dietary consultant*, *pharmacy consultant*, and *nurse consultant* if there are no nurses on staff. *Direct care staff* provide assistance with personal care and other resident services.

**Staff Ratios.** *No minimum ratios.* Staff must be available based on residents' needs. A minimum of two staff members must be on-duty and awake on all shifts if a facility has a unit or program designed to prevent or limit resident access to areas outside the designated unit or program, one of whom must be on-duty at all times in the restricted egress unit.

### **Residential Care Home**

**Type of Staff.** All homes must have an *administrator* who is responsible for daily operations and a signed, written agreement with a *registered nurse* consultant. Staff must be hired to provide personal care services to residents. All employees must be certified in first-aid and cardiopulmonary resuscitation (CPR).

**Staff Ratios.** RCHs must employ sufficient personnel appropriately qualified and trained to provide the essential services of the home. Homes must have a minimum of 0.75 of an hour of personnel per day per resident based on the average daily census. There must be at least one person in charge of the home and its operation on duty in the home whenever residents are present.

## **Training Requirements**

**Assisted Living Centers.** Administrators must complete 16 hours of continuing education per year. All direct care staff must be trained in first-aid and CPR. Staff working in a specialized unit must be trained to meet residents' needs.

**Residential Care Homes.** New employee orientation must cover the following topics: policies and procedures on abuse and neglect; confidentiality; residents' rights; handling emergencies; and job descriptions. All direct care staff must begin 8 hours of in-service training within 90 days of employment and completed within 12 months of employment. Eight hours of in-service training is required annually thereafter.

Staff responsible for administering or monitoring medications must receive 8 hours of training annually in patient reporting and observation; record-keeping; and such other training that is relevant to the residential care program. Administrators must complete 16 hours of continuing education, not including first-aid and CPR training, per year.

## **Provisions for Apartments and Private Units**

**Assisted Living Centers.** Apartment-style private units are not required. No more than two residents may share a bedroom. No more than four residents may share bathing and toilet facilities.

**Residential Care Homes.** Apartment-style private units are not required. There is no specified limit to the number of residents who may share a bedroom. Toilet facilities

must be provided for every six residents and a tub/shower for every ten residents. Male and female residents may not be housed in the same or adjoining rooms that lack a full floor-to-ceiling partition and lockable door (exceptions for immediate family).

Medicaid requires apartment-style units for waiver program participants, which may be shared by residents' choice.

## Provisions for Serving Persons with Dementia

*No provisions identified apart from those stated in assisted living center staffing and training.*

## Background Checks

*Both types of facilities* must follow the Long-Term Care National Background Check program rules to determine applicants' employment eligibility, including a search of criminal history records and the Oklahoma Department of Human Services Registry for each potential employee who is not a licensed health professional and who will provide, for compensation or as a volunteer, on a full-time or part-time basis, health-related services or assistance to a resident.

## Inspection and Monitoring

***Assisted Living Centers.*** The Department inspects each facility annually.

***Residential Care Homes.*** Before issuing a license, the Department must inspect the home and inform the applicant of any condition that requires correction prior to issuance of a license. Inspections are conducted every 15 months.

## Public Financing

Three Medicaid 1915(c) waiver programs pay for services in assisted living and residential care facilities: (1) the Advantage Program for adults age 65 and older, and age 21-64 with physical disabilities; (2) the Sooner Services Program for persons age 65 and older; and (3) the My Life My Choice Program for adults age 19-64 with physical disabilities. The latter two programs are specifically for Medicaid clients who have transitioned to the community from nursing facilities under the Living Choice/Money Follows the Person demonstration program.

## **Room and Board Policy**

In 2014, room and board charges for Medicaid waiver program participants were limited to 90 percent of the federal Supplemental Security Income (SSI) payment with 10 percent retained as a personal needs allowance.

The state does not provide an SSI payment to residents of assisted living centers and RCHs. Family supplementation is allowed.

## **Location of Licensing, Certification, or Other Requirements**

*Oklahoma Administrative Code*, Title 310, Chapter 663: Continuum of Care and Assisted Living. [July 1, 2008]

<http://www.ok.gov/health2/documents/LTC%20Continuum%20of%20Care%20&%20AL%20Rules.pdf>

*Oklahoma Statutes*, Title 63, Continuum of Care and Assisted Living Act. [November 1, 2013]

<http://www.ok.gov/health2/documents/HRDS%20663%20CC-AL%20Act%201113.pdf>

*Oklahoma Administrative Code*, Title 310, Chapter 680: Residential Care Homes. [July 25, 2010]

<http://www.ok.gov/health2/documents/HRDS-Chapt680%20ResCare.pdf>

*Oklahoma Administrative Code*, Title 317, Chapter 35-17-2: Level of care medical eligibility determination. [June 25, 2012]

<http://www.okdhs.org/library/policy/oac317/035/17/0002000.htm>

Oklahoma State Department of Health website: Long-Term Care National Background Check Program, with links to provider resources. [May 8, 2014]

[http://www.ok.gov/health/Protective\\_Health/Health\\_Resources\\_Development\\_Service/Oklahoma\\_Long\\_Term\\_Care\\_National\\_Background\\_Check\\_Program/](http://www.ok.gov/health/Protective_Health/Health_Resources_Development_Service/Oklahoma_Long_Term_Care_National_Background_Check_Program/)

## **Information Sources**

J. Megan Haddock, Esq.  
Medicaid Services Director  
Department of Human Services Aging Services

## OREGON

### Licensure Terms

Assisted Living Facility, Residential Care Facility, Memory Care Community

### General Approach

The Oregon Department of Human Services, Office of Licensing and Regulatory Oversight, licenses two types of residential care--assisted living facilities (ALFs) and residential care facilities (RCFs). General licensing requirements are the same for both types of facilities. The major distinction between the two settings pertains to the building requirements. ALFs must provide a private apartment, private bath, and kitchenette, whereas RCFs may have shared rooms and shared baths, or private apartments.

Oregon has a separate set of rules, for memory care communities (previously called Alzheimer's care units) that are either licensed as an ALF, a RCF, or a nursing facility. Such communities must meet the licensing requirements for the applicable licensed setting and additional requirements specified in the memory care community rules. Any facility that offers or provides care for residents with dementia in a memory care community must obtain an "endorsement" on its facility license. The rules emphasize person-directed care, resident protection, staff training specific to dementia care, and physical plant and environmental requirements.

*Adult Foster Care (AFC).* The Department of Human Services licenses adult foster homes, which provide care and services to five or fewer adults in a setting that protects and encourages resident dignity, choice, and decision-making while addressing residents' needs in a manner that supports and enables them to maximize their ability to function at the highest possible level of independence. *Regulatory provisions for AFC are not included in this profile but a link to the provisions can found at the end.*

*This profile includes summaries of selected regulatory provisions for ALFs and RCFs. The complete regulations can be viewed online using the links provided at the end.*

### Definitions

**Assisted living facility** means a building, complex, or distinct part thereof, consisting of fully self-contained, individual living units, where six or more seniors and adult individuals with disabilities may reside in home-like surroundings. The facility offers and coordinates a range of supportive services available on a 24-hour basis to

meet residents' health and social needs, including assistance with activities of daily living (ADLs).

**Residential care facility** means a building, complex, or distinct part thereof, consisting of shared or individual living units in a home-like surrounding where six or more seniors and adult individuals with disabilities may reside. The facility offers and coordinates a range of supportive services available on a 24-hour basis to meet residents' health and social needs, including assistance with ADLs.

**Memory care community** means a special care unit in a designated, separate area for individuals with Alzheimer's disease or other dementias that is locked, segregated, or secured to prevent or limit access by a resident outside the designated or separated area.

## Resident Agreements

The residency agreement must include the following:

- Terms of occupancy and discharge policies and procedures, payment provisions, refund and proration conditions, and policy for increases, additions, or changes to the rate structure.
- The method for evaluating a resident's service needs and assessing the costs for the services provided.
- The staffing plan, medication policies, and the facility system for packaging medications.
- A description of the scope of services available, the service planning process, and how health care and ADL services are provided.
- Residents' rights and responsibilities, including the right to choose a pharmacy.

## Disclosure Provisions

A written disclosure statement must be provided to prospective residents. A Uniform Disclosure Statement template, available on the Department website, includes sections on costs, services, and operations.

Memory care communities must have a written policy of pre-admission screening, and admission and discharge procedures, including policies for moves to a different unit within the facility. Prior to admission, the facility must provide the resident or the resident's legal guardian (if any) and/or a member of the resident's family (if appropriate), with a copy of the disclosure statement.

## Admission and Retention Policy

The Department encourages facilities to support residents' choice to remain in the facility while recognizing that some residents may no longer be appropriate for community-based care due to safety or medical limitations. Involuntary discharge is permitted for urgent medical and psychiatric needs or if a facility discovers that a resident was convicted of sex crimes that were not previously disclosed. Other reasons for discharge include the following:

- The resident's needs exceed the level of ADL services the facility provides as specified in the disclosure information.
- The resident engages in behavior or actions that repeatedly and substantially interferes with the rights, health, or safety of residents or others.
- The resident has a medical or nursing condition that is complex, unstable, or unpredictable and exceeds the level of health services the facility provides as specified in the facility's disclosure information.
- The facility is unable to accomplish resident evacuation in accordance with fire and life safety rules.
- The resident engages in illegal drug use or commits a criminal act that causes potential harm to the resident or others.

Only individuals with a diagnosis of dementia who are in need of support for the progressive symptoms of dementia for physical safety or physical or cognitive functioning may reside in a memory care community.

## Services

Facilities provide supervision or assistance to help, develop, increase, maintain, or maximize the resident's level of independent psychosocial and physical functioning.

Minimum required services include laundry; a program of social and recreational activities; assistance with ADLs, including one-person transfers; medication administration; and household services. Facilities must also provide or arrange for social and medical transportation, and ancillary services for related medical care (i.e., physician, pharmacy, therapy, and podiatry appointments).

The facility must provide health services and have systems in place to respond to residents' 24-hour care needs. The systems must include medical emergency response policies and procedures, and access to a licensed nurse who is regularly scheduled for

on-site duties at the facility and who is available for phone consultation. Required nursing services include:

- Assessing resident health and well-being.
- Delegating and teaching staff to perform tasks in accordance with Board of Nursing rules.
- Participating on the service planning team, as needed.
- Providing health care teaching and counseling based on service plans.
- Providing intermittent direct nursing services, as needed.

Memory care communities must deliver services that are required under the facility license in a manner that addresses the needs of persons with cognitive or physical limitations due to dementia. Daily structured and unstructured activities must be provided and can include chore-related tasks; entertainment; and individual, group, sensory stimulation, physical, and outdoor activities.

### ***Service Planning***

A resident evaluation is required before admission and must be updated during the first 30 days of residence and at least quarterly after, or following a change of condition. The evaluation must assess resident routines and preferences, physical health, mental health, cognition, communication and sensory limitations, ADLs, instrumental activities of daily living, pain treatments, skin condition, nutrition habits, treatment types, nursing needs, and risk indicators (e.g., fall history, emergency evacuation ability, complex medication regimen, elopement history, smoking, and alcohol and drug use).

The service planning team includes two or more individuals who assist the resident in determining what services and care are needed, preferred, and may be provided. When applicable, a registered nurse (RN), the resident's family, a state or Area Agency on Aging case manager (if the resident receives publicly funded services), and/or the resident's physician or other health practitioner must be included. The service plan must reflect the resident's needs identified in the evaluation and describe who will provide services, and what, when, how, and how often services will be provided. The resident must actively participate in the development of the service plan to the extent of his/her ability to do so. The service plan is reviewed and updated at least quarterly.

When a resident's actions or choices pose a potential risk to that resident's health or well-being, a managed risk agreement may be developed to identify potential consequences of a resident's actions and possible alternatives. The risk plan must explain the cause of concern, possible negative consequences, possible alternatives, and services provided by the facility to minimize the risk. The resident's preferences take precedence over those of family member(s). A managed risk plan cannot be entered into or continued with on behalf of a resident who is unable to recognize the consequences of his/her behavior or choices. The risk plan is reviewed at least quarterly or when there is a change of condition.

Behavioral symptoms that negatively impact the resident and others in a memory care community must be evaluated, and approaches for addressing them must be included in the service plan.

### ***Third-Party Providers***

If a resident requires nursing services that are not available through hospice, home health, a third-party referral, or the task cannot be delegated to facility staff, the facility must arrange to have such services provided on an intermittent or temporary basis.

## **Medication Provisions**

Facilities may administer medications to residents and must have medication and treatment administration systems in place that are approved by a pharmacist consultant, RN, or physician. The facility administrator is responsible for ensuring adequate professional oversight of the medication and treatment administration system. Direct care staff may administer medications. Appropriate facility staff, in accordance with applicable regulations, must document that they have observed and evaluated the staff person's ability to safely administer medications and treatments unsupervised.

Residents may keep over-the-counter and prescription medications in their unit if they are capable of self-administration. Residents who self-administer prescription medications must have a physician's or other legally recognized practitioner's written order of approval and be evaluated by the facility as well for ability and safety in medication administration. When two residents share a unit, a safety evaluation must be conducted.

The staff person who administers the medication must visually observe the resident take (e.g., ingest, inhale, apply) the medication unless the prescriber's order for that specific medication states otherwise. Psychoactive medications may be used to treat a resident's medical symptoms and/or improve functioning and not for the facility's convenience. Staff who administer psychoactive medications must understand the reasons for use, common side effects, and when to contact a health professional regarding side effects. Medications administered as-needed (PRN) to treat behavior must have a written, resident-specific parameter that defines use.

## **Food Service and Dietary Provisions**

Facilities must provide three meals a day and snacks in accordance with the recommended dietary allowances of the U.S. Department of Agriculture Food Guide Pyramid, appropriate to residents' needs and choices. Modified special diets must be provided and include but are not limited to small frequent meals, no added salt, reduced or no added sugar, and textural modifications.

## Staffing Requirements

**Type of Staff.** Each facility must employ a full-time *administrator* and *caregivers* who provide assistance with ADLs, medication administration, resident-focused activities, supervision, and support. Caregivers who have additional duties, such as housekeeping, laundry, or food service, are called *universal workers*. A *licensed nurse* must be available, either on staff, or as a consultant.

**Staff Ratios.** *No minimum ratios.* The facility must have sufficient qualified awake staff to meet residents' 24-hour scheduled and unscheduled needs. If a facility employs universal workers, staffing must be increased to maintain adequate resident care and services. Direct care staffing must be calculated based on resident acuity, staff training, facility census, and facility structural design (e.g., to meet the fire safety evacuation standards).

The number of licensed nurse hours that are scheduled must be relevant to the census and acuity of the resident population.

## Training Requirements

All staff must receive an orientation on residents' rights and the values of community-based care, abuse and reporting requirements, standard precautions for infection control, and fire safety and emergency procedures. Within the first 30 days of hire, staff must demonstrate knowledge and performance in several areas, including but not limited to the following:

- The role of service plans in providing individualized resident care.
- Providing assistance with ADLs.
- Changes associated with normal aging, and identifying changes in the resident's physical, emotional, and mental functioning.
- Conditions that require assessment, treatment, observation, and reporting.
- Understanding residents' actions and behavior as a form of communication.
- Understanding and providing support for residents with dementia.
- Food safety, serving, and sanitation.

All staff must be trained in the use of the abdominal thrust and first-aid; training in cardiopulmonary resuscitation is recommended.

Administrators must complete 20 hours of approved continuing education and direct caregivers must complete 12 hours of in-service training annually.

## Provisions for Apartments and Private Units

**Assisted Living Facilities.** All resident units are individual apartments with a lockable door, private bathroom, and kitchenette conforming to relevant state and federal building codes as well as the Americans with Disabilities Act and Fair Housing Act. Shared units are allowed by resident choice. Unit bathrooms must have a toilet, sink, and a roll-in, and curbless shower. Each unit must have a kitchen area equipped with a sink, refrigerator, a cooking appliance that can be removed or disconnected, space for food preparation, and storage space. All units must have an escape window that opens directly onto a public street, public alley, yard, or exit court.

**Residential Care Facilities.** Units may be private or shared by no more than two residents. Resident units may be limited to a bedroom only; if so, the door must open to an indoor, temperature controlled common area/corridor. Bathroom facilities may be centrally located off common corridors.

If the unit has a bathroom, it must include a toilet, hand-washing sink, mirror, and towel bar, and must be accessible for persons who use wheelchairs. If cooking facilities are provided, cooking appliances must be readily removable or able to be disconnected.

In facilities that do not provide full bathrooms in each unit, centralized bathing rooms must be provided at a minimum ratio of 1:10 residents. At least one centralized shower/tub must be accessible without requiring substantial lifting by staff.

## Provisions for Serving Persons with Dementia

**Dementia Care Staff.** For memory care communities, staffing rules for the applicable licensed facility--assisted living, residential care, and nursing facilities--apply.

**Dementia Staff Training.** Staff in memory care communities must be specially trained to work with persons who have dementia. Administrators must complete at least 10 hours of their required continuing education on dementia care.

**Dementia Facility Requirements.** A memory care community is a designated separate unit that is locked, segregated, or secured to prevent or limit access by a resident outside the unit. The licensing rules include requirements for lighting, floor and wall finishes, common areas, resident rooms, exit doors, outdoor recreation areas, building codes, and fire safety.

## Background Checks

Facility owners, administrators, and staff must satisfy a criminal records clearance. A fingerprint check may be required for conducting a national background check.

## Inspection and Monitoring

Department staff visit and inspect every facility at least once every 2 years to determine whether they are maintained and operated in accordance with the licensing rules.

## Public Financing

The state's Medicaid Aged and Disabled 1915(c) Waiver program pays for services for eligible residents of ALFs and RCFs (and also adult foster homes).

### ***Room and Board Policy***

In 2015, the room and board cap is \$570 for Medicaid-eligible residents and the personal needs allowance is \$163. The state does not provide an optional state supplement. In 2009, family supplementation was not permitted.<sup>107</sup>

## Location of Licensing, Certification, or Other Requirements

*Oregon Administrative Rules*, Chapter 411, Division 54: Residential Care and Assisted Living Facilities. [November 1, 2007]

[http://www.dhs.state.or.us/policy/spd/rules/411\\_054.pdf](http://www.dhs.state.or.us/policy/spd/rules/411_054.pdf)

Oregon Department of Human Services, Seniors and People with Disabilities: Uniform Disclosure Statement, Assisted Living/Residential Care Community.

<https://apps.state.or.us/Forms/Served/se9098a.pdf>

*Oregon Administrative Rules*, Chapter 411, Division 57: Memory Care Communities. [November 1, 2010]

[http://www.dhs.state.or.us/policy/spd/rules/411\\_057.pdf](http://www.dhs.state.or.us/policy/spd/rules/411_057.pdf)

*Oregon Administrative Rules*, Chapter 411, Division 50: Adult Foster Homes. [September 1, 2013]

[http://www.dhs.state.or.us/policy/spd/rules/411\\_050.pdf](http://www.dhs.state.or.us/policy/spd/rules/411_050.pdf)

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<sup>107</sup> Mollica, R.L. (2009). *State Medicaid Reimbursement Policies and Practices in Assisted Living*, National Center for Assisted Living, American Health Care Association.  
<http://www.ahcanal.org/ncal/resources/Documents/MedicaidAssistedLivingReport.pdf>. Current information about family supplementation policy, was not available online or from other sources.

## Information Sources

Linda Kirschbaum  
Oregon Health Care Association

Ruth Gulyas  
Leading Age Oregon

Cory Oace  
Department of Human Services  
Office of Licensing and Regulatory Oversight

## PENNSYLVANIA

### Licensure Terms

Assisted Living Residence, Personal Care Home

### General Approach

Assisted living residences (ALRs) are licensed by the Department of Aging, Office of Long Term Living, Division of Licensing, and personal care homes are licensed by the Department of Public Welfare, Adult Residential Licensing. The two licensure types differ in concept, the type of units provided, and the level of care provided. Personal care homes may not serve individuals who need a nursing home level of care but ALRs can serve such individuals.

ALRs must support aging in place, are constructed with private living units that include kitchen capacity, and provide a level of care higher than personal care homes. A personal care home and ALR may be co-located within a building under a dual license. This profile includes the regulations for both types, as well as the provisions for special care units (SCUs) for residents with Alzheimer's disease or other dementias for the two types.

*Adult Foster Care.* The state licenses domiciliary care for up to three residents, which provides a supervised living arrangement in a home-like setting to adult clients placed there by Area Agencies on Aging (AAAs). The AAAs screen providers to ensure that both they and their homes pass safety and background checks. The majority of providers serve only one resident. *Regulatory provisions for domiciliary care are not included in this profile but a link to the provisions can found at the end.*

*This profile includes summaries of selected regulatory provisions for ALRs and personal care homes. The complete regulations can be viewed online using the links provided at the end of the profile.*

### Definitions

**Assisted living residences** provide food, shelter, assisted living services, and supplemental health care services to four or more adults who are not relatives of the operator, who require assistance or supervision with activities of daily living (ADLs), instrumental activities of daily living (IADLs), or medication administration.

**Personal care homes** provide food, shelter, and personal assistance or supervision to four or more adults who are not relatives of the operator and who do not require a nursing home level of care. Personal care home residents typically require assistance or supervision with ADLs and/or IADLs.

## Resident Agreements

The **assisted living residence** agreement must provide information about a range of topics, including: a fee schedule; optional services and amenities; assessment and service planning policies; payment and refund policies; arrangements for financial management; the residence's rules; contract terms and policies; a list of assisted living services, supplemental health care services, or both, to be provided based on the resident's support plan; residents' rights; and complaint procedures.

If a resident chooses to opt-out of an assisted living service defined by the licensing rules, the agreement must state that the service is not being provided and that the corresponding charges reflect the reduction in services to be provided.

**Personal care home** agreements must provide information similar to that provided by ALRs.

For both facility types, the admission agreement must include the services provided in a dementia care unit, admission and discharge criteria, change in condition policies, special programming, and costs and fees.

## Disclosure Provisions

**Assisted living residences** must, in addition to the information provided in the resident agreement, provide each potential resident or designated representative with a written disclosure that includes the:

- Services and the core packages that the residence offers and their costs.
- Circumstances under which a potential resident may require the services offered in a different core package.
- Most recent inspection reports and instructions for access to the Department's public website.
- Number of living units in the residence that comply with the public accommodation provisions of the Americans with Disabilities Act.

When a residence holds itself out to the public as providing services or housing for individuals with Alzheimer's disease or dementia, the residence must disclose to individuals and provide materials that include the following:

- The residence's written statement of its philosophy and mission which reflects the needs of individuals with Alzheimer's disease or dementia.
- A description of the residence's physical environment and design features to support the functioning of individuals with Alzheimer's disease or dementia.
- 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.
- A description of the security measures the residence provides.
- A description of the training provided to staff regarding provision of care to individuals with Alzheimer's disease or dementia.
- A description of availability of family support programs and family involvement.
- 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.

**Personal care homes** must, in addition to the information provided in the resident agreement, disclose information about admission and discharge criteria, special programming costs and fees, and a written description of its program that includes the services to be provided and the long-term care needs that can be safely met in the home.

## Admission and Retention Policy

**Assisted living residences** may not admit or retain an individual with any of the following conditions or health care needs unless the residence seeks approval from the licensing agency: 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 that requires isolation of the individual or requires infectious disease precautions, unless the Department directs that isolation be established within the residence; nasogastric tubes; physical restraints; or continuous skilled nursing care 24 hours a day. However, the licensing agency may approve an exception related to any of the conditions or health care needs listed above under specified conditions and procedures.

In facilities licensed as ALRs, a SCU may be the complete residence or a portion of a residence that provides specialized care and services for residents with Alzheimer's disease or other dementias.<sup>108</sup> Admission to a SCU must occur only in consultation with the resident's family or designated representative and documentation must include the resident's diagnosis of Alzheimer's disease or dementia and the need for the resident to be served in a SCU.

**Personal care homes** may not admit or retain residents who meet the state's eligibility criteria for nursing home care.

## Services

**Assisted living residences** provide an "independent core package" for residents who do not require ADL assistance, which includes 24-hour supervision, laundry, social activities, and cognitive supports. The "enhanced core package" includes the services in the independent core package plus assistance with ADLs/IADLs for an undefined period of time, transportation, and assistance with self-administration of medication or medication administration.

Facilities must also provide financial management, monitoring, and emergency response, and must make reasonable accommodations for aging in place that may include the provision of supplemental services provided by the resident's family.

Dementia-specific assisted living services are described as intermittent cuing, redirecting, environmental cues, measures to address wandering, dementia-specific activity programming, and specialized communication techniques.

**Personal care homes** provide many of the same services as ALRs, including medication administration.

**Both facility types** require that the following be offered in dementia care units at least weekly: gross motor activities and exercise; self-care activities, such as personal hygiene; group and individual activities; sensory and memory enhancement activities; and outdoor activities. Resident participation in offered activities must be voluntary.

### Service Planning

Within 60 days prior to admission to an ALR, a medical evaluation, using a Department-required form and conducted by a physician, physician's assistant, or nurse practitioner must be completed. The medical evaluation may be completed within 15 days after admission under specified conditions, such as admission from an acute care hospital or to escape an abusive situation.

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<sup>108</sup> SCUs may also provide intense neurobehavioral rehabilitation for residents with severely disruptive and potentially dangerous behaviors as a result of brain injury. The rules applying to this resident group are not included in this profile but can be viewed online using the links provided at the end of the profile.

The medical evaluation must include information needed to determine if the applicant can be safely served and to inform the development of the service plan, including: (1) health status; (2) medical information pertinent to diagnosis and treatment in case of an emergency; (3) special health or dietary needs; (4) allergies; (5) immunization history; (6) medication regimen, contraindicated medications, medication side effects, and the ability to self-administer medications; (7) the need for body positioning and movement stimulation; (8) mobility assessment; (9) tuberculin skin test results within the past 2 years; and (10) information about day-to-day assisted living service needs.

Within 30 days after admission to an assisted living facility (ALF)--or 15 days with certain exceptions--the administrator, administrator-designee, a registered nurse (RN), or a licensed practical nurse (LPN) under the supervision of RN must complete an initial assessment, using a Department-provided form or an approved facility-developed form. The assessment is used to develop a preliminary support plan, which must be reviewed and approved by an LPN or RN. The following items, at a minimum, must be assessed: ADLs and IADLs; mobility; ability to self-administer medication; medical history and medical conditions that affect the individual's service needs; supplemental health care service needs; dietary needs; the individual's ability to safely operate key-locking devices; and the individual's ability to evacuate from the residence. The final support plan must be signed by the resident or his/her designated representative and implemented within 30 days of admission.

Reassessments must be conducted annually and support plans updated following a significant change in condition or at the Department's request. Medical evaluations may be updated as needed.

**Personal care homes** must complete a pre-admission screening to assess whether the home can meet an applicant's needs. A medical evaluation must be completed 60 days prior to or 30 days after moving into the home. Within 15 days of admission, the facility must conduct an assessment of mobility needs, medication administration needs, cognitive functioning communication abilities, ADLs, IADLs, referral sources, and personal interests and preferences. A support plan must be developed to meet the needs identified in the assessment and be implemented within 30 days after admission. The facility must use Department-specified forms.

**Both Facility Types.** Within 72 hours prior to an individual's admission to a secured dementia care unit, both ALRs and personal care homes must conduct a written cognitive pre-admission screening in collaboration with a physician or a geriatric assessment team. The resident must be assessed annually to determine the need for continuing residency.

### **Third-Party Providers**

**Assisted living residences** must provide or arrange for the provision of supplemental health care services, including hospice services, occupational therapy, skilled nursing services, physical therapy, behavioral health services, home health services, escort service to and from medical appointments if indicated in the resident's support plan or requested by the resident, and specialized cognitive support services.

**Personal care homes** may permit residents to use hospice services and must encourage residents to use services available in the community, as relevant, including mental health services, drug and alcohol counseling, senior centers, home health agencies, or services provide by an AAA.

### **Medication Provisions**

Both facility types must provide assistance, as needed, with resident self-administration of prescribed medications. 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 prescribed times. The facility must provide medication administration services for residents assessed to need them and for residents who choose not to self-administer. Prescription medication that is not self-administered by a resident must be administered by a licensed professional or a staff person who has completed Department-approved medication administration training and has passed the performance-based competency test.

### **Food Service and Dietary Provisions**

Assisted living residents must be permitted to prepare food in their apartment unless stated otherwise in their support plan.

Both facility types must offer three daily meals that meet recommended dietary allowances established by the U.S. Department of Agriculture. Between meal snacks and beverages must be available at all times, unless medically contraindicated. Prescribed dietary needs must be met.

Residents must receive adequate physical assistance with eating or be provided with appropriate adaptive devices, or both, as indicated in their support plan. The facility must have a dietician on staff or under contract to provide for residents' special dietary needs as indicated in their support plan.

## Staffing Requirements

### ***Assisted Living Residence***

**Type of Staff.** *Administrators* are responsible for daily operations and must be able to provide assisted living services and supervise direct care workers. An *administrator-designee* is responsible when the administrator is absent. *Direct care staff* provide personal care assistance. A *registered nurse* must be available in the building or on call at all times.

**Staff Ratios.** *No minimum ratios.* Administrators must be present in the residence an average of 36 hours or more per week. Direct care staff persons on duty must be awake at all times and must provide at least 1 hour per day of assisted living services to each mobile resident and at least 2 hours per day to each resident with mobility needs. At least 75 percent of the assisted living service hours must be available during waking hours.

Staffing must be sufficient to meet residents' needs as specified in their individual support plans. For every 35 residents, at least one staff person trained in first-aid and certified in obstructed airway techniques and cardiopulmonary resuscitation (CPR) must be present in the residence at all times.

### ***Personal Care Homes***

**Type of Staff.** An *administrator* oversees facility operations. At least one direct care staff person must be awake whenever residents are present.

**Staff Ratios.** *No minimum ratios.* The administrator must be present in the home an average of 20 hours or more per week. The direct care staffing requirements are the same as for ALFs except that at least one staff person who is trained in first-aid, and certified in obstructed airway techniques and CPR must be present in the home at all times for every 50 residents.

## Training Requirements

**Assisted Living Residences.** Prior to or during the first work day, direct care and other staff, including ancillary staff, substitute personnel, and volunteers must have an orientation in fire safety and emergency preparedness. These staff and all administrative staff must also receive at least 4 hours of dementia-specific training within 30 days of hire and at least 2 hours annually thereafter.

Within 40 scheduled working hours, direct care staff, ancillary staff, substitute personnel, and volunteers must have an orientation training that includes numerous topics related to their job responsibilities, including residents' rights; mandatory reporting of abuse and neglect; behavior management techniques; person-centered

care; communication, problem solving, and relationship skills; assisting with ADLs/IADLs; care of residents with mental illness, neurological impairments, mental retardation, and other mental disabilities; and nutrition, food handling, and sanitation.

All ALR administrators must successfully complete an orientation program approved and administered by the licensing agency, a 100-hour standardized administrator training course, and a competency-based training test with a passing score. Administrators must have at least 24 hours of annual training relating to their job duties.

Assisted living direct care staff may not provide unsupervised services until they have completed 18 hours of training, including a demonstration of their job duties, followed by supervised practice; and successfully completed and passed the licensing agency-approved direct care training course, which includes a competency test.

Assisted living direct care staff must have 16 hours of annual training on a range of topics related to their job responsibilities, including medication self-administration; care for residents with dementia, cognitive, and neurological impairments; infection control and general principles of cleanliness and hygiene; preventing complications of immobility, such as decubitus ulcers, incontinence, malnutrition, and dehydration; and care for residents with mental illness or intellectual disabilities, or both, if served in the residence.

***Personal Care Homes.*** Administrators must have at least 24 hours of annual training relating to their job duties and direct care staff must have 12 hours of annual training in the same topics required for staff in ALRs.

## Provisions for Apartments and Private Units

***Assisted living residences*** must provide each resident with his or her own living unit, unless two residents voluntarily agree in writing to share one living unit, and such agreement is included in their resident contracts. The maximum number of residents in any living unit is two. Bathrooms in living units must include a toilet, a sink, and a bathtub or shower. Shared units must be larger than single-occupancy units and the bathroom door in a double-occupancy living unit must be lockable by the resident, unless contraindicated by the support plan.

Each living unit must: (1) have storage space, a telephone jack, and individually controlled thermostats for heating and cooling; (2) have a door with a lock, except where a lock would pose a risk or be unsafe; and (3) be equipped with an emergency notification system. The doors, including entrance doors, must be accessible or adaptable for wheelchair use.

The residence must provide space in the unit with electrical outlets suitable for small appliances, such as a microwave oven and small refrigerator, and provide such

equipment at the request of the resident. Residents may choose to provide their own cooking appliances or refrigerator, or both, which must meet the residence's safety standards. An appliance must be designed so it can be disconnected and removed for resident safety or if the resident chooses not to have the appliance within the living unit.

The residence must provide access to a sink for dishes, a stovetop for hot food preparation, and a food preparation area in a common area, which must not include the kitchen used by staff for the preparation of resident or employee meals, or the storage of goods.

For new construction of residences after January 18, 2011, the kitchen capacity in each unit, 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.

**Personal care homes** may have single-occupancy and multiple-occupancy bedrooms with bathrooms shared by up to six users (toilet and sink) and bathtub or shower rooms for up to ten users.

## Provisions for Serving Persons with Dementia

**Dementia Care Staff.** Each resident in a secured dementia care unit is considered to be a resident with mobility needs, therefore direct care staff persons on duty must be awake at all times and must provide at least 2 hours per day of personal care services to each resident.

**Dementia Staff Training.** In addition to the training requirements required in a standard ALR, each direct care staff person working in a SCU must 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, which at a minimum must include the following topics: (1) an overview of Alzheimer's disease and other dementias; (2) managing challenging behaviors; (3) effective communications; (4) assistance with ADLs; and (5) creating a safe environment.

Personal care home direct care staff must have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training required of all personal care home staff.

**Dementia Facility Requirements.** SCUs in both ALRs and personal care homes must provide indoor and outdoor exercise space. No more than two residents may occupy a living unit regardless of its size. Facilities must provide a full description of the measures that will be implemented to enhance environmental awareness, minimize environmental stimulation, and maximize residents' independence in public and private spaces.

Doors equipped with key-locking devices, electronic card-operated systems, or other devices that prevent immediate egress are permitted if the facility receives written approval from the state's Department of Labor and Industry, Department of Health, or appropriate local building authority permitting the use of the specific locking system.

## Background Checks

Both facility types require criminal history and background checks under Pennsylvania adult protective services statutes and regulations.

## Inspection and Monitoring

Both facility types must be inspected at least annually, and more often if violations are found during the annual inspection. The Department may conduct abbreviated visits to facilities that have a history of compliance.

## Public Financing

The state does not cover services in ALRs or personal care homes through either the Medicaid State Plan or a waiver program.

### ***Room and Board Policy***

If an ALR or a personal care home agrees to admit a resident eligible for Supplemental Security Income (SSI) benefits, the residence's charges for rent and other services may not exceed the SSI resident's actual current monthly income reduced by the current personal needs allowance (PNA).<sup>109</sup>

The state adds money to the federal SSI payment. A single payment that includes both the federal SSI payment and the state supplement is issued to residents of domiciliary care homes and personal care homes. In 2015, the maximum state supplement is \$434.30 for domiciliary care residents and \$439.30 for personal care home residents.<sup>110</sup>

Family supplementation for items not included in the room and board rate is permitted if paid directly to the home or residence.

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<sup>109</sup> The amount of the PNA in 2015 was not available online for from other sources.

<sup>110</sup> Social Security Administration. *Supplemental Security Income in Pennsylvania, 2015*. <http://www.socialsecurity.gov/pubs/EN-05-11150.pdf>. ALRs were licensed as a new category of residential care from January 2011. We were unable to confirm, either online or from other sources, that the state supplement is also paid to SSI recipients in ALRs, although it seems reasonable to assume so as the SSI policy described in the licensing regulations is identical for both settings.

## Location of Licensing, Certification, or Other Requirements

*The Pennsylvania Code*, Title 55, Chapter 2800: Assisted Living Residences. [January 18, 2011]

<http://www.pacode.com/secure/data/055/chapter2800/chap2800toc.html>

*The Pennsylvania Code*; Title 55, Chapter 2600: Personal Care Homes. [April 24, 2007]

<http://www.pacode.com/secure/data/055/chapter2600/chap2600toc.html>

*The Pennsylvania Code*, Title 6, Chapter 21: Domiciliary Care Services for Adults. [January 6, 1990]

<http://www.pacode.com/secure/data/006/chapter21/chap21toc.html>

## Information Sources

Brandon Smeltzer  
Pennsylvania Healthcare Association

## RHODE ISLAND

### Licensure Terms

Assisted Living Residence

### General Approach

The Department of Health, Office of Residences Regulation, licenses assisted living residences (ALRs) for individuals who do not require the level of medical or nursing care provided in a health care facility but who require room and board and personal assistance, and may require medication administration.

Residences are licensed based on levels according to fire code and medication classifications and also for dementia care. Fire code Level 1 licensure is for residents who are not capable of self-preservation and Level 2 is for residents who are capable of self-preservation in an emergency.

Medication Level 1 licensure is used when one or more residents require central storage and/or medication administration, and Level 2 is used when residents require only assistance with self-administration of medications.

Dementia care licensure is required when one or more resident's dementia symptoms affects their ability to function based on several specified criteria. Dementia care licensure must be at Level 1 for both fire and medication-related requirements. A residence may have distinct areas with separate licenses.

The state does not have separate licensing requirements for adult foster care. ALR rules<sup>111</sup> apply to all facilities that serve two or more adults.

*This profile includes summaries of selected regulatory provisions for ALRs and additional provisions for Alzheimer's dementia special care units (SCUs) where relevant. The complete regulations are online at the links provided at the end. The state is revising the regulations in 2015.*

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<sup>111</sup> The ALR rules do not include residences licensed by or under the jurisdiction of the Department of Mental Health, Retardation and Hospitals; the Department of Children, Youth and Families; or any other state agency.

## Definitions

**Assisted living residence** means a publicly or privately operated residence that provides lodging, meals, and personal assistance--directly or indirectly through contracts--to two or more adults who are unrelated to the licensee or administrator. Services are provided to meet each resident's changing needs and preferences.

**Alzheimer's dementia special care unit** means a distinct living environment within a residence that has been physically adapted to accommodate the particular needs and behaviors of persons with dementia. The unit provides a higher level of staffing, additional staff training, and therapeutic activities designed for persons with dementia. Residences must be licensed at the highest fire and medication services level ("F1-M1").

## Resident Agreements

The residency agreement must include information about residents' rights; admission and discharge policies and procedures; the unit to be rented; shared space and residences; services to be provided or arranged; financial terms (i.e., basic rates, extra charges at admission or in the future, deposits and advanced fees, and the rate increase policy); special care provisions; resident responsibilities and house rules; initial and ongoing assessment and service plans; and the grievance procedure.

## Disclosure Provisions

ALRs must disclose the following information to each potential resident and interested family member or representative early in the decision-making process and at least prior to the admission decision being made:

- The residence owner and operator.
- Explanation of licensure level.
- Admission and discharge criteria.
- Available services.
- Financial terms to include all fees and deposits and the residence's policy regarding increases in fees and rates.
- Terms of the residency agreement.
- Contact information for the Department of Health, the Medicaid Fraud and Patient Abuse Unit of the Department of the Attorney General, the state ombudsperson, and local police offices.

In addition, an Alzheimer's dementia SCU must include information about the unit's philosophy and mission; occupancy criteria; the assessment and plan of service process, including provisions related to changes in condition; staff training and continuing education requirements; the physical environment and design features

appropriate to support the functioning of cognitively impaired adult residents; the frequency and types of resident activities; the involvement of families and family support programs; and the cost of care and any additional fees.

## **Admission and Retention Policy**

Admission and residency are limited to persons with the physical mobility and decision-making ability to take appropriate action in emergency situations, except in dementia care units. Residences may not admit or retain persons needing medical or skilled nursing care, including daily professional observation and evaluation, and/or persons who are bedbound or in need of the assistance of more than one person for ambulation. However, an established resident may receive daily skilled nursing care or therapy from a licensed health care provider for a condition that results from a temporary illness or injury for up to 21 days, subject to an extension of additional days as approved by the Department, or if the resident is under the care of a licensed hospice agency.

Residents may be discharged only if they:

- Do not meet the residency criteria stated in the residency agreement or the requirements of state or local laws or regulations.
- Are a danger to self or others, and the residence has without success made reasonable accommodations to address resident behavior in ways that would make the termination of the residency agreement or change unnecessary.

The residents of an Alzheimer's dementia SCU must have had a standard medical diagnostic evaluation and have been determined to have a diagnosis of Alzheimer's dementia or another type of dementia.

## **Services**

ALRs provide assistance with activities of daily living, medication management, arrange for support services, and monitor residents' recreational, social, and personal activities.

### ***Service Planning***

Prior to admission, a comprehensive assessment of each applicant's health, physical, social, functional, activity, and cognitive needs and preferences must be conducted and signed by a registered nurse (RN). The assessment determines if the residence can meet the individual's needs and preferences and is the basis for service planning. The Department-approved assessment form, or another approved tool, must be used. The assessment must be updated at least annually and following any

significant change in the resident's condition. In addition, an RN must visit the residence at least once every 30 days to complete the following activities:

- Monitor residents' medication regimens and complete a quarterly evaluation of the residence's unlicensed staff members' administration of medication in accordance with a state-approved protocol.
- Review any new physician orders and evaluate the health status of all residents by identifying symptoms of illness and/or changes in mental/physical health status.
- Evaluate the appropriateness of placement.
- Make any necessary recommendations to the administrator and follow up on any previous recommendations.

Residences that employ one or more RNs may complete this review every 90 days.

### ***Third-Party Providers***

A resident may contract with an outside agency to receive skilled nursing care or therapy from a licensed health care provider or care from a licensed hospice agency. The residence must ensure that third-party services are received.

## **Medication Provisions**

Residences are licensed in part based on the type of medication services permitted. For ALRs licensed at the Level M1, licensed employees (RNs, licensed practical nurses) or unlicensed persons who have completed a state-approved course in drug administration and have demonstrated competency, in accordance with the state-approved protocol in drug administration, may administer oral or topical drugs and monitor health indicators if indirect supervision is provided for unlicensed staff by a nurse or physician. However, Schedule II medications may only be administered by licensed personnel, and injectable medications, including but not limited to insulin, which cannot be self-administered by the resident, must be administered by a licensed nurse.

In Level M2 residences, unlicensed staff may assist residents with self-administration by reminding them to take medication and observing them. A resident who self-administers may request the residence to provide a 1-week medi-set (pre-poured packaging distribution system). A licensed nurse, pharmacist, or an unlicensed person who has completed a state-approved course in drug administration and who has demonstrated competency, in accordance with the state-approved protocol in drug administration, may organize a medi-set.

## Food Service and Dietary Provisions

Residences must provide three balanced and varied meals each day and provide a diet that is appropriate to the resident's medical regimen.

## Staffing Requirements

**Type of Staff.** A Department-certified *administrator* must be responsible for the safe and proper operation of the residence at all times by competent and appropriate *employees*, who provide direct care services to residents. At least one employee who has completed the required training and who is trained in cardiopulmonary resuscitation must be designated in charge of the operation of the residence, must be awake and on the premises at all times, and must be capable of communicating with emergency personnel.

**Staff Ratios.** *No minimum ratios.* Staffing levels must be sufficient to provide the necessary care and services to attain or maintain residents' highest practicable physical, mental, and psychosocial well-being.

## Training Requirements

New employees must receive at least 2 hours of orientation and training in specified topics within 10 days of hire and prior to beginning work alone in the ALR, in addition to any job-specific training that may be required. Employees who have regular contact with residents and provide them with personal care must receive at least 10 hours of orientation and training within 30 days of hire in additional topics, to include universal precautions; medical emergency procedures; basic knowledge of aging-related behaviors; personal assistance; assistance with medications; safety; record-keeping; service plans; reporting; and where appropriate, basic knowledge of cultural differences.

Employees must have ongoing in-service training as appropriate for their job classifications. Administrators must complete at least 32 hours of continuing education every 2 years.

## Provisions for Apartments and Private Units

Apartment-style private units are not required. Resident rooms or apartments may be single-occupancy or double-occupancy. Residents must have access to a locked area for keeping personal possessions. Residents have the right to share a room or unit

with a spouse or other consenting resident in accordance with terms of the resident contract.

Residences must have at least one bath for each ten beds and one toilet for each eight beds on each floor where residents' rooms are located and when bathing facilities within the resident's room are not provided.

## Provisions for Serving Persons with Dementia

A license for an Alzheimer's dementia SCU is required when the residence has one or more residents whose dementia symptoms affect their ability to function as demonstrated by any of the following: safety concerns due to elopement risk or other behaviors; inappropriate social behaviors that adversely impact the rights of others; inability to self-preserve; a physician's recommendation that the resident needs dementia support; or if the residence advertises or represents dementia services or segregates residents with dementia. Each ALR licensed for providing dementia care must specifically design recreational and social activities in order to engage each resident at his/her individual level of functioning.

***Dementia Care Staff.*** An RN with approved training in dementia-related health and behavioral issues must be on staff and available for consultation at all times.

***Dementia Staff Training.*** In addition to the training required of assisted living staff, new employees must receive 12 hours of training about the various types of dementia; communicating effectively with individuals who have dementia; and managing behaviors.

***Dementia Facility Requirements.*** Residences must provide a secure environment appropriate for the resident population that may include, but not be limited to, a locked unit, secured perimeter, or other mechanisms to ensure resident safety and quality of life.

## Background Checks

Within 1 week of employment, all employees are subject to a statewide criminal records check through the state or local police departments. Fingerprinting is not required. If disqualifying information is found, the administrator makes a judgment regarding the employee's continued employment.

## Inspection and Monitoring

The licensing agency determines the frequency of inspections based on a consideration of the residence's past compliance with regulations, complaint investigations, any quality of care issues, and license type.

## Public Financing

The Department of Human Services administers a Medicaid 1115 demonstration waiver program called the Rhode Island Comprehensive Demonstration that covers assisted living services. This program consolidated all prior 1915(c) waiver programs.

### ***Room and Board Policy***

The state provides an optional state supplement (OSS) to Supplemental Security Income recipients who reside in ALRs. In 2015, the maximum amount of the OSS is \$332. The personal needs allowance is \$100. Family supplementation is not allowed.

## Location of Licensing, Certification, or Other Requirements

*Rules and Regulations for Licensing Assisted Living Residences.* State of Rhode Island and Providence Plantations, Department of Health. [September 2012]  
<http://sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/6999.pdf>

*Rules and Regulations for the Certification of Administrators of Assisted Living Residences.* State of Rhode Island and Providence Plantations, Department of Health. [September 2012]  
<http://sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/7048.pdf>

## Information Sources

Virginia Burke  
Rhode Island Health Care Association

## SOUTH CAROLINA

### Licensure Terms

Community Residential Care Facilities

### General Approach

Community residential care facilities (CRCFs), also called assisted living facilities, are licensed by the state Board of Health and Environmental Control, Division of Health Licensing to provide room, board, and a degree of personal care to two or more adults unrelated to the owner. They are designed to accommodate residents' changing needs and preferences, maximize residents' dignity, autonomy, privacy, independence, and safety, and encourage family and community involvement. Personal care services are covered under the Medicaid State Plan.

Facilities owned by the same entity but which are not located on the same adjoining or contiguous property must be separately licensed. There is no category of licensure for adult foster care. Providers that care for two or more persons are licensed as CRCFs.

*This profile includes summaries of selected regulatory provisions for CRCFs. The complete regulations are online at the links provided at the end.*

### Definitions

**Community Residential Care Facility.** A CRCF offers room and board and a degree of personal assistance for a period of time in excess of 24 consecutive hours for two or more adults. Any facility that offers a beneficial or protected environment specifically for individuals who have mental illness or disabilities are included in this definition, as well as facilities that are referred to as *assisted living*, provided they meet the definition of CRCF.

**Alzheimer's special care unit (SCU) or program** means a facility, or area within a facility, providing a secure, segregated special program or unit for residents with a diagnosis of probable Alzheimer's disease or other dementia to prevent or limit access by a resident outside the designated or separated areas; and that advertises, markets, or otherwise promotes the facility as providing specialized care and services for persons with Alzheimer's disease or other dementias, or both.

## **Resident Agreements**

The written agreement between the resident (or his/her responsible party) and the facility must include at least the following: (1) an explanation of the specific care, services, and equipment provided by the facility, such as administration of medications, special diets, and assistance with activities of daily living (ADLs), including their costs; (2) advance notice requirements to change fee amounts; (3) discharge/transfer provisions and refund policies; (4) the date a resident is to receive his/her personal needs allowance (PNA); (5) transportation policies; and (6) an explanation of the resident's bill of rights and the grievance procedure.

## **Disclosure Provisions**

Facilities advertised as offering SCUs or programs for residents with Alzheimer's disease are required to disclose the form of care and treatment provided that distinguishes it as being suitable for people with Alzheimer's disease. Disclosure must include the admission/transfer and discharge criteria, care planning process, staffing and training, physical environment, activities, the role of family members, and the cost of care.

## **Admission and Retention Policy**

A facility must not admit or retain any person whose needs it cannot meet; who displays serious aggressive, violent, or socially inappropriate behavioral symptoms; who is dangerous to themselves or others; who is in need of daily attention of a licensed nurse; or who requires hospital or nursing care, including the following:

- Daily skilled monitoring/observation due to an unstable/complex medical condition.
- Medications that require frequent dosage adjustment, or regular intramuscular and subcutaneous injections.
- Intravenous medications or fluids.
- Care of urinary catheter that cannot be cared for by the resident.
- Treatment of Stage II, III, or IV decubitus, or multiple pressure sores.
- Nasogastric tube feeding.
- Suctioning.
- Tracheostomy or sterile care that cannot be managed by the resident.
- Receiving oxygen for the first time, which requires adjustment and evaluation of oxygen concentration.
- Dependency in all ADLs for more than 14 days.
- Sterile dressing changes.

Short-term (no more than 14 consecutive days), intermittent nursing needs may be furnished by a licensed nurse facility staff member or a home health agency nurse.

## **Services**

Facilities must provide appropriate assistance with ADLs, medication assistance, at least one structured recreation activity each day, and transportation.

### ***Service Planning***

A facility direct care staff member must assess residents' needs no later than 72 hours after admission. The assessment must include a procedure for determining the nature and extent of residents' problems and needs to ascertain if the facility can adequately address those problems, meet those needs, and to secure information for use in the development of the individualized care plan (ICP).

Within 7 days of a resident's admission, the facility must develop an ICP with participation by the resident, facility administrator, and the resident's responsible party when appropriate. The plan must be reviewed and/or revised as changes in a resident's needs occur, but not less than semi-annually. The ICP describes the resident's needs, including the ADLs for which the resident requires assistance; requirements and arrangements for visits by or to physicians or other authorized health providers; advanced care directives/health care power-of-attorney, as applicable; recreational and social activities that are suitable, desirable, and important to the resident's well-being; and dietary needs.

### ***Third-Party Providers***

Individuals requiring short-term, intermittent nursing care while convalescing from illness or injury may utilize the services of home health agency nurses.

The resident or the resident's responsible party may contract with a private provider not associated with or employed by the facility to provide sitter or companion services.

## **Medication Provisions**

Medications that residents are taking at admission may be administered to residents provided the medication is in the original labeled container and the order is subsequently obtained as a part of the admission physical examination.

Facility staff members may administer routine medications, acting in a "surrogate family role," provided these staff members have been trained to perform these tasks in the proper manner by individuals licensed to administer medications. Facility staff

members may administer injections of medications only in instances where medications are required for diabetes and conditions associated with anaphylactic reactions under established medical protocols. A staff licensed nurse may administer influenza and vitamin B-12 injections and perform tuberculin skin tests. Although facility staff members may monitor blood sugar levels, if they meet specified requirements, the provision of sliding scale insulin injections by facility staff members is prohibited.

Self-administering of medications by a resident is permitted only upon the specific written orders of the physician or other authorized health care provider, obtained on a semi-annual basis; or the facility must ascertain by resident demonstration to the staff, at least quarterly, that she or he remains capable of self-administering medications. Facilities may elect not to permit self-administration.

## Food Service and Dietary Provisions

Three meals and snacks that meet dietary needs must be provided daily. Not more than 14 hours may elapse between the serving of the evening meal and breakfast the following day. Tray service is not permitted unless the resident is medically unable to go to the dining room or occasionally, if the resident prefers. If special diets are provided, the menus must be prepared by a professionally qualified dietician or reviewed by a physician or other qualified medical provider.

## Staffing Requirements

**Type of Staff.** The licensee must designate an *administrator*, appropriately licensed as a CRCF administrator by the state Board of Long Term Health Care Administrators, to be in charge of all the facility's functions and activities. A staff member must be designated in writing to act in the absence of the administrator.

The facility must designate a *recreational program staff member* responsible for the development of the program and for obtaining and maintaining recreational supplies. At least one staff person must be responsible for providing/coordinating recreational activities for the residents.

Facilities that serve Medicaid-eligible residents must contract with a *licensed nurse* at least 1 day a week who is responsible for providing personal care training to staff, and developing and monitoring care plans of individuals served by the Medicaid State Plan.

Each facility must have a responsible staff member actively on duty and accessible at all times that residents are present to ensure that appropriate action is taken promptly in the event of injuries, symptoms of illness, or emergencies. This responsible staff member must be an adult, who through training or work experience, is capable of

recognizing and reporting significant changes in each resident's physical and mental condition.

Unless the written agreement between a resident and the facility prohibits the use of private sitters, the facility must establish a formalized private sitter program directed by a facility staff member, so that residents or their responsible party may contract for sitter services if they want to.

**Staff Ratios.** The number and qualifications of staff members/volunteers is determined by the number and condition of the residents. In each building, there must be at least one staff member/volunteer on duty for each eight residents or fraction thereof during all periods of peak hours (i.e., during the day), and at least one staff member/volunteer on duty for each 30 residents or fraction thereof during nighttime (non-peak) hours. Facilities with more than eight residents must have one staff member awake and dressed at night. Awake staff are required in facilities with fewer than eight beds if there are residents with dementia. In multi-floor facilities that are licensed for more than ten beds, staff must be available on each floor at all times that residents are present. Privately hired sitters may not be included in the minimum staffing requirements.

## Training Requirements

All new staff members/volunteers must be oriented to acquaint them with the facility's organization and environment, specific duties and responsibilities of staff members and volunteers, and residents' needs. In addition, they must receive emergency procedures, disaster preparedness, and fire response training within 24 hours of their first day on-the-job in the facility.

Training in the following topics must be provided to all staff members/direct care volunteers and private sitters in the context of their job duties and responsibilities:

- Basic first-aid to include emergency procedures, as well as procedures to manage/care for minor accidents or injuries.
- Procedures for checking and recording vital signs (for designated staff members only).
- Management/care of persons with contagious and/or communicable disease (e.g., hepatitis, tuberculosis, HIV infection).
- Medication management including storage, administration, receiving orders, securing medications, interactions, and adverse reactions.
- Care of persons specific to the physical/mental condition being cared for in the facility (e.g., Alzheimer's disease and other dementias, cognitive disability) to

include communication techniques (cueing and mirroring), understanding and coping with behaviors, safety, and activities.

- Use of restraints (for designated staff members only).
- Occupational Safety and Health Administration standards regarding blood-borne pathogens.
- Cardiopulmonary resuscitation (CPR) for designated staff members/volunteers to ensure that there is a certified staff member/volunteer present whenever residents are in the facility.
- Confidentiality of resident information and records and review of the Bill of Rights for Long-Term Care Facilities.

This training must be provided prior to resident contact and at a frequency determined by the facility, but at least annually unless otherwise specified by certification requirements, such as for CPR.

The staff member responsible for recreational programming must receive appropriate training prior to contact with residents and at least annually thereafter.

## Provisions for Apartments and Private Units

Apartment-style units are not required. No more than three residents may share a room. One toilet is required for every six residents and one tub/shower for every eight residents.

## Provisions for Serving Persons with Dementia

***Dementia Care Staff.*** Facilities must have sufficient staff members/volunteers to provide supervision, direct care, and basic services for residents with Alzheimer's disease and/or other dementias.

***Dementia Staff Training.*** Training must be provided to all staff members/direct care volunteers prior to resident contact and as often as the facility determines is necessary, but at least annually. Training should be specific to the needs of residents in the facility, including communication techniques, understanding and coping with behaviors, resident safety, and appropriate activities.

***Dementia Facility Requirements.*** No provisions identified.

## Background Checks

Staff members, direct care volunteers, and private sitters of the facility must have a criminal record check and not have a prior conviction or have pled no contest to abuse, neglect, or exploitation of a child or a vulnerable adult as defined in South Carolina code.

## Inspection and Monitoring

The Department conducts inspections prior to initial licensing of a facility and subsequently as it deems appropriate. All facilities are subject to inspection/investigation at any time by individuals authorized by state law and without prior notice.

## Public Financing

The state covers personal care in residential settings under the Medicaid State Plan. To be eligible for coverage, individuals must meet all Medicaid program criteria and be receiving the optional state supplement (OSS) to the federal Supplemental Security Income (SSI) program, which is available to persons residing in CRCFs. Facilities participating in the Medicaid program must be able to provide medical monitoring, medication administration, personal care, and must be Americans with Disabilities Act compliant.<sup>112</sup>

### ***Room and Board Policy***

The state pays an OSS to SSI recipients and other eligible residents, and limits room and board charges for Medicaid-eligible residents in CRCFs to the combined SSI and OSS payments minus a PNA retained by the resident. In 2014, the federal SSI payment was \$721, the average OSS payment was \$682, and the PNA was \$65, providing an average room and board payment of \$1,338 per month. Family supplementation was not allowed.

## Location of Licensing, Certification, or Other Requirements

*State Register*, Regulation Number 61-84: Standards for Licensing Community Residential Care Facilities. Promulgated by the Board of Health and Environmental Control, administered by the Division of Health Licensing. [June 25, 2010]

<https://www.scdhec.gov/Agency/docs/health-regs/61-84.pdf>

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<sup>112</sup> Mollica, R.L. (2009). *State Medicaid Reimbursement Policies and Practices in Assisted Living*, National Center for Assisted Living, American Health Care Association.

<http://www.ahcancal.org/ncal/resources/Documents/MedicaidAssistedLivingReport.pdf>.

*Assisted Living and Community Residential Care Facilities, A Practical Guide for Consumers.*  
Developed by the South Carolina Community Residential Care Facilities Committee. [January 4,  
2013]  
[http://www.state.sc.us/dmh/crcf/crcf\\_guide.pdf](http://www.state.sc.us/dmh/crcf/crcf_guide.pdf)

## **Information Sources**

Alexis Martin  
Program Manager I  
South Carolina Medicaid  
Department of Health and Human Services

## SOUTH DAKOTA

### Licensure Terms

Assisted Living Centers

### General Approach

The South Dakota Department of Health, Office of Health Care Facilities Licensure and Certification, licenses assisted living centers. Facilities must receive additional certification to provide specified services and/or to admit residents with specified conditions or needs.

*Adult foster care (AFC)* is licensed by the Department of Health as a family-style residence that provides household service, health services, and supervision of personal care for one to four adults. *Regulatory provisions for AFC are not included in this profile but a link to the provisions can be found at the end.*

*This profile includes summaries of selected regulatory provisions for assisted living centers. The complete regulations are online at the links provided at the end.*

### Definitions

**Assisted living center** means any premise, institution, rest home, boarding home, or agency that is maintained and operated to provide personal care and services to adults. Facility licensure may include special approvals to provide medication administration, care of the cognitively impaired, care of the physically impaired, oxygen administration, therapeutic diets, hospice care, dining assistance, and/or two-person assistance for activities of daily living (ADLs).

### Resident Agreements

Resident agreements must provide information about: (1) the services available and the charges; (2) how to file a complaint concerning abuse, neglect, and misappropriation of funds; (3) contact information for the resident's physician; (4) how to apply for Medicaid and Medicare; (5) the facility's bed hold policy; and (6) the responsibilities of residents and their families with regard to self-administration of medications.

## Disclosure Provisions

*No provisions identified.*

## Admission and Retention Policy

Assisted living centers may not admit or retain residents who require more than intermittent nursing care or rehabilitation services. They may admit or retain individuals who are incapable of self-preservation only if the building meets specified life safety standards.

A resident may not be discharged unless the resident's needs and welfare cannot be met by the facility; the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; or the resident endangers the safety or health of other individuals in the facility.

Facilities with a secured unit must have a physician's order for confinement of each resident, including medical symptoms that warrant seclusion; and make certain that confinement is a necessity based on a comprehensive assessment of a resident's physical, cognitive, and psychosocial needs. The risks and benefits of confinement must be communicated to the resident's family.

## Services

Facilities must provide supportive services for activities and spiritual needs individualized to each resident and must coordinate resident access to a physician, physician assistant, or nurse practitioner at least annually. If skilled care is provided, it must be delivered by facility staff or a Medicare-certified home health agency for a limited time with a planned end date. A call system is required for facilities serving people who cannot walk independently. Facilities with a secured unit must provide therapeutic programming.

### ***Service Planning***

Prior to admission, applicants must make available the results of a physical examination conducted by a physician certifying that the applicant is in reasonable good health and free from communicable disease, chronic illness, or a disability that requires services beyond supervision, cueing, or limited hands-on physical assistance to carry out ADLs and instrumental activities of daily living (IADLs).

Each resident must be evaluated at move-in, 30 days after admission, and annually thereafter to determine if the resident's needs can be met. The evaluation must assess at least the following domains: nursing care needs; medication administration needs; cognitive status; IADLs; mental health status; physical abilities, including ADLs,

ambulation, and the need for assistive devices; and dietary needs. All facilities must use a validated screening tool to assess each resident's cognitive status upon admission, yearly, and after a significant change in condition.

### ***Third-Party Providers***

Third-party service agencies contracted by residents must comply with and complement facility care policies. An unlicensed employee of a licensed facility may not accept any delegated skilled tasks from individuals who are not facility employees or who have not contracted directly with the facility. The rules provide a very detailed description of how hospice services are to be provided, including required Department notifications, staffing, medication administration services, and building requirements that address the life safety of individuals incapable of self-preservation.

## **Medication Provisions**

Facilities serving people who require medication administration must employ or contract with a licensed nurse who reviews resident care and conditions at least weekly, and with a registered nurse (RN) or pharmacist who provides medication administration training. Aides who have passed required training may administer medications.

Facilities that provide medication administration must have a pharmacist review the drug regimen at least monthly, which includes the resident's diagnosis and any pertinent laboratory findings and dietary considerations. The pharmacist must report potential drug therapy irregularities and make recommendations for improving the drug therapy of a resident to the resident's prescriber and the administrator.

Residents may self-administer drugs following evaluation by an interdisciplinary team. A resident with the requisite cognitive ability may self-administer medications or instruct another responsible person to administer the medications. At least every 3 months, an RN or physician must evaluate the medication record and the continued ability of the resident to self-administer medications.

Facilities must have a written policy that addresses the responsibilities of the resident and any family members related to self-administration of medications.

## **Food Service and Dietary Provisions**

At least three meals must be served daily at regular times. The facility must have an organized dietetic service to ensure that meals and snacks are nutritionally adequate in accordance with the Recommended Dietary Allowances. If residents require special diets, a dietician must be employed or consulted to approve special diet needs and written menus, plan individual diets, and provide guidance to dietary staff.

## Staffing Requirements

**Type of Staff.** Facilities must have an *administrator* who is responsible for daily overall management, *unlicensed assistive personnel* to provide personal care assistance, and a *licensed nurse* (employed or contracted) to review and document resident care and conditions. If medication administration is provided, a licensed nurse must act as the supervising nurse who trains and oversees unlicensed staff who administer medications.

**Staff Ratios.** *No minimum ratios.* The minimum staff contact time is at least 0.8 hours per resident per day. At least two staff persons must be on-duty at all times (or at least one per floor in multi-story buildings). There must be a sufficient number of qualified, awake personnel available to provide effective resident care. Facilities may apply for exceptions to these requirements based on the number of residents and the building configuration. For example, facilities with fewer than ten residents may have one person on duty and the overnight staff person may sleep if specified criteria are met.

## Training Requirements

The facility must have a formal orientation program and an ongoing education program for all personnel. Education topics include: fire prevention; emergency procedures; infection control and prevention; accident prevention and safety procedures; proper use restraints; resident rights; resident confidentiality; mandatory reporting policies; care of persons with unique needs; and nutritional risks and hydration needs of older persons.

For facilities that provide care to persons with cognitive impairment, residents who use supplemental oxygen, or hospice clients, training on these topics is required.

## Provisions for Apartments and Private Units

Apartment-style private units are not required. In facilities constructed or renovated after January 9, 2012, no higher than double-occupancy rooms are allowed. Each resident room must have a toilet room with a sink.

## Provisions for Serving Persons with Dementia

**Dementia Care Staff.** At least one caregiver must be awake and on-duty at all times.

***Dementia Staff Training.*** Staff in secured units must have annual in-service training regarding the needs of residents in the unit.

***Dementia Facility Requirements.*** Facilities must comply with the Life Safety Code regarding locked doors and must be located at ground level and have direct access to an outside area that is enclosed by a fence.

## **Background Checks**

A facility may not knowingly employ any person with a conviction for abusing another person.

## **Inspection and Monitoring**

The Department conducts a pre-license inspection and annually thereafter.

## **Public Financing**

The state's Medicaid 1915(c) waiver program covers services in assisted living centers.

### ***Room and Board Policy***

Room and board charges are capped for Medicaid waiver clients at \$693 per month. Family supplementation is not allowed.

The state provides an optional state supplement (OSS) to all Supplemental Security Income (SSI) recipients--or those whose net income is below the state's supplementation standard--and who live in assisted living facilities or in adult foster care homes. In 2015, the state's supplementation standard is \$1,524 per month (federal SSI payment of \$733 plus maximum OSS of \$791). The personal needs allowance is \$60 per month.

## **Location of Licensing, Certification, or Other Requirements**

South Dakota Department of Social Services website: Assisted Living with information and links to licensing regulations.

<http://dss.sd.gov/asa/services/assistedliving/>

South Dakota Department of Social Services website: Adult Foster Care with information and links to licensing regulations.

<http://dss.sd.gov/asa/services/fostercare.aspx>

*South Dakota Administrative Rules*, Article 44:70: Assisted Living Centers.  
<http://legis.sd.gov/ruleS/DisplayRule.aspx?Rule=44:70>

*South Dakota Administrative Rules*, Article 44:04:19 Adult Foster Care.  
<http://legis.sd.gov/rules/DisplayRule.aspx?Rule=44:04:19>

South Dakota Department of Health website: Healthcare Providers, Staffing Exception Forms for Assisted Living Centers. [2012]  
<https://doh.sd.gov/providers/licensure/Staffing-Exceptions.aspx>

## **Information Sources**

Lori Tracy  
South Dakota Health Care Association

Deb Wegleitner, RN, BSN, NHA  
Public Health Advisor for Assisted Living Communities  
South Dakota Department of Health

## TENNESSEE

### Licensure Terms

Assisted Care Living Facilities and Residential Homes for the Aged

### General Approach

The Tennessee Department of Health, Board for Licensing Health Care Facilities, licenses assisted care living facilities and residential homes for the aged to provide services to older persons who need assistance with personal care. Assisted care living facilities may provide a higher level of care than residential homes for the aged, including the provision of medical services. Licensing rules specify requirements for dementia care in both settings.

*Adult Foster Care.* The state licenses and administers a family home for adults program for up to five adults who are frail, disabled, or victims of abuse, through the Department of Health Adult Protective Services Program. In addition, the Department of Health licenses adult care homes (ACHs)-Level 2 for five or fewer adults. *Regulatory provisions for family homes for adults and ACHs are not included in this profile but a link to the provisions can found at the end.*

*This profile includes summaries of selected regulatory provisions for assisted care living facilities and residential homes for the aged. The complete regulations are online at the links provided at the end.*

### Definitions

**Assisted care living facilities** provide room and board and services, including medical services, to enable residents to age in place. *No provisions regarding the minimum number of residents required for licensure were identified.*

**Residential homes for the aged** provide room and board, and personal care services to four or more non-related persons.

### Resident Agreements

**Both facility types** must provide at admission a written agreement that includes a procedure for handling resident transfers or discharges, which does not violate the residents' rights under the law or licensing rules.

## Disclosure Provisions

**Assisted care living facilities** must, prior to the admission or execution of a contract for resident care, disclose in writing to the resident or the resident's legal representative, whether the facility has liability insurance and, if so, the insurance carrier's name. Facilities with secured units must report to the Department the following information during each annual survey: resident assessments by multidisciplinary teams and reviews; number of deaths, hospitalizations, and incidents; staffing patterns and ratios; staff training; and daily group activities.

**Residential Homes for the Aged.** *No provisions identified.*

## Admission and Retention Policy

**Assisted care living facilities** may not admit or retain individuals whose needs the facility cannot safely and effectively meet, including residents who require treatment of Stage III or IV decubitus ulcers; continuous nursing care; or physical or chemical restraints (this does not include psychotropic medications prescribed for a manageable mental disorder). Facilities may also not admit or retain individuals with active, infectious, and reportable diseases that require contact isolation; or verbal or physical aggressive behavior which poses an imminent physical threat to self or others.

A facility must not admit, but may retain residents who require nasopharyngeal or tracheotomy suctioning; nasogastric feedings; gastrostomy feedings; or intravenous (IV) therapy or IV feedings. However, residents cannot require these treatments on more than an intermittent basis (up to three 21-day periods per year), and the resident's physician must certify that the facility can safely and effectively provide the treatment.

The Board for Licensing Health Care Facilities may permit the treatments listed in the paragraph above to be provided on an ongoing basis to residents who receive hospice services. Residents who require any of the above treatments and who are able to independently manage them may be admitted and retained.

If the resident or legal representative, treating physician, or the facility administrator determine that the facility cannot meet the resident's needs, including the need for medical services, the resident must be transferred to an appropriate setting.

Facilities may admit residents in all but the later stages of Alzheimer's disease only after an interdisciplinary team assesses that care can be safely and appropriately provided. This assessment must be reviewed quarterly.

**Residential homes for the aged** may not admit or retain individuals who cannot self-administer medications; who require professional medical or nursing observation

and/or care on a continual or daily basis; who pose a clearly documented danger to themselves or other residents; who cannot safely evacuate the facility in 13 minutes; or who require chemical or physical restraints.

Homes may admit residents who are in the early stages of Alzheimer's disease or other dementias if an interdisciplinary team determines that care can appropriately and safely be provided in the facility. Residents must be assessed quarterly to ensure that the facility can continue to meet their needs.

## Services

**Assisted care living facilities** must provide personal services such as protective care; responsibility for the safety of the resident when in the facility; the ability and readiness to intervene if crises arise; assistance with activities of daily living (ADLs); laundry services; and dietary services. Facilities may provide and oversee medical services, such as medication administration; part-time intermittent nursing care; various therapies; podiatry; medical social services; and hospice services.

**Residential homes for the aged** must provide the same personal services listed above.

### Service Planning

**Assisted care living facilities** must assess residents within 72 hours of admission. The written assessment may be conducted by a direct care staff member. A plan of care must be written within 5 days of admission and must be reviewed at least semi-annually or when residents' needs change. The plan of care describes:

- The need for personal care assistance and medical services for which the resident requires assistance; how much assistance; who provides the assistance; how often, and when.
- Requirements and arrangements for visits by or to health care providers.
- Provisions of an advance care directive and the name of any individual named as a health care power-of-attorney.
- Recreational and social activities.
- Dietary needs.

**Residential Homes for the Aged.** *No provisions identified.*

### **Third-Party Providers**

**Assisted care living facility** residents must be able to receive hospice services in the facility as long as the resident's treating physician certifies that hospice care can be appropriately provided in the facility. In addition to appropriately licensed and qualified facility staff, medical services may be provided by licensed or qualified contractors, a licensed home care organization, licensed staff of a nursing home, or another appropriately licensed entity.

**Residential Homes for the Aged.** *No provisions identified.*

### **Medication Provisions**

**Both facility types** allow staff to assist residents with self-administration, including assistance in reading labels, opening dosage packaging, reminding residents to take their medications, and observing the resident while taking medication. Licensed health care professionals operating within their scope of practice, such as nurses, may administer medications.

### **Food Service and Dietary Provisions**

**Both facility types** must provide three meals a day that meet acceptable and/or prescribed diet standards. No more than 14 hours must elapse between the evening and morning meals. The food must be adapted to residents' habits, preferences, and physical abilities.

**Assisted care living facilities** are required to provide additional nourishment and/or snacks to residents with special dietary needs or upon request.

### **Staffing Requirements**

#### **Assisted Care Living Facilities**

**Type of Staff.** Facilities must have a *certified administrator* or a *licensed nursing home administrator*; a designated *attendant* who is awake and responsible for providing personal services to residents; and a *licensed nurse* available as needed. A qualified *dietician* must be hired on staff or as a consultant.

**Staff Ratios.** *No minimum ratios.* Facilities must have a sufficient number of staff to meet residents' needs, including the need for medical services.

## **Residential Homes for the Aged**

**Type of Staff.** Facilities must have a *certified administrator* or a *licensed nursing home administrator*; a designated *attendant* who is awake and responsible for providing personal services to residents; and additional staff as needed.

**Staff Ratios.** *No minimum ratios.* Facilities must have a sufficient number of staff to meet residents' needs.

## **Training Requirements**

**Both facility types** require administrators to be certified and recertified every 2 years. Administrator certification requires 24 classroom hours of Board-approved continuing education courses during the 2 years that includes instruction in the following topics: applicable state rules and regulations; health care management; nutrition and food service; financial management; and healthy lifestyles. All employees must be trained annually in fire safety, disaster preparedness, and other emergency procedures.

## **Provisions for Apartments and Private Units**

**Both Facility Types.** Apartment-style private units are not required. No more than two residents may share a bedroom and privacy screens or curtains must be provided and used when requested by the residents. Residents' rooms must always be capable of being unlocked by the resident. Bathrooms must serve no more than six residents.

## **Provisions for Serving Persons with Dementia**

**Dementia Care Staff.** Both facility types require a minimum of one attendant, awake, on-duty, and physically located on the unit at all times.

**Dementia Staff Training.** Both facility types require any staff working in a secured unit to have annual in-service training covering as a minimum the following topics:

- Basic facts about the causes, progression, and management of Alzheimer's disease and other dementias.
- Dealing with residents' dysfunctional behavior and catastrophic reactions.
- Identifying and alleviating safety risks.
- Providing ADL assistance.
- Communicating with families.

**Dementia Facility Requirements.** *No provisions identified for either facility type.*

## Background Checks

**Both facility types** require that administrators must not have been convicted of a criminal offense involving the abuse or intentional neglect of an elderly or vulnerable individual. Facilities may not employ any person listed on the Department's abuse registry.

## Inspection and Monitoring

**Assisted Care Living Facility.** A pre-licensure inspection is required and the Department makes an unannounced inspection of every facility within 15 months following the date of its last inspection and as needed.

**Residential homes for the aged** are inspected pre-licensure and periodically as a condition of re-licensing.

## Public Financing

The state covers services in assisted care living facilities through its Medicaid 1115 managed care Long-Term Services and Supports CHOICES program (CHOICES).

### **Room and Board Policy**

Medicaid policy limits the amount that assisted care living facilities can charge for room and board to 80 percent of the maximum personal needs allowance (PNA). The CHOICES program sets the PNA at 300 percent of the federal Supplemental Security Income (SSI) rate, which is \$2,199 per month in 2015. Thus, the maximum monthly room and board charges in an assisted living care facility for CHOICES members cannot exceed the lesser of \$1,759.20 per month or any lesser amount that would be charged to a resident not enrolled in the CHOICES program. This limitation applies only to CHOICES members, and not to other assisted living care facility residents.

The state does not provide an SSI payment. Family supplementation is permitted up to the maximum allowable charges for room and board.

## Location of Licensing, Certification, or Other Requirements

*Rules of the Tennessee Department of Health, Board for Licensing Healthcare Facilities, Chapter 1200-08-25: Standards for Assisted Living Care Facility Regulations. [December 23, 2009]*

<http://www.state.tn.us/sos/rules/1200/1200-08/1200-08-25.20091223.pdf>

*Rules of the Tennessee Department of Health, Board for Licensing Healthcare Facilities, Chapter 1200-08-11: Homes for the Aged. [May 2010]*  
<http://www.tennessee.gov/sos/rules/1200/1200-08/1200-08-11.20100523.pdf>

*Rules of the Tennessee Department of Health, Board for Licensing Healthcare Facilities, Chapter 1200-08-36: Standards for Adult Care Homes-Level 2. [November 2010]*  
[http://www.tn.gov/sos/rules\\_all/2010/1200-08-36.20101102.pdf](http://www.tn.gov/sos/rules_all/2010/1200-08-36.20101102.pdf)

Department of Human Services website: Adult Protective Services, Family Homes for Adults.  
[http://tennessee.gov/humanserv/adfam/aps\\_fh.html](http://tennessee.gov/humanserv/adfam/aps_fh.html)

TennCare website: Long Term Services and Supports CHOICES Program, with information and links to participant eligibility, service descriptions, and provider resources. [*TennCare is the name of the state's Medicaid program.*]  
[http://www.tn.gov/tenncare/long\\_choices.shtml](http://www.tn.gov/tenncare/long_choices.shtml)

## Information Sources

Brett McReynolds  
Tennessee Health Care Association

Ann Rutherford Reed, RN, BSN, MB  
Director of Licensure  
Division of Health Licensure and Regulation  
Office of Health Care Facilities

Will Hines  
Policy Specialist  
Quality and Administration  
Long-Term Services and Supports  
Bureau of TennCare

## TEXAS

### Licensure Terms

Assisted Living Facilities

### General Approach

The Texas Department of Aging and Disability Services (DADS) licenses several types of assisted living facilities (ALFs): assisted living apartments (single-occupancy), residential care apartments (double-occupancy), and residential care non-apartments. A person establishing or operating a facility that is not required to be licensed may not use the term "assisted living" in referring to the facility or the services provided. The ALF statute requires careful monitoring to detect and report unlicensed facilities.

A facility's licensure type--A or B--is based on residents' capability to evacuate the facility. Any facility that advertises, markets, or otherwise promotes itself as providing specialized care for persons with Alzheimer's disease or other disorders must be certified as such and have a Type B license.

*Adult foster care (AFC) provides a 24-hour living arrangement with supervision in an adult foster home for people who are unable to live independently in their own homes because of physical, mental, or emotional limitations. Providers and residents must live in the same household and share a common living area. With the exception of family members, no more than three adults may live in the foster home unless it is licensed as a Type C ALF, which is a four-bed facility that must have an active contract with the Department to provide AFC services before it can be licensed. A provider wishing to serve more than four individuals must obtain a DADS Type A ALF license. Separate rules apply to adult foster homes and Type C facilities, which are not included in this profile, but a link to the provisions can found at the end.*

*This profile includes summaries of selected regulatory provisions for Type A and Type B ALFs. The complete regulations are online at the links provided at the end.*

### Definitions

**Assisted living facility** means an establishment that furnishes, in one or more facilities, food and shelter to four or more persons who are unrelated to the proprietor and provides personal care services, supervision or direct administration of medications, and other permitted services.

## Resident Agreements

Facilities must have a written admission agreement with each resident that includes information about the services to be provided and their cost.

## Disclosure Provisions

The facility must have written policies regarding aging in place, admission criteria, services provided, charges, refunds, the normal 24-hour staffing pattern, residents' responsibilities and privileges, and other rules and regulations. Before admitting a resident, facility staff must explain and provide a copy of the disclosure statement to the resident, family, or responsible party and must also provide a copy of the Resident Bill of Rights.

An ALF that provides brain injury rehabilitation services must attach to its disclosure statement a specific statement that licensure as an ALF does not indicate state review, approval, or endorsement of the facility's rehabilitative services. The facility must document receipt of the disclosure statement.

If the facility provides services and supplies that could be covered Medicare benefits, the facility must disclose this information to the resident.

Facilities that provide care to residents with Alzheimer's disease or other dementias are required to disclose the services they provide using a DADS disclosure form, which includes the pre-admission and admission processes, discharge and transfer, planning and implementation of care, change in condition issues, staffing and staff training in dementia care, and the physical environment. The facility must give the required DADS disclosure statement to any individual seeking information about the facility's care or treatment of residents with Alzheimer's disease or other dementias. The disclosure statement must be updated and submitted to the Department as needed to reflect changes in special services for residents. Prior to admitting a resident to the facility, staff must discuss and explain the information in the disclosure statement with the family or responsible party.

## Admission and Retention Policy

In a *Type A* ALF, a resident must be mentally and physically capable of evacuating the facility unassisted in the event of an emergency and capable of following directions, and must not require routine attendance during sleeping hours.

In a *Type B* ALF, a resident may require staff assistance to evacuate the facility, be incapable of following directions under emergency conditions, require attendance

during sleeping hours, and may not be permanently bedfast but may require assistance in transferring to and from bed.

All residents must be appropriate for the facility licensure type when admitted. After admission, if the resident's condition changes, the resident may no longer be appropriate for the facility's license, and if so, the facility is not required to retain them.

The regulations list some general characteristics of residents in an ALF, including residents who: (1) exhibit symptoms of mental or emotional disturbance, but are not considered at risk of imminent harm to self or others; (2) need assistance with mobility, bathing, dressing, and grooming; (3) need reminders to encourage toilet routine and prevent incontinence; (4) need assistance with medication, supervision of self-medication, or administration of medication; or (5) are incontinent without pressure sores.

A facility must not admit or retain a resident whose needs cannot be met by the facility or who cannot secure the necessary services from an outside resource. As part of the facility's general supervision and oversight of the physical and mental well-being of its residents, the facility remains responsible for all care provided in the facility. If the individual is appropriate for placement in a facility, then the decision that additional services are necessary and can be secured is the responsibility of facility management with written concurrence of the resident, resident's attending physician, or legal representative.

If the Department or an ALF determines that a resident is inappropriately placed in the facility, or if a resident experiences a change of condition, but continues to meet the facility evacuation criteria, as long as the facility is willing the resident may be retained if certain conditions are met, including: (1) a physician describes the resident's medical conditions and related nursing needs, ambulatory and transfer abilities, and mental status, and states that the resident is appropriately placed; and (2) the resident or a legal representative desires retention in the facility.

If the DADS surveyor or an ALF determines that a resident is inappropriately placed because the resident no longer meets the evacuation criteria, a facility may request that the resident remain at the facility by obtaining an evacuation waiver and providing a detailed emergency plan that explains how the facility will meet the evacuation needs of the resident, which includes provisions for a sufficient number of trained staff on all shifts to move all residents to a place of safety. The facility must meet the previously listed conditions and submit additional information.

## Services

ALFs provide personal care, including assistance with activities of daily living (ADLs); general supervision or oversight of the physical and mental well-being of a person who needs assistance to maintain a private and independent residence in the

facility or who needs assistance to manage his or her personal life; and supervision or direct administration of medications. The facility must also provide an activity and/or social program for residents at least weekly.

An ALF may provide skilled nursing services for limited purposes: (1) coordinating resident care with an outside home and community support services agency or health care professional; (2) providing or delegating personal care services and medication administration; (3) assessing residents to determine required services; and (4) delivering, for a period not to exceed 30 days, temporary skilled nursing services for a minor illness, injury or emergency.

Facilities that provide care to residents with Alzheimer's disease or other dementias must encourage socialization, cognitive awareness, self-expression, and physical activity in a planned and structured activities program. Activities must be individualized, based upon the resident assessment, and appropriate for each resident's abilities. Residents must be encouraged, but never forced, to participate in activities. Residents who choose not to participate in a large group activity must be offered at least one small group or one-on-one activity per day. A health care professional may coordinate the provision of services to a resident within the professional's scope of practice authorized by the Texas Health and Safety Code, however, a facility must not provide ongoing services to a resident that are comparable to the services available in a licensed nursing facility.

### ***Service Planning***

Within 14 days of admission, the facility must conduct a comprehensive assessment and complete an individualized service plan (ISP). The comprehensive assessment must be completed by the appropriate staff and documented on a form developed by the facility.

Facilities that provide care to residents with Alzheimer's disease or other dementias must establish procedures, such as an application process, interviews, and home visits, to ensure that prospective residents are appropriate and their needs can be met. Within 14 days of admission, the facility must comprehensively assess the resident and develop an ISP. The service plan must address the residents' individual needs, preferences, and strengths and be designed to help the resident maintain the highest possible level of physical, cognitive, and social functioning. The service plan must be updated annually and upon a significant change in condition.

### ***Third-Party Providers***

A resident may contract with a licensed home and community support services agency or with an independent health professional to have health care services delivered at the facility.

## Medication Provisions

Residents who self-administer their own medications and keep them locked in their room must be counseled at least once a month by facility staff to ascertain if they continue to be capable of self-administering their medications/treatments and if security of medications can continue to be maintained.

Supervision of a resident's medication regimen by facility staff may be provided to residents who are incapable of self-administering without assistance. Supervision includes and is limited to: reminders to take medications at the prescribed time, opening containers or packages and replacing lids, pouring prescribed dosage according to the resident's medication profile record, returning medications to the proper locked areas, obtaining medications from a pharmacy, and listing the medication taken on a resident's medication profile record.

Residents who choose not to or cannot self-administer medication must have medication administered by a person who: (1) holds a current license to administer medication; (2) holds a current medication aide permit (this person must function under the direct supervision of a licensed nurse on duty or on call); or (3) is an employee of the facility to whom the administration of medication has been delegated by a registered nurse who has trained them to administer medications or verified their training, according to rules in the state's Nursing Practice Act.

## Food Service and Dietary Provisions

Facilities must provide at least three balanced and nutritious meals or the equivalent per day. The meals must be served daily, at regular times, with no more than a 16-hour span between a substantial evening meal and breakfast the following morning. All exceptions must be specifically approved by the Department. Menus must be prepared to provide a balanced and nutritious diet, such as that recommended by the National Food and Nutrition Board.

Therapeutic diets as ordered by the resident's physician must be provided according to the service plan. Therapeutic diets that cannot customarily be prepared by a layperson must be calculated by a qualified dietician. Therapeutic diets that can customarily be prepared by a person in a family setting may be served by the ALF.

## Staffing Requirements

**Type of Staff.** Each facility must have a *manager* who is on duty 40 hours per week and may manage only one facility, except for managers of small Type A facilities, who may have responsibility for no more than 16 residents in no more than four facilities. The managers of small Type A facilities must be available by telephone or pager when conducting facility business off-site. An employee competent and

authorized to act in the absence of the manager must be designated in writing. An *attendant* (direct care staff person) must be in the facility at all times when residents are present. Attendants are not precluded from performing other functions as required by the ALF.

**Staff Ratios.** *No minimum ratios.* A facility must develop and implement staffing policies that require staffing ratios based upon residents' needs as identified in their ISPs. A facility must have sufficient staff to: (1) maintain order, safety, and cleanliness; (2) assist with medication regimens; (3) prepare and serve meals that meet requirements; (4) assist with laundry; (5) ensure that each resident receives the kind and amount of supervision and care required to meet his/her basic needs; and (6) ensure safe evacuation of the facility in the event of an emergency.

In Type A facilities night shift staff in a small facility must be immediately available and in a large facility, they must be immediately available and awake. In Type B facilities, night shift staff must be immediately available and awake, regardless of the number of licensed beds.

## Training Requirements

All managers must complete a 24-hour course which must include information on the assisted living standards; resident characteristics (including dementia); resident assessment; skills for working with residents; basic principles of management; food and nutrition services; federal laws, such as the Americans With Disabilities Act (ADA), Civil Rights Act of 1991, the Rehabilitation Act of 1993, Family and Medical Leave Act of 1993, and the Fair Housing Act, with an emphasis on the ADA's accessibility requirements; community resources; ethics; and financial management.

All managers must have 12 hours of annual continuing education in at least two of the following areas: resident and provider rights and responsibilities, abuse/neglect, and confidentiality; principles of management; skills for working with residents, families, and other professional providers; resident characteristics and needs; community resources; accounting and budgeting; basic emergency first-aid; and federal laws as listed above.

All staff must receive 4 hours of orientation before assuming any job responsibilities, covering topics at a minimum: reporting abuse and neglect, confidentiality of resident information, universal precautions, conditions that require notification to the manager, resident rights, and emergency and evacuation procedures.

Attendants (direct care staff) must also complete 16 hours of on-the-job training and supervision on a range of topics, including: (1) providing assistance with ADLs; (2) resident health conditions and how they affect the provision of tasks; (3) safety measures to prevent injury and accidents; (4) emergency first-aid procedures and actions to take when a resident falls, suffers a laceration, or experiences a sudden change in physical and/or mental status; (5) behavior management, for example,

prevention of aggressive behavior and de-escalation techniques, practices to decrease the frequency of the use of restraint, and alternatives to restraints; and (6) fall prevention.

Attendants must complete 6 hours of education annually, including 1 hour on fall prevention and 1 hour on behavior management, as described above, and a range of other topics suggested by the regulations, including: (1) promoting resident dignity, independence, individuality, privacy, and choice; (2) resident rights and principles of self-determination; (3) communication techniques for working with residents with hearing, visual, or cognitive impairment; (4) communicating with families and other persons interested in the resident; (5) common physical, psychological, social, and emotional conditions and how these conditions affect residents' care; (6) essential facts about common physical and mental disorders, for example, arthritis, cancer, dementia, depression, heart and lung diseases, sensory problems, or stroke; (7) cardiopulmonary resuscitation; (8) common medications and side effects, including psychotropic medications, when appropriate; (9) understanding mental illness; (10) conflict resolution and de-escalation techniques; and (11) information regarding community resources. Subject matter must address the unique needs of the facility.

Facilities that employ licensed nurses, certified nurse aides, or certified medication aides must provide annual in-service training, appropriate to their job responsibilities, on one or more of several suggested topics, including: (1) communication techniques and skills useful when providing geriatric care (e.g., skills for communicating with the hearing impaired, visually impaired and cognitively impaired; therapeutic touch; recognizing communication that indicates psychological abuse); (2) assessment and interventions related to the common physical and psychological changes of aging for each body system; (3) geriatric pharmacology, including treatment for pain management, food and drug interactions, and sleep disorders; (4) common emergencies of geriatric residents and how to prevent them (e.g., falls, choking on food or medicines, injuries from restraint use); (5) how to recognize sudden changes in physical condition, such as stroke or heart attack, and obtain emergency treatment; (6) common mental disorders with related nursing implications; and (7) ethical and legal issues regarding advance directives, abuse and neglect, guardianship, and confidentiality.

## **Provisions for Apartments and Private Units**

The licensing rules do not require private units but some types of facilities provide them. In facilities that do not provide private units, a maximum of four people may share a room, and not more than 50 percent of the beds in a facility may be in rooms with more than two residents. One toilet and one sink are required for every six residents and one tub or shower for every ten residents. A minimum of one toilet, sink, and bathing unit must be provided on each sleeping floor accessible to residents of that floor.

The Medicaid STAR+PLUS home and community-based services (HCBS) waiver program pays for services in three types of settings: single-occupancy assisted living apartments, residential care apartments, and residential care non-apartment settings.

An *assisted living apartment* setting is an apartment for single-occupancy that is a private space with individual living and sleeping areas, a kitchen, a bathroom, and adequate storage space. Double-occupancy units may be provided if requested.

*Residential care apartments* are units with two bedrooms, each with a single occupant, with a shared kitchen and bathroom. Kitchens must be equipped with a sink, refrigerator, cooking appliance (stove, microwave, built-in surface unit) that can be removed or disconnected, and space for food preparation.

A *residential care non-apartment setting* is defined as a licensed ALF with 16 or fewer beds, with living units that do not meet the definition of either an assisted living apartment or a residential care apartment. Most have dual-occupancy rooms but some have rooms with up to four residents.

## Provisions for Serving Persons with Dementia

***Dementia Care Staff.*** Facilities must have a *manager* or *supervisor*. Facilities with 17 or more residents must have an *activity director* 20 hours a week. Smaller facilities may designate a person to plan and implement activities.

A facility must employ sufficient staff to provide services for and meet the needs of its residents with dementia. In large facilities or units with 17 or more residents, two staff members must be immediately available whenever residents are present.

***Dementia Staff Training.*** All staff in Alzheimer's facilities must receive 4 hours of dementia-specific orientation prior to assuming job responsibilities, providing basic information about the causes, progression, and management of dementia.

Direct care staff must receive 16 hours of on-the-job supervision and training within the first 16 hours of employment following orientation. Training must cover providing assistance with ADLs; emergency and evacuation procedures specific to the dementia population; behavior management, including prevention of aggressive behavior and de-escalation techniques; and fall prevention.

Direct care staff must complete 12 hours annually of in-service, competency-based training regarding Alzheimer's disease, 1 hour of which must address behavior management, as described above. Additional suggested topics include: (1) assessing resident capabilities and developing and implementing service plans; (2) promoting resident dignity, independence, individuality, privacy and choice; (3) planning and facilitating activities appropriate for the dementia resident; (4) communicating with families and other persons interested in the resident; (5) resident rights and principles of

self-determination; (6) care of elderly persons with physical, cognitive, behavioral and social disabilities; (7) medical and social needs of the residents; (8) common psychotropic medications and side effects; and (9) local community resources.

Managers or supervisors and activity directors or their designees must annually complete 6 hours of continuing education regarding dementia care.

***Dementia Facility Requirements.*** A monitoring station must be provided within the dementia care unit as well as access to at least two approved exits remote from each other. The outdoor area of at least 800 square feet must be provided in at least one contiguous space. This area must be connected to, be a part of, be controlled by, and be directly accessible from the facility. Locking devices may be used on control doors provided criteria specifically stated in the rules are met for their use.

## **Background Checks**

An ALF must keep current and complete personnel records on facility employees for review by DADS staff, including documentation that the facility performed a criminal history check (offenses which preclude employment are listed in statute), an annual employee misconduct registry check, and an annual nurse aide registry check.

## **Inspection and Monitoring**

To be licensed, a facility must pass an on-site life safety code inspection and a separate on-site health inspection. Licenses are renewed every 2 years, for which an on-site inspection is required, which must include observation of the care of a resident.

The Department developed a training program to provide specialized training to DADS employees who inspect ALFs. The training emphasizes the distinction between an ALF and a nursing facility.

## **Public Financing**

A Medicaid 1115 demonstration managed care waiver program--called STAR+PLUS--which includes the STAR+PLUS HCBS waiver program, covers services in licensed ALFs (and AFC homes) that contract with the resident's managed care organization to provide the HCBS waiver services. Under the waiver program, facilities may contract to provide services in two distinct types of living arrangements: assisted living apartments and assisted living non-apartment settings. In addition, the Medicaid Community-Based Alternatives 1915(c) Waiver program pays for assisted living and AFC services, although not all ALFs offer waiver services.

## **Room and Board Policy**

Providers may not charge Medicaid waiver program participants more for room and board than the federal Supplemental Security Income (SSI) benefit of \$733 (in 2015) minus a personal needs allowance of \$85. The state does not provide a supplement for SSI recipients in ALFs.

Family supplementation is allowed for amenities not included in the room and board rate.

## **Location of Licensing, Certification, or Other Requirements**

*Texas Statutes, Health and Safety Code, Title 4, Subtitle B, Chapter 247: Assisted Living Facilities. The chapter is cited as the Assisted Living Facility Licensing Act.*

<http://www.statutes.legis.state.tx.us/SOTWDocs/HS/html/HS.247.htm>

*Texas Administrative Code, Title 40, Part 1, Chapter 92: Licensing Standards for Assisted Living Facilities.*

[http://texreg.sos.state.tx.us/public/readtac\\$ext.ViewTAC?tac\\_view=4&ti=40&pt=1&ch=92](http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=4&ti=40&pt=1&ch=92)

*Texas Administrative Code, Title 40, Part 1, Chapter 48, Subchapter K: Minimum Standards for Adult Foster Care.*

[http://texreg.sos.state.tx.us/public/readtac\\$ext.ViewTAC?tac\\_view=5&ti=40&pt=1&ch=48&sch=K&rl=Y](http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=40&pt=1&ch=48&sch=K&rl=Y)

Texas Department of Aging and Disability Services Website: Adult Foster Care.

<http://www.dads.state.tx.us/services/faqs-fact/afc.html>

Texas Department of Aging and Disability Services Website: How to Become an Adult Foster Care Provider with links to regulations.

<http://www.dads.state.tx.us/providers/afc/howto.html>

Texas Health and Human Services Commission, STAR+PLUS Handbook Revision: 14-3. [September 2, 2014]

<http://www.dads.state.tx.us/handbooks/sph/1000/1000.htm#sec1143.2>

## **Information Sources**

Dotty Acosta

Assisted Living Facility and Adult Day Care Program Specialist

Regulatory Services

Department of Aging and Disability Services

Becky Hubik  
Long-Term Services and Supports Policy  
Center for Policy and Innovation  
Department of Aging and Disability Services

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Program Management  
Medicaid/CHIP Program Operations  
Texas Health and Human Services Commission

## UTAH

### Licensure Terms

Assisted Living Facility

### General Approach

The Department of Health, Facility Licensing and Certification, licenses two types of assisted living facilities (ALFs) according to the level of care required by residents. The regulations establish assisted living as a place of residence where elderly and disabled persons can receive 24-hour individualized personal and health-related services to help maintain maximum independence, choice, dignity, privacy, and individuality in a home-like environment. The regulations allow facilities to offer both respite services and adult day care services under the assisted living license without requiring a separate license from the Department of Human Services.

*Adult Foster Care (AFC).* AFC is licensed by the Department of Human Services and is defined as the provision of care to up to three adults in a private home owned by the provider. The services should be conducive to the physical, social, emotional, and mental health of elderly persons and adults with disabilities who are temporarily unable to remain in their own homes due to abuse, neglect, or exploitation. *Regulatory provisions for AFC are not included in this profile but a link to the provisions can found at the end.*

*This profile includes summaries of selected regulatory provisions for ALFs. The complete regulations are online at the links provided at the end.*

### Definitions

**Assisted living facility Type I** is a residential facility that provides assistance with activities of daily living (ADLs) and social care to two or more ambulatory residents who are capable of achieving mobility sufficient to exit the facility without the assistance of another person.

**Assisted living facility Type II** is a residential facility that provides an array of coordinated supportive personal and health care services, available 24 hours a day, to residents who are physically disabled but able to direct their own care or who are cognitively impaired or physically disabled but able to evacuate from the facility or to a zone or area of safety, with the physical assistance of one person.

Type I and Type II facilities may be classified as large (17 or more residents), small (6-16 residents), and limited capacity (2-5 residents). Depending on their classification facilities must comply with different building codes.

## **Resident Agreements**

The signed admission agreement must include room and board charges, and basic and optional services charges; a provision stating that a 30-day notice will be given for changes in base charges; refund policies; admission, retention, transfer, discharge, and eviction policies; conditions for termination of the agreement; the name of a responsible party (if any); and a notice that the state agency has the authority to examine resident records.

Only Type II facilities may operate secure units and admit residents with a diagnosis of Alzheimer's disease or dementia, and only if the resident is able to exit the facility with limited assistance from one person. The admission agreement must document that a Department-approved wandering risk management agreement has been negotiated with the resident or resident's responsible person,<sup>113</sup> and must identify discharge criteria that would initiate a transfer of the resident to a higher level of care than the facility is able to provide.

## **Disclosure Provisions**

*No provisions identified.*

## **Admission and Retention Policy**

Type I facilities may serve residents who are ambulatory or mobile and are capable of taking life-saving action in an emergency without assistance; have stable health; do not require assistance--or require only limited assistance with ADLs; and require and receive regular or intermittent care or treatment in the facility from a licensed health professional employed by the facility or through a contract with a third party. These facilities may serve individuals who do not require significant assistance during the night and do not require significant assistance with more than two ADLs.

Type II facilities are intended for residents who are independent or semi-independent but not dependent.<sup>114</sup> These facilities may serve individuals who require significant assistance in two or more ADLs providing their health and service needs can be met by staffing levels.

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<sup>113</sup> The legal status of a negotiated risk agreement with a person who has dementia and wanders is unclear.

<sup>114</sup> Dependent means the resident is totally dependent in ADLs, requiring the assistance of another person throughout the entire activity.

Neither Type I nor Type II facilities may serve anyone who requires inpatient hospital care or long-term nursing care; anyone who is suicidal, assaultive, or a danger to self or others; or anyone with active tuberculosis or another communicable disease that cannot be adequately treated at the facility, or on an outpatient basis, or that may be transmitted to other residents through the normal course of activities.

Persons receiving hospice care may be admitted and retained in both types of facilities that meet specified conditions regarding physician orders, service planning, staffing, and evacuation plans.

Both types of facilities may discharge, transfer, or evict residents if the facility is no longer able to meet their needs or the resident fails to comply with the facility's policies or rules.

## **Services**

Both facility types must provide personal care, housekeeping, laundry, maintenance, activity programs, medication administration, and assistance with self-administration of medications; and must arrange for necessary medical and dental care. Facilities may provide some nursing services, including assessment, health monitoring, routine nursing tasks, and medication administration.

Type II facilities provide substantial assistance with ADLs, supervision or coordination, nursing services, activities, and medication administration. Residents must have a service plan that includes specified intermittent nursing services, medication administration, and support services that promote residents' independence and self-sufficiency. These facilities must employ or contract with a registered nurse (RN) to provide or supervise nursing assessment, general health monitoring, and to provide and delegate routine nursing tasks.

Facilities do not provide skilled nursing care but must assist the resident in obtaining it. Whether a service is considered skilled is determined by its complexity or specialized nature, which includes tasks that can be safely or effectively performed only by or under the close supervision of licensed health care professionals, and care that is needed to prevent deterioration of a condition or to sustain residents' current capacities.

### ***Service Planning***

An assessment must be conducted before move-in and at least every 6 months thereafter, and must be reviewed and signed by a licensed health care professional. An individualized service plan based on the initial resident assessment must be developed within 7 days of admission. Service plans must meet residents' unique cognitive, medical, physical, and social needs and must describe the services provided, how,

when, how often, and by whom they will be provided. Service plans must be updated as needed.

### ***Third-Party Providers***

Residents have the right to arrange directly with an outside agency for the provision of medical and personal care.

## **Medication Provisions**

Both facility types require that a licensed health care professional assess each resident to determine what type and level of medication administration assistance is needed. The rules specify four types: (1) The resident may self-administer medications; (2) the resident may self-administer medications with staff assistance, including reminders to take medication, help opening containers, and reminders to refill prescription orders; (3) family members may administer medications (described below); and (4) facility-staff may administer medications, including unlicensed staff who have received appropriate delegation from a licensed health care professional. A licensed health care professional or licensed pharmacist must review all resident medications at least every 6 months.

Family members or a designated responsible person may administer medications; they must sign a waiver indicating that they will agree to assume the responsibility of filling prescriptions, administering medications, and documenting the administration.

## **Food Service and Dietary Provisions**

Facilities must be capable of providing three meals a day and snacks. Facilities admitting residents with therapeutic diets must have an approved dietary manual available.

## **Staffing Requirements**

### ***Assisted Living Facility Type I***

***Type of Staff.*** Facilities must have an *administrator* whose duties include responsibility for recruiting, employing, and training the number of licensed and unlicensed staff needed to provide services; *direct care staff* who provide personal care services; and a *licensed nurse* who is either employed or contracted with to provide health monitoring and to provide or delegate nursing tasks to staff. The administrator must be on the premises a sufficient number of hours to manage the facility and must designate, in writing, a competent employee, 21 years of age or older, to act as administrator when the administrator is unavailable for immediate contact.

**Staff Ratios.** *No minimum ratios.* A sufficient number of qualified direct care staff must be in the facility 24 hours a day to provide the level of care residents need. An RN must be available as needed to provide or delegate medication administration for any resident who is unable to self-medicate or to self-direct medication management.

### **Assisted Living Facility Type II**

**Type of Staff.** Facilities must have an *administrator* whose duties are described under ALF Type I above, *certified nursing aides* who provide personal care services, and a *licensed nurse* who is either employed or contracted with to provide health monitoring and to provide or delegate nursing tasks to staff.

**Staff Ratios.** *No minimum ratios.* Direct care worker requirements are the same as for Type I. At least one certified nurse aide must be on-duty 24 hours per day, and an RN must be available as needed.

## **Training Requirements**

Both facility types require that all employees receive an orientation as well as in-service training relevant to their job duties. The orientation must include job descriptions; ethics, confidentiality, and residents' rights; fire and disaster plans; policies and procedures; and reporting responsibility for abuse, neglect, and exploitation.

In-service training must be tailored to include all of the subjects that are relevant to an employee's job, including nutrition and food preparation; housekeeping standards; personal and social care; medication assistance; early signs of illness and when to seek professional help; accident prevention; communication skills that enhance resident dignity; first-aid; residents' rights and reporting requirements; and the needs of residents with Alzheimer's disease or other dementias.

## **Provisions for Apartments and Private Units**

Both facility types must provide each resident with a separate living unit. No more than two residents may share a unit and only when both residents request to do so in writing.

A unit is described as having a living and sleeping space, bathroom, and optional kitchen area. However, the rules also state that in Type I ALFs, at least one toilet and sink must be available on each floor for each six residents not otherwise served by a toilet and sink in the residents' rooms, and at least one bathtub or shower for each ten residents not otherwise served by bathing facilities in residents' rooms. A large Type I ALF must have separate toilet and bathing facilities for live-in family and staff.

In Type II ALFs, if resident living units do not have a private bathroom, the facility must provide a toilet and sink for every four residents and a bathtub or shower for every ten residents; the shower must accommodate residents in wheelchairs and have sufficient space to allow staff to assist a resident in taking a shower. If resident living units have private bathrooms that do not allow staff assistance, then each floor must provide a bathroom equipped with a bathtub or shower, toilet, and sink that opens from a corridor and provides wheelchair clearances and allows for staff assistance in bathing.

Apartment-style units are required for Medicaid waiver program participants, which may be shared by residents' choice.

## Provisions for Serving Persons with Dementia

***Dementia Care Staff.*** Type II ALF staffing requirements must be met and at least one staff with documented training in Alzheimer's disease/dementia care must be present in the secure unit at all time.

***Dementia Staff Training.*** *No additional provisions identified.*

***Dementia Facility Requirements.*** Each secure unit must have an emergency evacuation plan that addresses the ability of the secure unit staff to evacuate the residents in case of emergency.

## Background Checks

All staff must undergo criminal background checks.

## Inspection and Monitoring

Licenses are issued for a 2-year period. Facilities are surveyed "as possible" by the Department, or in response to a formal complaint.<sup>115</sup>

## Public Financing

The state pays for adult residential services in ALFs and other residential settings under the Medicaid New Choices 1915(c) Waiver program. The program serves adults over the age of 21 with disabilities and adults age 65 or older who have been covered by Medicaid in a nursing home for at least 90 days and want to relocate to the community; or who receive services in another waiver program and are at immediate or

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<sup>115</sup> "As possible" is not defined.

near immediate need of admission to a nursing home; or who have been residing in a licensed ALF on an extended stay basis of 180 days or more.

### **Room and Board Policy**

In 2009, the room and board payment amount was negotiated between the facility and each individual, and family supplementation was allowed.<sup>116</sup> The state does not provide an Supplemental Security Income payment to ALF residents.

## **Location of Licensing, Certification, or Other Requirements**

*Utah Administrative Code*, Rule R432-270: Assisted Living Facilities. [February 1, 2015]  
<http://www.rules.utah.gov/publicat/code/r432/r432-270.htm>

*Utah Administrative Code*, Rule R432-6: Assisted Living Facility General Construction. [February 1, 2015]  
<http://www.rules.utah.gov/publicat/code/r432/r432-006.htm>

*Utah Administrative Code*, Rule R501-17: Adult Foster Care. [February 1, 2015]  
<http://www.rules.utah.gov/publicat/code/r501/r501-17.htm>

Assisted Living Type I and Type II Nursing Guidelines. [March 14, 2011]  
<http://health.utah.gov/hflcra/forms/AssistedLivingNursingGuidelines.pdf>

Utah Department of Health website, Utah Home and Community-Based Waiver Programs: New Choices Waiver information and links to provider resources.  
<http://health.utah.gov/ltc/NC/NCHome.htm>

## **Information Sources**

Dirk Anjewierden  
Executive Director  
Utah Health Care Association

Carmen Richins  
Utah Department of Health

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<sup>116</sup> Mollica, R.L. (2009). *State Medicaid Reimbursement Policies and Practices in Assisted Living*, National Center for Assisted Living, American Health Care Association.  
<http://www.ahcancal.org/ncal/resources/Documents/MedicaidAssistedLivingReport.pdf>. Current information about Medicaid room and board policies, the personal needs allowance, and family supplementation policy was not available online or from other sources.

## VERMONT

### Licensure Terms

Assisted Living Residence, Residential Care Home

### General Approach

The state licenses two settings that provide housing, meals, and supportive services to adults who cannot live independently but do not require the type of care provided in a nursing home: assisted living residences (ALRs) and residential care homes (RCHs). RCHs are divided into two groups depending on the level of care they provide--Level III or Level IV.

Assisted living regulations require private apartments that promote resident self-direction and active participation in decision-making while emphasizing individuality, privacy, and dignity. As well as meeting their own licensing requirements, ALRs must meet Level III RCH licensing requirements.

Special care units (SCUs) that provide specialized services to a specific population must meet RCH licensing requirements, which are incorporated by reference into the ALR licensing regulations.

Services in both settings are covered by the Medicaid State Plan program and the 1115 Choices for Care Waiver program. Licensed ALRs and RCHs must be enrolled as Medicaid providers. Requests for continued participation in the Medicaid program must be submitted on an annual basis with the license re-application.

*Adult Foster Care.* Adult family care is a new Medicaid option provided under the Choices for Care Waiver program to individuals in the highest and high-needs groups.<sup>117</sup> Authorized Agencies<sup>118</sup> contract with private, unlicensed family homes to provide 24-hour care and room and board to 1-2 people who are not related to the home provider. Services include (but are not limited to) personal care, companion, and adult day services. Providers may also serve residents on a respite basis. Adult family care providers who serve only private pay residents are not regulated by the state. *The Medicaid regulatory provisions for adult family care are not included in this profile but a link to them can found at the end.*

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<sup>117</sup> Choices for Care participants are assigned to three groups based on an assessment: highest needs, high-needs, and moderate needs.

<sup>118</sup> The Authorized Agency must be authorized by the Vermont Department of Disabilities, Aging and Independent Living and must meet the adult family care qualifications, standards and responsibilities.

*This profile includes summaries of selected regulatory provisions for ALRs and RCHs. The complete regulations are online at the links provided at the end.*

## Definitions

**Assisted living residence** means a program or facility that combines housing and health and other services to support residents' independence and aging in place. In addition to the services specified in Level III RCH regulations, ALRs are required to offer a private bedroom, private bathroom, living space, kitchen capacity, and a lockable door.

**Residential care homes** serve three or more residents, who are unrelated to the licensee, and are licensed as either Level III or Level IV. Both licensure levels must provide room and board, assistance with personal care, general supervision, and medication management.<sup>119</sup> Level III homes must provide the additional service of nursing overview.<sup>120</sup>

## Resident Agreements

**Assisted Living Residences.** The terms of occupancy of a resident unit, together with information about any utilities, maintenance, or management services provided by the facility, must be included in a written admission agreement and, if applicable, a written lease separate from the admission agreement. When a separate lease agreement regarding the resident unit is entered into, the existence of that agreement must be noted in the admission agreement.

In addition, information with regard to payment for services and transfer and discharge policies are required by the following RCH licensing regulations.

**Residential Care Homes.** Prior to or at the time of admission, each resident, and the resident's legal representative, if any, must be provided with a written admission agreement that describes the daily, weekly, or monthly rate to be charged; the services included in the rate; and all other applicable financial issues. The agreement must also specify how services will be provided, transfer and discharge rights, and refund policies.

**Medicaid Programs.** Resident agreements for Level III homes and ALRs that participate in the Medicaid programs must disclose the provider's policies about

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<sup>119</sup> Medication management means a formal process of: (1) assisting residents to self-administer their medications; or (2) administering medications, under the supervision of and delegation by RNs, to designated residents by designated staff of the home. It includes procuring and storing medications, assessing the effects of medications, documentation, and collaborating with the residents' personal physicians.

<sup>120</sup> Nursing overview means a process in which a nurse ensures that the health and psychosocial needs of the resident are met. The process includes observation, assessment, goal setting, staff education, and the development, implementation, and evaluation of a written, individualized treatment plan to maintain the resident's well-being.

accepting Supplemental Security Income (SSI) and/or Medicaid payments. Agreements with Medicaid participants must include a description of the Medicaid services to be provided, the room and board rate, the personal needs allowance (PNA) amount, and the provider's agreement to accept room and board and Medicaid as the sole payment.

## Disclosure Provisions

***Assisted Living Residences.*** A facility must state in a uniform consumer disclosure the services it will provide, the public programs or benefits that it accepts or delivers, the policies that affect a resident's ability to remain in the residence, and any physical plant features that vary from the ALR regulations. The disclosure must also include information about service packages, tiers and rates, and reasons for rate increases. The required information must be entered on a form provided by the licensing agency and must be available to residents prior to or at admission, to the public upon request, and must be noted prominently in all marketing brochures and written materials.

A facility that has specialized programs, such as a dementia care unit, must include a written statement of the program's philosophy and mission and a description of how the ALR can meet residents' specialized needs, and also meet the following RCH licensing requirements.

***Residential Care Homes.*** If there are specialized programs offered, such as a dementia care unit, the facility must obtain approval from the licensing agency prior to establishing and operating the program. To obtain approval, the facility must provide all of the following:

- A statement outlining the philosophy, purpose, and scope of services to be provided.
- A definition of the categories of residents to be served.
- A description of the organizational structure of the unit consistent with the unit's philosophy, purpose, and scope of services.
- A description and identification of the physical environment.
- The criteria for admission, continued stay, and discharge.
- A description of unit staffing, including staff qualifications, orientation, in-service education and specialized training, and medical management and credentialing as-necessary.

## Admission and Retention Policy

*The following admission and retention requirements in each setting also apply to residents in SCUs within the setting.*

**Assisted Living Residences.** The facility may accept and retain any individual--including those whose needs meet the definition of nursing home level of care if those needs can be met by the ALR--with the following exceptions: an individual who: (1) has a serious, acute illness requiring the medical, surgical, or nursing care provided by a general or special hospital; (2) needs a ventilator or respirator; (3) needs treatment for a Stage III or IV decubitus ulcer; or (4) requires nasopharyngeal, oral or tracheal suctioning, or two-person assistance to transfer from bed or chair or to ambulate.

A current resident who develops a need for equipment, treatment, or care as listed above or who develops a terminal illness may remain in the residence so long as the facility can safely meet the resident's needs and/or the resident's care needs are met by an appropriate licensed provider.

The expectation is that individuals will be permitted to age in place provided that their mobility, ambulation, and transfer needs can be met by one staff person; cognitive impairment is at a moderate or lesser degree of severity; and behavioral symptoms consistently respond to appropriate intervention.

Residents may only be involuntarily discharged if: (1) they are not capable of entering into a negotiated risk agreement and they pose a serious threat to self, staff, or other residents that cannot be resolved through care planning and interventions; or (2) the resident has care needs that the residence can no longer meet.

**Residential Care Homes.** The facility may not accept or retain as a resident any individual who meets the level of care eligibility criteria for nursing home admission; has care needs that exceed what the home is able to safely and appropriately provide; or has a serious, acute illness requiring the medical, surgical, or nursing care of a general or special hospital. On admission, each resident must have a physician's statement with a medical diagnosis, including psychiatric diagnosis if applicable.

Homes may retain residents who need nursing services beyond nursing overview and medication management if they meet a number of conditions specified in the regulations, including the following: (1) residents receiving such care are fully informed of their options and agree to receive such care in the home; (2) the home is able to meet the resident's needs without detracting from services needed by other residents; and (3) the nursing service provided is limited in nature or is provided by a Medicare-certified Hospice program.

The following services are not permitted in a RCH except under a variance<sup>121</sup> granted by the licensing agency: intravenous therapy, ventilators or respirators, daily catheter irrigation, feeding tubes, care of Stage III or IV decubitus ulcers, suctioning, and sterile dressings. Variances are considered and issued on a case-by-case basis.

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<sup>121</sup> Variance means a written determination from the licensing agency, based upon the written request of a licensee, which temporarily and, in limited, defined circumstances, waives the need for compliance with a specific regulation.

Residents may be discharged only when their care needs exceed those for which the home is licensed to provide--or approved through a variance--or when the home is unable to meet the resident's assessed needs, or the resident presents a threat to his or herself or to the welfare of other residents or staff.

## Services

**Assisted Living Residences.** A facility must provide personal care and supportive services, which may include nursing services, to meet residents' needs, and also provide the following: (1) a daily program of activities and socialization opportunities, including periodic access to community resources; and (2) social services, which include information, referral and coordination with other appropriate community programs and resources, such as hospice, home health, transportation, and other services necessary to support the resident who is aging in place.

Residents who have an identified acute or chronic medical problem or who are deemed to need nursing overview or supervision must be under the continuing general supervision of a physician of their choosing.

**Residential care homes** provide personal care, medication management, transportation for medical services and local community functions, laundry, and additionally in Level III homes, nursing overview.

### Service Planning

**Assisted Living Residences.** The facility, the resident, and/or the resident's legal representative must work together to develop and maintain a written resident care plan that describes the resident's assessed needs and choices and supports the resident's dignity, privacy, choice, individuality, and independence. The facility must review the plan at least annually, and whenever the resident's condition or circumstances warrant a review, including whenever a resident's decision, behavior, or action places the resident or others at risk of harm or the resident is incapable of engaging in a negotiated risk agreement.

Whenever the facility determines that a resident's decision, behavior, or action places the resident or others at risk of harm, the facility must initiate a service negotiation process to address the identified risk and to reach a mutually agreed-upon plan of action. A negotiated risk agreement does not constitute a waiver of liability.

*The following rules for RCHs also apply to ALRs.*

**Residential Care Homes.** An assessment must be completed for each resident within 14 days of admission, consistent with a physician's diagnosis and orders, using an assessment instrument provided by the licensing agency. The resident's abilities regarding medication management must be assessed within 24 hours and nursing

delegation implemented, if necessary. If a resident requires nursing overview or nursing care, he or she must be assessed by a licensed nurse within 14 days of admission to the home or the commencement of nursing services, using an assessment instrument provided by the licensing agency. Each resident must also be reassessed annually and at any point in which the resident's physical or mental condition changes.

### ***Third-Party Providers***

***Assisted Living Residences.*** Residents have the right to arrange for third-party services, not available through the ALR, through a provider of their choice.

***Residential Care Homes.*** Residents of Level III or Level IV RCHs may receive home health services on a resident-specific basis to provide care the home cannot readily provide, including skilled nursing, speech therapy, physical therapy and occupational therapy on an intermittent basis (less than three times per week) or more intensively for a short term (up to 7 days a week for no more than 60 days) to the extent agreed upon by the service provider and the resident if all other provisions of the licensing regulations are met.

If a resident requires skilled nursing services from a home health agency because the home cannot provide the services and the services will continue for more than 60 days, the home must request a variance in writing from the licensing agency to retain the resident.

## **Medication Provisions**

*The following requirements of the RCH licensing regulations apply to both ALRs and RCHs.*

The facility manager is responsible for ensuring that all medications are handled according to the home's policies and that designated staff are fully trained in medication policies and procedures.

Residents who are capable of self-administration may purchase and self-administer over-the-counter medications. However, the facility must make every reasonable effort to be aware of such medications and monitor and educate residents about possible adverse reactions or interactions with other medications. If a resident's over-the-counter medications use poses a significant threat to the resident's health, staff must notify the physician.

Staff responsible for assisting residents with medications must receive training in the following areas from a licensed nurse:

- The basis for determining "assistance" versus "administration," and policies and procedures for assisting with medications.

- Residents' right to direct their own care, including the right to refuse medications.
- Proper techniques for assisting with medications, including hand-washing and checking for the right resident, medication, dose, time, and route.
- Signs, symptoms, and likely side effects to be aware of for any medication a resident receives.

If a resident requires medication administration, unlicensed staff may administer medications under the following conditions:

- A registered nurse (RN) must delegate the responsibility for the administration of specific medications to designated staff for designated residents.
- The RN must accept responsibility for the proper administration of medications, including: (1) teaching designated staff proper techniques for medication administration and providing appropriate information about the resident's condition, relevant medications, and potential side effects; (2) establishing a process for routine communication with designated staff about the resident's condition and the effect of medications, as well as changes in medications; (3) assessing the resident's condition and the need for any changes in medications; and (4) monitoring and evaluating the designated staff performance in carrying out the nurse's instructions.
- All medications must be administered by the person who prepared the doses unless the nurse responsible for delegation approves of an alternative method of medication preparation and administration.

Staff other than a nurse may administer PRN psychoactive medications<sup>122</sup> only when the home has a written plan for their use that describes the specific indications for administering the medication.

Staff other than a nurse may administer insulin injections only when: (1) the diabetic resident's condition and medication regimen is considered stable by the RN who is responsible for delegating the administration; (2) the designated staff to administer insulin to the resident have received additional training in the administration of insulin and the responsible RN has deemed them competent; and (3) the RN monitors the resident's condition regularly and is available when changes in condition or medication might occur.

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<sup>122</sup> PRN medication means medication ordered by the physician that is not to be administered routinely but is prescribed to be taken only as-needed and as indicated by the resident's condition. Psychoactive drug means a drug that is used to alter mood or behavior, including antipsychotic, antianxiety agents and sedatives, as well as antidepressants or anticonvulsants when used for behavior control.

## Food Service and Dietary Provisions

**Assisted Living Residences.** The facility must have the capacity to provide three meals a day and snacks, but may allow residents to purchase fewer meals. The facility must also meet the following RCH licensing requirements.

**Residential Care Homes.** Three nutritionally balanced, attractive, and satisfying meals per day are required and they must provide 100 percent of the Recommended Dietary Allowances as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences and comply with the Dietary Guidelines for Americans. Residents must be provided with alternatives to the planned meal upon request and offered snacks between meals and at bedtime. No more than 14 hours may elapse between the end of an evening meal and the morning meal. Written physicians' orders are needed for therapeutic diets.

## Staffing Requirements

*The following provisions apply to both ALRs and RCHs.*

**Type of Staff.** The home/residence must employ a *manager*--however named--who works in the facility an average of 32 hours per week and is responsible for its daily management, including supervision of employees and residents.

The manager must not leave the premises without delegating necessary authority to a competent staff person qualified by experience to carry out the manager's responsibilities, including being sufficiently familiar with residents' needs to ensure that their needs are met in a safe environment. Staff left in charge must be fully authorized to take necessary action to meet residents' needs or be able to contact the manager immediately if necessary.

The home/residence must have a *registered nurse* on staff, or a written agreement with an RN or home health agency, to provide required nursing services and to delegate related appropriate nursing care to qualified staff.

A home/residence that provides Medicaid services must designate a staff person responsible for providing the following *case management* services at a minimum: maintenance and implementation of a current assessment and plan of care, and coordination of available community services.

**Staff Ratios.** *No minimum ratios.* Homes/residences must have a sufficient number of qualified personnel available at all times to provide necessary care; to maintain a safe and healthy environment; and to ensure prompt, appropriate action in cases of injury, illness, fire or other emergencies. At least one staff member must be on-

duty, in charge, and awake at all times.<sup>123</sup> The licensing agency may require a home/residence to have specified staffing levels in order to meet the needs of residents.

## Training Requirements

**Assisted Living Residences.** The facility must provide training in the philosophy and principles of assisted living to all staff. Direct care staff must have training in communications skills specific to persons with Alzheimer's disease and other types of dementia. ALRs must also comply with the following training requirements for RCHs.

**Residential Care Homes.** At least 12 hours of training each year is required for each staff person providing direct care to residents. The training must include, but is not limited to, the following topics:

- General supervision and care of residents.
- Fire safety and emergency evacuation.
- Resident emergency response procedures, such as first-aid, the Heimlich maneuver, responding to accidents, and contacting the police or an ambulance service.
- Policies and procedures regarding mandatory reporting requirements for abuse, neglect, and exploitation.
- Residents' rights and respectful and effective interaction with residents.
- Infection control measures, including but not limited to, hand-washing, handling of linens, maintaining clean environments, blood-borne pathogens, and universal precautions.

## Provisions for Apartments and Private Units

**Assisted Living Residences.** All resident units must be private occupancy unless a resident voluntarily chooses to share the unit. At a minimum, all units must include a private bathroom, private bedroom, living space and kitchenette, adequate storage, lockable door, individual temperature controls, and must be equipped with emergency response systems to alert on-duty staff. Studio/efficiency apartments that offer a private bedroom, living space, and kitchen capacity in one large room and include a private bathroom meet these requirements. Kitchenettes must include food preparation and storage area, cabinets, counter space, refrigerator with freezer, sink

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<sup>123</sup> If a facility has fewer than 15 residents, staff may be asleep if there are no residents that routinely need services at that time, although this is rare. The majority of residents need 24/7 care.

with hot and cold running water, a stove or microwave that can be removed or disconnected, and electrical outlets.

The licensing agency may grant a variance for residences constructed prior to 2003 that differ from the minimum requirements. For example, preexisting structures that do not meet the requirements for private kitchen space may have a community kitchen that includes a refrigerator, sink, cabinets for storage, stove or microwave oven, and a food preparation area. If such a variance is granted, its terms must be stated on the license and included in the uniform disclosure form. A community resident kitchen may not be used by the ALR staff for the preparation of resident or employee meals, or for the storage of goods.

The ALR must have an accessible common dining space outside residential units that is sufficient to accommodate residents, and there must be at least one public restroom that is convenient to the common areas and meets applicable federal accessibility laws and guidelines.

***Residential Care Homes.*** The home must provide and maintain a safe, functional, sanitary, home-like, and comfortable environment. Since October 1993, all new homes may offer only single-occupancy or double-occupancy rooms. A minimum of one bathing unit, toilet, and sink must be exclusively available for each eight residents on each floor. Licensed beds with private washing facilities are not included in this ratio. The home must have at least one full bathroom that meets the requirements of the Americans with Disabilities Act and the state's building accessibility requirements.

## Provisions for Serving Persons with Dementia

*No provisions identified other than the general training requirements above.*

## Background Checks

*The following provisions apply to both ALRs and RCHs.*

The facility must not employ a person who has had a charge of abuse, neglect, or exploitation substantiated against him or her, or has been convicted of an offense for actions related to bodily injury, theft, or misuse of funds or property, or other crimes inimical to the public welfare, in any jurisdiction whether within or outside of the State of Vermont. This provision applies to the manager of the home as well, regardless of whether or not the manager is the licensee.

The facility must take all reasonable steps to comply with this requirement, including, but not limited to, obtaining and checking personal and work references and contacting the Division of Licensing and Protection to check if prospective employees are on the abuse registry or have a record of convictions.

## Inspection and Monitoring

The state conducts surveys for both ALRs and RCHs prior to license issuance and may inspect a home any other time it considers necessary to determine compliance with the regulations. Authorized staff of the licensing agency have access to the home at all times, with or without notice.

A facility that has received approval to operate a SCU will be surveyed to determine if the SCU is providing the services, staffing, training, and physical environment that were outlined in the request for approval.

## Public Financing

Two Medicaid programs cover services in both settings: the Assistive Community Care Services (ACCS) program and the Choices for Care 1115 Waiver program.

ACCS is a State Plan program that pays for services for individuals who do not need a nursing home level of care. Services include case management; assistance with the performance of activities of daily living (ADLs); medication assistance, monitoring, and administration; 24-hour on-site assistive therapy;<sup>124</sup> restorative nursing; nursing assessment; health monitoring; and routine nursing tasks.

The Choices for Care program serves people in ALRs and RCHs who meet Medicaid's nursing home level of care criteria. The program provides an enhanced residential care service for persons at the "highest" classification of need as an entitlement, and to as many persons at the "high" need classification as state funds permit. Services include personal care, housekeeping, activities, nursing oversight, and medication management.

### ***Room and Board Policy***

The state pays an optional state supplement (OSS) to SSI recipients and limits room and board charges for Medicaid-eligible residents of ALRs, residential care facilities, and adult family care homes to the combined SSI and OSS payments minus a PNA retained by the resident. In 2014, the federal SSI payment was \$721, the maximum OSS payment was \$223.94, and the maximum PNA was \$115, providing a maximum room and board payment of \$829.94. However, providers may choose to charge less for room and board so the resident may retain a greater personal needs spending allowance.

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<sup>124</sup> Assistive therapy means activities, techniques, and methods designed to maintain or improve ADLs, cognitive status, or behavior.

Medicaid-eligible residents who are not eligible for SSI and are living in a private room may be charged up to 85 percent of their Medicaid-adjusted income<sup>125</sup> for room and board. Family supplementation was not allowed in 2014.

## Location of Licensing, Certification, or Other Requirements

Division of Licensing and Protection, Department of Disabilities, Aging and Independent Living website: *Care Facility Regulations* with links to the Assisted Living Residence and Residential Care Home licensing regulations in PDF format.

<http://www.dlp.vermont.gov/regs>

Division of Disability and Aging Services, Department of Disabilities, Aging and Independent Living website: *Choices for Care (1115 Medicaid Long Term Care Waiver)*.

<http://ddas.vermont.gov/ddas-programs/programs-cfc/programs-cfc-default-page#services>

Division of Disability and Aging Services, Department of Disabilities, Aging and Independent Living website: *Enhanced Residential Care*.

<http://ddas.vermont.gov/ddas-programs/programs-cfc/programs-cfc-addl-webpages/programs-cfc-erc/programs-cfc-erc-default-page>

Division of Disability and Aging Services, Department of Disabilities, Aging and Independent Living website: *Adult Family Care Homes* with link to Adult Family Care Services “At a Glance” in PDF format. [August 2013]

<http://ddas.vermont.gov/ddas-programs/programs-cfc/programs-cfc-addl-webpages/adult-family-care-homes>

## Information Sources

Megan Tierney-Ward  
Director  
Adult Services Division  
Department of Disabilities, Aging and Independent Living

Suzanne Leavitt, RN, MS  
Assistant Director  
Division of Licensing and Protection  
State Survey Agency Director  
Department of Disabilities, Aging and Independent Living

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<sup>125</sup> After Medicaid standard deductions and medical deductions.

## VIRGINIA

### Licensure Terms

Assisted Living Facilities

### General Approach

The Virginia Department of Social Services licenses two levels of care in assisted living facilities (ALFs): residential living care (minimal assistance) or assisted living care (at least moderate assistance). Facilities licensed to provide assisted living care may also provide residential care. Excluded from this licensure category are facilities licensed by the Virginia Department of Behavioral Health and Developmental Services, and housing for persons age 62 or older that is financed by state or federal funds (e.g., by the U.S. Department of Housing and Urban Development).

Facilities that care for adults with serious cognitive impairments who cannot recognize danger or ensure their own safety or welfare, must meet additional requirements; these requirements apply whether the facility serves only such individuals or when the resident population is mixed. Facilities licensed for ten or fewer residents, or that house no more than three residents with a serious cognitive impairment, are exempt from the requirements.

*Adult Foster Care (AFC).* AFC is a program that provides room and board, supervision, and other services for up to three adults who have a physical or mental health condition, including an emotional or behavioral health issue. This setting is regulated through the Department for Aging and Rehabilitative Services, Adult Protective Services Division. *Regulatory provisions for AFC are not included in this profile but a link to the provisions can found at the end.*

*This profile includes summaries of selected regulatory provisions for ALFs. The complete regulations are online at the links provided at the end.*

### Definitions

**Assisted living facility** means a non-medical group residential setting that provides or coordinates personal and health care services, 24-hour supervision, and assistance for the care of four or more adults who are aged, infirm, or disabled.

**Residential living care** is a level of service defined as minimal assistance with activities of daily living (ADLs) and/or medication administration. Minimal assistance

means dependency in only one ADL or one or more instrumental activities of daily living. Minimal assistance includes services provided by the facility to individuals who are assessed as capable of maintaining themselves in an independent living status.

**Assisted living care** is a level of service defined as moderate assistance with ADLs. Moderate assistance is provided to persons who are dependent in two or more ADLs and/or who are dependent in behavior patterns (e.g., abusive, aggressive, disruptive) as documented on a uniform assessment instrument (UAI).

## Resident Agreements

The agreement, signed by the resident or appropriate legal representative and by the licensee or administrator, must describe financial arrangements, including specific charges for accommodations, services, and care; payment and refund policies; policies related to charge increases; and rules for resident conduct.

Residents must receive information about bed hold, transfer, and discharge policies; weapons policies; residents' rights and responsibilities; grievance policies; the right to form or participate in a Residence Council; smoking policies; and medications and dietary supplement storage and administration policies. The resident agreement must include an acknowledgement that all required information was provided.

## Disclosure Provisions

Facilities must provide a statement to prospective residents and their legal representatives (if any) that discloses information about the facility, including several of the topics required for the resident agreement, as well as:

- Ownership structure and the management company, if other than the licensee.
- Licensed capacity and characteristics of the resident population.
- General number, functions, and qualifications of staff on each shift.
- A description of all basic and optional accommodations, services, and care offered, and their cost.

## Admission and Retention Policy

Before admitting a prospective resident, the facility must interview the individual and his/her representative (if any), conduct an assessment, receive a physical examination report from a physician, and conduct a mental health screening, if needed.

Facilities may not admit or retain individuals with certain serious medical conditions and extensive nursing needs, including: (1) ventilator dependency; (2) some Stage III and all Stage IV dermal ulcers; (3) intravenous (IV) therapy or injections directly into the

vein; (4) nasogastric and gastric tubes; (5) continuous nursing care; and (6) individuals who present a danger to themselves or others; require maximum physical assistance; meet Medicaid nursing facility level of care criteria; or whose health care needs cannot be met as determined by the facility. Private pay residents who require IV therapy or gastric tubes may be retained if their physician approves and they receive care from a licensed physician or nurse.

To reside in a secure unit that cares for residents with serious cognitive impairments, an individual must have a primary diagnosis of dementia. This rule is waived for a spouse, parent, adult sibling, or adult child who wishes to live with the individual. Before a resident with dementia is placed in a secure unit, written approval must be obtained from the resident (if possible) or from (in order of priority) a guardian or legal representative, family member, or a physician. A physician or clinical psychologist must conduct an initial assessment and the licensee/administrator or designee must conduct periodic reviews to assess the appropriateness of the placement.

## Services

Facilities are permitted but are not required to offer all services as long as they provide services that are appropriate for the needs of current residents. Skilled nursing services--except continuous skilled nursing--may be provided by a facility nurse or a nurse contracted from a licensed home care agency. Eleven hours of activities per week for residential living care and 14 hours for assisted living care must be scheduled. The facility may include informal caregivers who wish to be included in the service delivery plan. A facility's program of care must:

- Meet residents' physical, mental, emotional, and psychosocial needs.
- Provide protection, guidance, and supervision.
- Promote a sense of security and self-worth.
- Promote the resident's involvement with appropriate community resources.
- Meet the service plan objectives.

Facilities must also provide periodic health care and oversight through a licensed health care professional--either directly employed or retained on a contractual basis. Residents at the residential care level must be evaluated every 6 months and assisted living care residents every 3 months. When on-site, the health care professional must perform a range of activities, including the following:

- Reviewing service plans and recommending needed changes.
- Monitoring direct care staff's performance of health activities, providing consultation and technical assistance to staff as needed, and recommending topics for staff training as needed.

- Reviewing documentation of health care services, including medication and treatment records, to determine that services correspond with physicians' and other prescribers' orders.
- Assessing residents for whom restraints are in use.
- Monitoring the facility's medication management plan and infection control plans.

Secure dementia units must provide at least 16 hours per week of scheduled activities, including cognitive stimulation, physical functioning (involving both gross and fine motor skills), and sensory, social, reflective, and natural world activities, such as interaction with pets or having a picnic.

### ***Service Planning***

The facility must complete an assessment with the Department's UAI for all residents prior to admission, every 12 months, and following a significant change in condition. The assessment is used to develop a care plan with the input of the resident, family, direct care staff, case manager, and health care providers, as relevant.

Residents eligible for public programs, must be assessed by a case manager or other qualified individual who is a trained employee of a public human services agency. Assessments for private pay residents may also be completed by an independent physician, or an employee of the facility who has documented training in the completion of the UAI. Assessments completed by facility staff must be signed by the administrator or designated representative.

### ***Third-Party Providers***

If residents need skilled nursing treatments they must be provided by a licensed nurse--through direct or contractual employment. For each resident requiring mental health services, appropriate services based on an assessment must be secured from a mental health provider.

## **Medication Provisions**

The facility must have a medication management plan that is reviewed and approved by the Department. The rules provide detailed requirements for providers' orders, storage, staff qualifications, administration, medication review, and oxygen therapy.

Residents may self-administer medications if they are capable of doing so and their rooms have a secure place for storing medications.

Medications may be administered by licensed individuals or by medication aides who have successfully completed a Board of Nursing-approved training program, have passed a competency evaluation, and are registered with the Virginia Board of Nursing.

At the residential living care level, a licensed health care professional must annually review all residents' medications (except for those who self-administer all of their medications). This review is required every 6 months for residents at the assisted living care level.

## Food Service and Dietary Provisions

Three nutritious meals must be provided each day, and bedtime and between meal snacks must be available. Periodic oversight of special diets by a dietitian or nutritionist, either through direct or contractual employment, is required, and religious dietary practices respected.

## Staffing Requirements

**Type of Staff.** The facility must have an *administrator* who is responsible for the facility's general administration and management, and who oversees its day-to-day operation. Facilities may share an administrator if specified conditions are met. *Direct care staff* provide personal care services. *Medication aides* are certified to administer medications.

A *licensed health care professional* must be hired or under contract to monitor direct care staff performance of health-related activities, including the identification of any significant gaps in the staff person's ability to function competently; advise the administrator of the need for staff training; provide consultation and technical assistance to staff; and recommend in writing any needed changes in the care provided or in residents' individual service plans. The licensed health care professional must be on site to evaluate residents who are at the assisted living level of care at least quarterly, and every 6 months for residents who are at the residential living level of care.

**Staff Ratios.** *No minimum ratios.* Facility staff must be present in sufficient numbers to provide services to help residents attain and maintain their physical, mental, and psychosocial well-being, as determined by resident assessments and service plans, and to implement the fire and emergency evacuation plan. At least one staff member must be awake and on-duty at all times in each building that houses at least 20 residents. A staff member with a current first-aid certificate and cardiopulmonary resuscitation (CPR) certification must be on site at all times, unless the facility has an on-duty registered nurse (RN) or licensed practical nurse (LPN). Facilities licensed for more than 100 residents must have at least one additional employee with current CPR certification for every 100 residents or portion thereof.

## Training Requirements

All staff must complete an orientation within 1 week of employment. In addition, each direct care staff member, unless he/she is an RN or LPN, must receive certification in the provision of first-aid within 60 days of employment and then maintain current certification. Medication aides must meet continuing education requirements of the Board of Nursing.

All personnel must be sufficiently educated regarding relevant laws, regulations, the facility's policies and procedures, and other topics, including:

- Specific duties and requirements of their positions.
- Emergency and disaster plans, including those for evacuating residents.
- Hand-washing techniques, standard precautions, and infection risk reduction behavior.
- Procedures for detecting suspected abuse, neglect, or exploitation of residents and reporting and documenting incidents.
- Residents' rights and responsibilities.
- Confidential treatment of personal information.

Administrators must attend at least 20 hours of annual training related either to resident-specific needs or to the management and operation of a residential facility for adults. When adults with mental impairments reside in the facility, at least 5 hours of training must focus on their needs.

Direct care staff at the residential living care level must complete at least 8 hours of training annually in addition to first-aid and CPR training and, for medication aides, continuing education required by the Board of Nursing. If any residents have mental impairments, 2 of the 8 hours of training must be devoted to mental impairment.

Direct care staff in facilities licensed for both residential living and assisted living levels of care must complete at least 16 hours of training annually in addition to first-aid and CPR training and medication aide training. If any residents have mental impairments, 4 of the 16 hours of training must be devoted to care of individuals with mental impairments. Direct care workers who are licensed health care professionals or certified nurse aides may complete 12 hours of training annually.

All direct care staff who care for residents who meet the criteria for assisted living care must have satisfactorily completed an approved training program prior to employment, or within 30 days of employment they must enroll in and successfully complete the program within 2 months of employment. Licensed health care professionals are exempt from this training requirement. Examples of approved training programs are:

- A Virginia Board of Nursing-approved educational curriculum from a Virginia Board of Nursing accredited institution--or a Department-approved educational curriculum for nursing assistants, geriatric assistants, or home health aides.
- A personal care aide training program approved by the Virginia Department of Medical Assistance Services.
- The Department-approved 40-hour direct care staff training provided by a licensed health care professional.

Staff who serve residents who are--or may be--aggressive or need restraints must receive additional training that covers self-protection, and the prevention and de-escalation of aggressive behavior. Training to serve residents who are restrained must cover proper techniques for applying and monitoring restraints; skin care and active assisted range of motion exercises; assessment of blood circulation; turning and positioning; provision of sufficient bed clothing and covering to maintain body temperature; provision of additional attention to meet the physical, mental, emotional, and social needs of restrained residents; and awareness of possible risks, and methods of reducing or eliminating such risks.

## Provisions for Apartments and Private Units

Apartment-style units are not required. Facilities constructed or modified after 2006 can have up to two occupants per room; those constructed before that time may have up to four occupants. Facilities built or modified after 2006 must provide one toilet and sink for every four residents and one bathtub or shower for every seven residents.

## Provisions for Serving Persons with Dementia

***Dementia Care Staff.*** At least two direct care staff must be awake and on-duty at all times in each secure special care unit (SCU) when residents are present.<sup>126</sup> During trips away from the facility, sufficient direct care staff must be available to provide “sight and sound” supervision to all residents who cannot recognize danger or ensure their own safety and welfare. A designated staff person who is responsible for managing or coordinating the structured activities program must be on site at least 20 hours a week.

***Dementia Staff Training.*** In facilities that serve a mixed population, commencing immediately upon employment and within 3 months, the administrator must complete 12 hours of training in cognitive impairment; and commencing immediately upon

<sup>126</sup> Only one direct care staff member has to be awake and on-duty in the unit if sufficient to meet the needs of the residents, and if: (1) no more than five residents are present in the unit; and (2) at least two other direct care staff members are present in the building, one of whom is readily available to assist with emergencies in the SCU, provided that supervision necessary to ensure that the health, safety, and welfare of residents throughout the building is not compromised.

employment and within 4 months, direct care staff must complete 4 hours of training in cognitive impairment. The training curriculum for direct care staff and administrators must be developed by a qualified health professional or by a licensed social worker and be relevant to the population in care. Topics must include but are not limited to: (1) an overview of cognitive impairments; (2) resident care techniques; (3) behavior management; (4) communication skills; (5) activity planning; and (6) safety.

In secure SCU s, commencing immediately upon employment and within 2 months, the administrator and direct care staff must attend at least 4 hours of training in cognitive impairments due to dementia, and at least 6 more hours of training within the first year. The training must be developed by a licensed health care professional who has at least 12 hours of training in the care of individuals with dementia; or a person who has been approved by the Department to develop the training.

At a minimum, the training must include: (1) information about cognitive impairment (e.g., cause, progression, behaviors, and management of the condition); (2) communicating with the resident; (3) managing dysfunctional behavior; (4) identifying and alleviating safety risks to residents with cognitive impairment; (5) assessing resident needs and capabilities and understanding and implementing service plans; (6) resident care techniques for persons with physical, cognitive, behavioral and social disabilities; (7) creating a therapeutic environment; (8) promoting resident dignity, independence, individuality, privacy and choice; (9) communicating with families and other persons interested in the resident; (10) planning and facilitating activities appropriate for each resident; and (11) common behavioral problems and behavior management techniques.

Within the first month of employment, in both mixed population facilities and in secure SCU s, staff other than the administrator and direct care staff must complete 1 hour of training on the nature and needs of residents with cognitive impairments, relevant to the population in care.

***Dementia Facility Requirements.*** A facility may have one or more self-contained SCU s or an entire facility may be a SCU. Exit doors must be monitored or secured unless they lead to protected areas. Staff-supervised or secure outdoor areas must be available. Protective devices must be in place on bedroom and bathroom windows and on common area windows that are accessible to residents with dementia. Unrestricted access to an indoor area for walking must be provided. Facilities must take precautions to limit environmental hazards for residents who cannot recognize danger.

## Background Checks

A separate regulatory document describes background check requirements. Staff must submit a sworn statement disclosing criminal convictions or pending charges. False statements are a Class 1 misdemeanor. For all employees, the facility must

obtain original criminal records checks from the Virginia State Police Central Criminal Records Exchange.

## Inspection and Monitoring

An inspection has six components: (1) an initial meeting with the inspection team and facility staff; (2) a facility tour; (3) interviews with residents, family members, and staff; (4) observations of staff activities, including medication administration; (5) a review of documentation; and (6) an exit interview. Unannounced inspections are conducted at least annually.

## Public Financing

A Medicaid 1915(c) waiver program--Virginia Alzheimer's Assisted Living--serves up to 200 assisted living residents with Alzheimer's disease. To be eligible, residents must meet the state's nursing facility/waiver level of care criteria and be receiving the state supplement to the federal Supplemental Security Income (SSI) payment.

### **Room and Board Policy**

The state provides an optional state supplement (OSS) through its Auxiliary Grant Program to needy aged, blind, and disabled persons who live in an ALF or in an approved AFC home and who are eligible for federal SSI benefits or would be eligible except for excess income.<sup>127</sup> The grant program is administered by the Department for Aging and Rehabilitative Services.

The state establishes an SSI standard from which the federal SSI payment (\$721 in 2014) minus a personal needs allowance (\$82 in 2014) and any countable income are deducted; the remainder is the amount of the auxiliary grant (the OSS). Providers serving residents who receive auxiliary grants may not charge more than the total SSI payment. In 2011, the maximum auxiliary grant was \$686 in Northern Virginia and \$519 in the rest of the state.<sup>128</sup>

Family supplementation is not allowed to pay for the cost of a private room but is allowed to pay for goods and services beyond those covered by the total SSI payment.

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<sup>127</sup> Facilities can use the grant to cover room, board, basic supportive services, and supervision.

<sup>128</sup> Social Security Administration. *State Assistance Programs for SSI Recipients*, January 2011. [http://www.socialsecurity.gov/policy/docs/progdesc/ssi\\_st\\_asst/2011/va.html](http://www.socialsecurity.gov/policy/docs/progdesc/ssi_st_asst/2011/va.html). Current information about the state's SSI payment was not available online or from other sources.

## Location of Licensing, Certification, or Other Requirements

Virginia Department of Social Services website: Assisted Living Facilities with information and links to the regulations and other provider resources.

<http://www.dss.virginia.gov/facility/alf.cgi>

Virginia Department of Social Services website: Adult Services information, including AFC, assisted living and other adult services, and links to resources.

<http://www.dss.virginia.gov/family/as/servtoadult.cgi>

Virginia Department of Social Services website: Auxiliary Grant information and links to rules and resources.

<http://www.dss.virginia.gov/family/as/auxgrant.cgi>

## Information Sources

Beverley Soble  
Virginia Health Care Association

Judith McGreal  
Virginia Department of Social Services

Tishaun Harris Ugworji  
Virginia Department for Aging and Rehabilitative Services

Steve Ankiel  
Virginia Department of Medical Assistance Services

## WASHINGTON

### Licensure Terms

Assisted Living Facility

### General Approach

The Washington State Department of Social and Health Services (DSHS), Aging and Long-Term Support Administration (Department) licenses assisted living facilities (ALFs), which provide room and board and help with activities of daily living (ADLs) to seven or more residents. Some ALFs provide limited nursing services (LNS); others may specialize in serving people with mental health problems, developmental disabilities, or dementia.

Three levels of services are provided by licensed ALFs that contract with Medicaid: enhanced adult residential care and assisted living services through a 1915(c) waiver program, and adult residential care services through the Medicaid State Plan. Facilities that contract with Medicaid must meet additional contracting requirements and provide specific services not required by licensure, including personal care and medication administration.

*Adult Foster Care.* The Department also licenses adult family homes that provide room and board and personal and special care for 2-6 adults who are not related by blood or marriage to the person or persons providing the services. Homes do not have to be operated by live-in providers. *Regulatory provisions for adult family homes are not included in this profile but a link to the provisions can found at the end.*

*This profile includes summaries of selected regulatory provisions for ALFs. The complete regulations are online at the links provided at the end.*

### Definitions

**Assisted living facility** means any home or other setting serving seven or more residents, however named, which is advertised, announced, or maintained for the express or implied purpose of providing housing and basic services, and assuming general responsibility for the safety and well-being of the residents. As of July 1, 2000, ALFs were allowed to provide--directly or indirectly--assistance with ADLs, health support services, or intermittent nursing services.

The term ALF does not include independent senior housing, independent living units in continuing care retirement communities, or other similar living situations, including those subsidized by the U.S. Department of Housing and Urban Development.

## **Resident Agreements**

Facilities must complete a negotiated service agreement using the pre-admission assessment, initial resident service plan, and full reassessment information (described below under service planning). The facility must include the resident and the resident's legal or other representative if any, in the development of the agreement. If the resident is a Medicaid client, the Department's case manager must also be involved.

The negotiated service agreement must be completed or updated within 30 days of the move-in date; as-necessary following the annual full assessment of the resident; and whenever the resident's negotiated service agreement no longer adequately addresses the resident's current needs and preferences.

## **Disclosure Provisions**

Facilities are required to disclose on a Department-provided form: (1) the scope of care and services offered and their cost; (2) activities not covered by the facility's per diem rate or applicable public benefit programs; (3) facility operation rules required by regulation; and (4) information that residents or their legal representatives can independently arrange for outside services. The disclosure form must be provided to residents, their representative if any, and to interested consumers upon request. Residents must be notified in advance if the facility is going to decrease or increase the scope of services it provides.

## **Admission and Retention Policy**

ALFs may not admit or retain any individual requiring nursing or medical care of a type provided by nursing facilities, except when a registered nurse (RN) is available. Also, facilities may not admit or retain persons who require frequent evaluation by an RN, excluding persons who are receiving hospice care or persons who have a short-term illness that is expected to be resolved within 14 days.

A facility must admit or retain only those individuals whose needs it can safely and appropriately serve in the facility with appropriate available staff and through the provision of reasonable accommodations required by state or federal law. Residents may be discharged for their own welfare or if the health or safety of other individuals in the facility is endangered.

## Services

Facilities must assume general responsibility for each resident and promote each resident's health, safety, and well-being consistent with the resident negotiated care plan.

ALFs are not required to provide assistance with ADLs, health support services, and intermittent nursing services. If they choose to provide assistance with ADLs, they must provide at least the minimal level of assistance with: bathing, dressing, eating, personal hygiene, transferring, toileting, and ambulation/mobility.

Facilities may choose to provide any of the following health support services: blood glucose testing, puree diets, calorie-controlled diabetic diets, dementia care, and mental health care. Facilities may also choose to provide intermittent nursing services through appropriately licensed and credentialed staff. These services include: medication administration, administration of health care treatments, diabetic management, non-routine ostomy care, tube feeding, and nurse delegation.

When providing any of these services, the facility must observe the resident for changes in overall functioning and respond appropriately when there are observable or reported changes in the resident's physical, mental, or emotional functioning.

### ***Service Planning***

Except in cases of emergency, the facility must not admit an individual before obtaining a thorough assessment of his or her needs and preferences. The assessment must cover recent medical history; necessary and contraindicated medications; a licensed medical or other health professional's diagnosis, unless the individual objects for religious reasons; significant known behaviors or symptoms that may cause concern or require special care; mental illness; level of personal care needs; activities and service preferences; and preferences regarding other issues important to the resident applicant, such as food and daily routines.

Based on the assessment, the facility must complete an initial resident service plan upon move-in to identify the resident's immediate needs and to provide direction to staff and caregivers. Within 14 days after move-in, the facility must complete a full assessment of the resident's functional and health needs as specified in regulation. Facilities must repeat a limited assessment when a resident's condition changes and the resident's negotiated service agreement no longer addresses the resident's needs.

### ***Third-Party Providers***

Facilities must permit the resident, or the resident's legal or other representative if any, to independently arrange for or contract with licensed health care professions, or a licensed home health, hospice, or home care agency, to provide on-site care and services to the resident. The ALF licensee may establish policies and procedures that

describe limitations, conditions, or requirements that must be met prior to an outside service provider being allowed on site.

Facilities are not required to supervise the activities of a person providing care or services to a resident when the resident, or legal representative, has independently arranged for or contracted with the person and the person is not directly or indirectly controlled or paid by the ALF. However, the ALF is required to coordinate services with such persons to the extent allowed by the resident, or legal representative, and consistent with the resident's negotiated care plan. Further, the ALF is required to observe the resident and respond appropriately to any changes in the resident's overall functioning.

## Medication Provisions

Facilities may provide medication services, which include medication administration, medication administration provided through nurse delegation, medication assistance, or resident self-administration of medication. Residents negotiated service agreements must state whether they will receive medication assistance or medication administration services.

If licensed to do so, a facility may permit a resident's family member to administer medications or treatments or to provide medication or treatment assistance to the resident. If so, the facility must request and family member provide a written medication or treatment plan, with information specified in the rules.

## Food Service and Dietary Provisions

Facilities must provide a minimum of three meals a day at regular intervals with no more than 14 hours between the evening meal and breakfast, unless the facility provides a nutritious snack after the evening meal and before breakfast. Meals must be nourishing and palatable and must be adjusted to meet individual preferences to the extent reasonably possible. Facilities must also make available, as needed by residents, prescribed general low-sodium, general diabetic, and mechanical soft food diets, and nutrient concentrates and supplements when prescribed in writing by a health care practitioner.

## Staffing Requirements

**Type of Staff.** Facilities must have an *administrator*. Facilities that admit and retain individual requiring LNS or medical care of a type provided by nursing facilities, must have a *registered nurse* available.

**Staff Ratios.** *No minimum ratios.* Facilities must provide sufficient, trained staff to furnish the services and care needed by each resident consistent with his or her negotiated service agreement, to maintain the facility free of safety hazards, and to implement fire and disaster plans. Facilities must also ensure that at least one staff person 18 years of age or older has current cardiopulmonary resuscitation (CPR) and first-aid certification and is present and available to assist residents at all times.

## Training Requirements

Orientation and training requirements are presented in the table below. Orientation must cover the following topics: residents' rights, communication skills, fire and life safety, and universal precautions. Orientation must be provided before the employees have routine interaction with residents.

Training Requirements			
Type of Training	ALF Administrator or Designee	ALF Long-Term Care (LTC) Worker	DSHS Required to Approve Curriculum?
First-aid and CPR	Within 30 days of employment; maintain valid card.	Within 30 days of employment; maintain valid card.	No
Orientation 2 hours	Prior to providing care to a resident unless exempt from training.	Prior to providing care unless exempt from training.	Yes
Safety training 3 hours	Prior to providing care to a resident unless exempt from training.	Prior to providing care to a resident unless exempt from training.	Yes
Basic training 70 hours	Within 120 days of employment unless exempt from training.	Within 120 days of employment unless exempt from training.	Yes
Continuing education	12 hours per year.	12 hours per year	Yes
HIV/AIDS	All ALF staff, 2 hours within 30 days of employment. Basic training includes this topic.	All ALF staff, 2 hours within 30 days of employment. Basic training includes this topic.	Educational materials are supplied by the Office on AIDS
Nurse delegation and core diabetes	Must be a certified or RN assistant, or certified home care aide and complete nurse delegation core training before accepting a delegated task.	Must be a certified or RN assistant or certified home care aide and complete nurse delegation core training before accepting a delegated task. Must complete Special Focus on Diabetes training before accepting insulin injections as delegated task.	Must use DSHS curriculum. Instructors must be DSHS-contracted community instructors.

Type of Training	ALF Administrator or Designee	ALF Long-Term Care (LTC) Worker	DSHS Required to Approve Curriculum?
Specialty training	<p>If an ALF serves 1 or more residents with special needs, the administrator or designee must complete manager specialty training and demonstrate competency by passing the DSHS test.</p> <p>If a resident develops special needs while living in an ALF without a specialty designation, the administrator or designee have 120 days to complete manager specialty training and demonstrate competency.</p>	If an ALF serves one or more residents with special needs, all LTC workers must receive training regarding the specialty needs of individual residents in the facility.	<p>Yes</p> <p>Instructors must be DSHS-contracted community instructors to provide manager specialty training.</p>

Basic training consists of modules on the core knowledge and skills that caregivers need to effectively and safely provide care to residents, including specific duties and responsibilities; how to report resident abuse and neglect; policies, procedures, and equipment necessary to perform duties; and the needs and service preferences identified in the negotiated service agreements of residents with whom the staff persons will be working. Basic training must be outcome-based, and its effectiveness measured by demonstrated competency in the core areas through the use of a competency test.

## Provisions for Apartments and Private Units

Private apartments or rooms are not required. No more than two residents may live in an apartment, and both must mutually agree to share a sleeping room. For facilities licensed before July 1, 1989, no more than four residents may share a room; if after this date, no more than two residents.

When providing common-use toilet rooms and bathrooms for residents who do not have a private toilet room, a facility must provide one toilet and one sink for every eight residents. When providing common-use bathrooms, facilities must provide one bathing fixtures for every 12 residents. Facilities must locate a toilet room on the same floor or level as the sleeping room of the resident served.

Facilities that want to provide assisted living services covered by the Washington State DSHS Aging and Disability Services Administration must provide private apartment-like units to Medicaid-eligible residents; shared units are not permitted unless the residents are married and both agree and understand that they are entitled to separate apartments. The unit must have a separate private bathroom, which includes a

sink, toilet, and a shower or bathtub; a lockable entry door; a kitchen area equipped with a refrigerator, a microwave oven or stovetop and a counter or table for food preparation; and a living area wired for telephone and, where available in the geographic location, wired for television service.

Private apartments are not required in facilities that contract with the Department to provide enhanced adult residential care and adult residential care; units may be shared but no more than two people may share a unit.

## Provisions for Serving Persons with Dementia

The state has a specialized dementia care program for persons with dementia who need residential care. The Department pays for the person to receive a package of specialized dementia care services in a contracted ALF. (Due to limited funding, the Department contracts with a small number of ALFs throughout the state to offer this program.)

The package of specialized dementia care services a contracted ALF must provide include (in part): (1) care, supervision, and activities tailored to the specific needs, interests, abilities, and preferences of the person; (2) coordination with the person's family to ensure the person's routines and preferences are honored; and (3) intermittent nursing services, help with medications, personal care, and other support services.

***Dementia Care Staff.*** Facilities that offer specialized dementia care must have awake staff 24 hours a day.

***Dementia Staff Training.*** For facilities that serve residents with special needs, including dementia, specialty training is required of administrators, or designees, and caregivers. Specialty training consists of modules on the core knowledge and skills that caregivers need to effectively and safely provide care to residents with special needs. Specialty training must be outcome-based, and the effectiveness of the specialty training measured by demonstrated competency in the core specialty areas through the use of a competency test.

Caregivers must complete specialty training within 120 days of the date on which they begin to provide hands-on care to a resident having special needs. However, if specialty training is not integrated with basic training, the specialty training must be completed within 90 days of completion of basic training. Until competency in the core specialty areas has been demonstrated, caregivers must not provide hands-on personal care to residents with special needs without direct supervision.

If a facility serves one or more residents with dementia, the administrator or designee must complete specialty training and demonstrate competency within 120 days from the date on which the administrator or designee is hired.

***Dementia Facility Requirements.*** Facilities that contract with the state to provide specialized dementia care must have a safe outdoor environment with walking paths and access to a secure outdoor area.

## **Background Checks**

All facility owners, partners, officers, directors and managerial employees, group or association members, and the administrator must undergo a background check when applying for licensure.

It is the licensee's responsibility to require and submit fingerprint background check authorization forms on all individuals associated with the ALF who have unsupervised access to residents, including, but not limited to, employees, managers, volunteers who are not residents, contractors, and students.

Facilities must not employ, directly or by contract, an administrator or caregiver who has been convicted of a crime or pending charge for a disqualifying crime as specified in the rules, or who has been found in any disciplinary board final decision to have abused a vulnerable adult, or found by the Department to have abused, neglected, or exploited a vulnerable person in any manner.

## **Inspection and Monitoring**

The Department inspects all ALFs at least every 18 months with an annual average of 15 months. The Department may delay an inspection to 24 months if the ALF has had three consecutive inspections with no written notice of violations and has received no written notice of violations resulting from complaint investigation during that same time period. The Department may at any time make an unannounced inspection of a licensed facility to ensure that the licensee is in compliance with all rules.

## **Public Financing**

The state's Medicaid 1915(c) Waiver program--Community Options Program Entry System (COPES)--pays for personal care and other services in adult family homes, adult residential care facilities, and ALFs.

Three levels of services are provided by licensed ALFs that contract with Medicaid: enhanced adult residential care and assisted living services through the COPES Waiver program, and adult residential care services through the Medicaid State Plan. Facilities that provide enhanced adult residential care services may also contract with the Department to provide specialized dementia care.

Adult residential care services include assistance with self-administration of medications, limited supervision for safety, and assistance with ADLs (personal care). Enhanced adult residential care services include all of the adult residential care services, plus medication administration, and some types of nursing care on an occasional basis. (No more than two people may share a room.) Assisted living services include some types of nursing care on an occasional basis, medication administration, and personal care. (A private apartment is required.)

### **Room and Board Policy**

The room and board rates for Medicaid waiver participants and Supplemental Security Income (SSI) recipients are capped at the SSI rate--\$733 in 2015--minus a personal needs allowance of \$62.79. The state does not supplement the federal SSI payment for residents in ALFs.

Family supplementation is allowed for items or services not covered by Medicaid.

## **Location of Licensing, Certification, or Other Requirements**

*Revised Code of Washington*, Title 18, Chapter 18.20 RCW: Assisted Living Facilities (Formerly Boarding Homes).

<http://apps.leg.wa.gov/rcw/default.aspx?cite=18.20>

*Revised Code of Washington*, Title 388, Chapter 388-76 RCW: Adult Family Home Minimum Licensing Requirements. [June 24, 2014]

<http://apps.leg.wa.gov/WAC/default.aspx?cite=388-76>

*Washington Administrative Code*, Title 388, Chapter 388-78A WAC: Assisted Living Facility Licensing Rules. [June 24, 2014]

<http://app.leg.wa.gov/WAC/default.aspx?cite=388-78A>

*Washington Administrative Code*, Title 388, Chapter 388-78A, Section 24641: Background checks. [July 25, 2014]

<http://app.leg.wa.gov/WAC/default.aspx?cite=388-78A-24641>

*Washington Administrative Code*, Chapter 388-110 WAC: Contracted Residential Care Services. (*Provisions for facilities contracting to provide services to Department of Social and Health Services, Aging and Long-Term Support Administration clients.*) [March 7, 2014]

<http://apps.leg.wa.gov/WAC/default.aspx?cite=388-110>

Washington State Department of Social and Health Services, Aging and Long-Term Support Administration Website: Information for Assisted Living Professionals.

<http://www.dshs.wa.gov/altsa/residential-care-services/information-assisted-living-facility-professionals>

## Information Sources

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## WEST VIRGINIA

### Licensure Terms

Assisted Living Residences, Residential Care Communities

### General Approach

Two types of residential care settings are licensed by the Department of Health and Human Resources (DHHR), Bureau for Public Health, Office of Health Facilities Licensure and Certification: assisted living residences (ALRs) and residential care communities. The primary difference between ALRs and residential care communities is that residents in the latter must be capable of self-preservation in an emergency.<sup>129</sup>

If a facility advertises or promotes itself as having a specialized unit for persons with Alzheimer's disease or other dementia, a separate license must be obtained. Such facilities must be licensed as either an ALR or a skilled nursing facility. Licensed facilities that do not market themselves as offering Alzheimer's/dementia special care units (ASCUs), may serve residents with early dementia symptoms.

*Adult Foster Care.* Health care homes are required to register with the DHHR and comply with applicable standards. These homes provide accommodations and personal assistance for up to three residents who are not related to the service provider or his or her spouse. Limited and intermittent nursing services may be provided by a registered nurse (RN). Providers must make arrangements for the administration or self-administration of medications. Payment is private pay only.

The DHHR, Adult Residential Services, certifies adult family care homes (AFCHs) that provide support and protection for up to three adults who are placed in the home because they lack either family and/or financial resources to provide for their needs. Eligibility criteria include age 65 or older, age 18 or older with an established disability, or age 18 or older and receiving Adult Protective Services. DHHR staff must either make or approve placements in these settings. Agency staff recruit suitable homes for certification, place residents, and provide ongoing support, monitoring, and review to ensure that providers offer appropriate care. *Regulatory provisions for health care homes and AFCHs are not included in this profile but a link to the provisions can found at the end.*

*This profile includes summaries of selected regulatory provisions for ALRs and residential care communities. Unless otherwise stated, ASCUs must comply with the*

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<sup>129</sup> Only two residential care communities are licensed in the state and they accept only private pay residents.

requirements of their relevant licensure category. The complete regulations can be viewed online using the links provided at the end.

## Definitions

**Assisted living residences** are accommodations, however named, available for four or more residents, which are advertised, offered, maintained or operated by the ownership or management for the express or implied purpose of providing personal assistance, supervision, or both, to any residents who are dependent upon the services of others because of physical or mental impairment, and who may also require limited nursing care. Small facilities have a bed capacity of 4-16; large facilities have 17 or more beds.

**Residential care community** means any group of 17 or more residential apartments, however named, which are part of a larger independent living community and which are advertised and operated for the purpose of providing residential accommodations, personal assistance, and supervision to persons who are or may be dependent upon the services of others by reason of physical or mental impairment, or who may require limited and intermittent nursing care but who are capable of self-preservation and are not bedfast.

**Alzheimer's/Dementia Special Care Units (SCUs) and Programs.** A SCU (in a licensed ALR or a skilled nursing facility) is one that provides specialized services, 24 hours per day, for residents with a diagnosis of Alzheimer's disease or other dementia. A program is a licensed facility that offers specialized services for a specified number of hours per day.

## Resident Agreements

**Assisted living residence** agreements must indicate the type of resident population served; services provided; costs of basic and optional services; medication policies; the refund policy; discharge criteria and notification policies; complaint procedures; management of residents' funds; and liability insurance coverage (if any).

**Residential care community** agreements provide information about admission, retention, and discharge policies; assurance that the community will meet the resident's needs; costs and payment and refund policies; how health care will be provided or arranged; medication policies; and the complaint process.

Both ALRs and residential care communities must also provide the following information: house rules governing resident behavior and responsibilities; the residents' bill of rights; how residents' personal property will be protected from loss and theft; requirements for medical examinations and treatment orders; how the resident will be assisted in making appointments for medical, dental, nursing or mental health services,

and how transportation to and from these services will be arranged; and how to access information about the residence's (or community's) policies and procedures.

**Alzheimer's/dementia special care units and programs** must have a written policy that explains pre-admission screening, admission, transfer and discharge procedures, including an explanation of the level of care the facility is licensed to provide, and the conditions that may necessitate a resident's transfer or discharge.

## Disclosure Provisions

**Assisted living residences' and residential care communities'** licensing rules do not require a specific disclosure document, but they require that specific information be provided at or before admission, including the cost of basic and optional services, and any other fees.

**Alzheimer's/dementia special care units and programs** must prepare a written disclosure document describing the form of care or treatment provided that distinguishes it as being especially applicable to, or suitable for persons with dementia. The disclosure form must be given to the resident or family before admission, and signed and dated by the resident and/or legal representative.

## Admission and Retention Policy

**Assisted living residences** may not admit or retain individuals who: (1) require a level of service that the residence is not licensed to provide or does not provide; (2) need extensive or ongoing nursing care; (3) require the use of routine physical or chemical restraints; (4) or are likely to cause serious harm to themselves or to others if appropriate interventions are not provided in a timely manner.

Residents who become bedfast may remain in the home for 90 days during a temporary illness or post-surgery if they do not require nursing care in excess of limited and intermittent nursing care. Residents may be immediately discharged if they require transfer to a hospital or other higher level of care.

A resident whose condition declines after admission, and who is receiving services coordinated by a licensed hospice or certified home health agency, may receive these services in the residence. The licensee must ensure that such residents are provided the care and services necessary to meet their needs.

**Residential care community** residents must be certified by a physician to be capable of self-preservation. Residents may need personal assistance in activities of daily living (ADLs), supervision because of mental or physical impairment, or limited and intermittent nursing services. Following admission, facilities may retain residents who receive hospice services. Residents who are not capable of self-preservation because

of a temporary illness or recovery from surgery may be retained for 90 days if they do not require nursing care exceeding the type and amount allowed by regulation.

***Alzheimer's/Dementia Special Care Units and Programs.*** Before move-in, the resident's physician must provide written documentation of the individual's diagnosis of Alzheimer's disease or other dementia.

## Services

All facility types provide the following services: personal assistance; help with self-administration of medications and medication administration; help in following planned diets, activity regimens, or use of equipment; and assistance in making appointments for dental and medical services. In addition, Alzheimer's/dementia SCUs and programs must provide behavior management services to residents whose evaluation indicates the need based on behaviors that are persistent and constitute sources of distress or dysfunction for the resident, or present a danger to the resident or other individuals.

### ***Service Planning***

***Assisted Living Residences and Residential Care Communities.*** Not more than 60 days prior to a resident's admission and no more than 5 working days following admission, and at least annually after that, each resident must receive a functional needs assessment completed in writing by a physician or other licensed health care professional authorized under state law to perform the assessment. The assessment must provide information about the resident's health status and functional, psychosocial, activity, and dietary needs. Within 45 days of admission, the facility must develop a service plan based on the assessment.

***Alzheimer's/dementia special care units and programs*** must, within 3 days of admission, review the immediate care needs of the resident and establish a preliminary care plan, with the resident's and/or his/her legal representative's input. Within 7 days of admission, an interdisciplinary team that includes the unit coordinator, a social worker, the activities director, direct care staff, a RN, and other professional disciplines as appropriate, must complete an initial assessment of a new resident.

This assessment must include a social history; family supports; ADL functioning; cognitive level; behavioral impairment; and nutritional status, including weight and nutritional requirements. Within 21 days, an individualized care plan must be finalized that addresses several topics, including a description of specific needs, choices, problems and any inappropriate behaviors; specific desired outcomes and specific interventions to be used; and the job titles of staff who will provide the described services. The care plan must be reviewed by the interdisciplinary care team at least quarterly.

The unit or program must also evaluate residents who have behavioral problems to determine their intensity, duration, and frequency; antecedent behaviors; recent changes or risk factors in the resident's life; environmental factors; the resident's medical status; activities that have been successful in addressing the behaviors in the past; staffing patterns; and effective behavioral management techniques.

### ***Third-Party Providers***

Assisted living and residential care communities must arrange for limited and intermittent nursing care and hospice care for residents whose needs it cannot meet, and who have insurance coverage or the financial means to pay privately for these services. If the resident needs services that use electronic equipment requiring auxiliary electrical power in the event of a power failure (such as a suction apparatus and intravenous or tube feeding pumps), the facility must have a backup power generator.

If a resident in an ALR exhibits symptoms of a developmental or mental disorder that poses a risk to self or others, and the resident is not receiving behavioral health services, the residence must advise the resident--or his or her legal representative--of the availability of local behavioral health services.

If the resident or his or her legal representative fails to seek treatment within 30 days, then the residence, after consultation with the resident's physician, must refer the resident to a licensed behavioral health provider. However, the residence must seek immediate treatment for a resident if there is reason to believe that the resident may suffer serious harm, or is likely to cause serious harm to himself or herself or others if appropriate interventions are not provided in a timely manner.

## **Medication Provisions**

***Assisted living residence*** staff may supervise self-administration of medications if a licensed health care professional determines that a resident is capable of self-administration. Supervision includes reminding residents to take medication, opening medication containers for residents, reading the medication label to residents, observing residents while they take the medication, checking the self-administered dose against the label on the container, and reassuring residents that they have obtained and are taking the dosage as prescribed.

Staff may also administer medications, which includes opening a container of medication and giving the medication to the person for whom it is prescribed, giving injections, and administering eye drops. Approved Medication Assistive Personnel who complete required competency training and testing may administer medications and perform specified health maintenance tasks. Regulatory provisions address the evaluation of staff competency, re-training requirements, and requirements of RNs who approve unlicensed staff to administer medications.

An attending physician, or other health care professional, or a consulting pharmacist must review each resident's medication regimen as needed, but at least annually.

**Residential care communities** may administer medications and assist with self-administration of medications. A licensed health care professional must administer medication and determine whether or not a resident is capable of self-administration. An attending physician, or other health care professional, or a consulting pharmacist must review the medication regimen of each resident as needed, but at least annually.

**Alzheimer's/dementia special care units and programs** must follow medication administration provisions for their relevant state licensure category. In addition, the state provides guidelines for psychotropic and behavioral modifying medications, as well as for the use of non-medication behavioral management approaches. If these medications are used, the facility must ensure the following: (1) that the diagnosis justifies the medication use; (2) that the dosage is based on age recommendations; (3) that staff monitor daily for side effects or adverse effects and report such effects to the resident's physician; and (4) that measures to reduce the dose over time are taken. Monthly evaluation by a licensed health care professional is required for residents who take psychotropic medications, and a physician must review the resident's record every 6 months and assess the need for continued use of the prescribed medication and the potential to decrease the dose.

## Food Service and Dietary Provisions

**Assisted living residences and residential care communities** must provide three meals a day, snacks, and special diets that substantially comply with the recommended dietary allowances of the National Academy of Science's Food and Nutrition Board. Therapeutic or modified diets must be prepared according to a physician's or dietician's orders. Staff training must include the topic of nutrition. The residence must accommodate residents who are unable to eat at planned mealtimes and provide for meal substitution if the resident does not tolerate or like the food provided.

## Staffing Requirements

### **Assisted Living Residences**

**Type of Staff.** Facilities must employ an *administrator* and *direct care staff*. If nursing services are provided, a *registered nurse* must be employed to provide oversight and supervision. At least one employee with current first-aid training and cardiopulmonary resuscitation (CPR) certification must be on-duty at all times.

**Staff Ratios.** *No minimum ratios.* Specific ratios of direct care staff are required on each work shift based on the numbers of residents who have the following care needs: (1) dependence on staff for eating, toileting, ambulating, bathing, dressing, repositioning, special skin care; (2) one or more inappropriate behaviors that reasonably requires additional staff to control, such as sexually acting out, removing clothing in public settings, refusing basic care, or destroying property; or (3) injurious behavior to self or others.

Facilities must have a minimum of one direct care staff person on duty 24 hours per day, including awake staff present in the residence during normal resident sleeping hours, and a sufficient number of qualified employees on duty to provide all the care and services residents require. In multilevel residences, at least one awake staff person must be on-duty while residents are sleeping, unless the residents have been certified by a physician or licensed psychologist as not requiring sleep-time supervision.

### **Residential Care Communities**

**Type of Staff.** Facilities must employ an *administrator* and *residential staff*.

**Staff Ratios.** *No minimum ratios.* Sufficient staff must be available to care for residents. Awake staff are required when residents need supervision or intermittent nursing services. Multi-story facilities must have one awake staff person per floor unless supervision or intermittent nursing services are not needed and there is a call system.

## **Training Requirements**

**Assisted Living Residences.** Administrators must complete at least 8 hours per year of continuing education related to the operation and administration of the residence.

Facilities must provide orientation for staff within 15 days of hire, and in-service training annually thereafter on the following topics: emergency procedures and disaster plans; the residence's policies and procedures; residents' rights; confidentiality; abuse prevention and reporting; the ombudsmen's role; complaint procedures; specialty care based on individualized residents' needs and service plans; group and individual resident activities; and infection control.

In addition, facilities must provide a minimum of 2 hours of training to all new employees within 15 days of hire and annually thereafter on Alzheimer's disease and other dementias; how to communicate with persons who have dementia; the prevention and management of problem behaviors; and activities and programming appropriate for persons with dementia.

**Residential Care Communities.** Administrators must receive annual training of at least 10 hours on relevant topics, including facility operation and administration.

Within the first 24 hours of hiring and admission, facilities must provide an orientation to all new employees and residents about emergency procedures; evacuation procedures; and how to report a missing resident, a medical emergency, accident, fire, natural disaster, or other emergency.

Within 15 days of hire staff must receive training on facility policies and procedures, residents' rights, complaint procedures, capabilities and needs of older persons and persons' with disabilities, personal assistance procedures, requirements of current residents, CPR, and infection control.

## Provisions for Apartments and Private Units

**Assisted living residences** may provide both private and shared rooms. In facilities constructed or renovated after May 1, 2006, no more than two persons can share a bedroom. Facilities must have a minimum of one toilet and sink for every six residents and a minimum of one bathing facility per floor with a bathtub or shower for every ten residents.

**Residential care communities** must offer apartment units with lockable doors, at least one bedroom, a kitchenette with a sink and refrigerator, and one full bathroom. No more than two residents can occupy a multi-occupancy apartment.

## Provisions for Serving Persons with Dementia

**Dementia Care Staff.** Staffing categories include an *administrator*, *direct care staff*, and a *program coordinator* whose job includes coordinating, as needed, with third-party behavioral health specialists; advocacy; and support group facilitation. A *licensed nurse* must be available on-site if any resident requires nursing procedures, including as-needed (PRN) injections, and as required by the facility's state licensure rule. The facility must have a licensed *social worker* or licensed professional *counselor* available to provide specified social services. Appropriate activities must be provided by a *therapeutic specialist*, *occupational therapist*, or *activities professional*.

Staffing patterns must enable the facility to provide 2.25 hours of direct care time per resident per day. At least two staff must be present for units serving more than five residents. An RN must be available if residents require nursing procedures.

Direct care staff may not have housekeeping, laundry, food preparation, or maintenance duties as their primary responsibilities. Any unlicensed direct care staff included to meet the minimum staffing ratio may not be responsible for medication administration during the day or evening shift, including staff who have completed training and passed the competency test as Approved Medication Assistive Personnel.

***Dementia Staff Training.*** SCU and program staff must complete a minimum of 30 hours of training related to the care of residents with Alzheimer's disease or other dementias. Topics include the nature, stages, and treatment of dementia; positive therapeutic interventions; communication; behavior management; medication management; the role of family; staff burn-out prevention; abuse prevention; and service planning. Eight hours of annual continuing education are required.

***Dementia Facility Requirements.*** SCUs and programs are required to have environmental features to ensure the safety of residents who might attempt to leave the residence, for example, high visual contrast between floor, walls, and walkways; non-reflective surfaces; secured outdoor space; a multipurpose room for dining, group and individual activities, and family visits; a monitoring or nurses' station, which includes a communication system; secured outdoor areas; and locking devices that promote safety.

## Background Checks

***Assisted living residences and residential care communities*** may only hire staff who do not have a prior record of, or evidence of: (1) abuse, fraud, or substantial and repeated violations of applicable laws and rules in the operation of any health or social care facility or service organization, or in the care of dependent persons; or (2) conviction of crimes related to the care of a dependent person, which are documented in the state's central abuse registry.

## Inspection and Monitoring

***Assisted living residences and residential care communities*** are inspected at initial licensing and then as-needed and to investigate complaints.

***Alzheimer's/dementia special care units and programs*** are evaluated for compliance with applicable rules and their disclosure statement during the facility's state licensure surveys.

## Public Financing

The state does not use Medicaid to cover services in any type of residential care setting.

### ***Room and Board Policy***

The state does not provide an optional supplement payment, but does provide assistance under the category of special needs circumstances that includes every aged or disabled person living in a supported living setting who has been approved for

Supplemental Security Income (SSI) and persons who are not eligible for SSI but are eligible for the state assistance payment.

In 2011, the state made a maximum monthly payment of \$879.90 to AFCHs, and \$1,122.32 to ALRs on behalf of eligible residents. Residents' income (minus a personal needs allowance [PNA]) was subtracted from the maximum payment to determine the amount of the state assistance payment.<sup>130</sup>

Family supplementation is allowed.

## Location of Licensing, Certification, or Other Requirements

*Administrative Law*, Assisted Living Residences. [May 1, 2006]  
<http://apps.sos.wv.gov/adlaw/csr/ruleview.aspx?document=2705>

*Administrative Law*, Residential Care Communities. [July 1, 1999]  
<http://apps.sos.wv.gov/adlaw/csr/rule.aspx?rule=64-75>

*Administrative Law*, Alzheimer's/Dementia Special Care Units and Programs. [May 1, 2006]  
<http://apps.sos.wv.gov/adlaw/csr/rule.aspx?rule=64-85>

*Administrative Law*, Legally Unlicensed Health Care Home. [July 1, 1999]  
<http://apps.sos.wv.gov/adlaw/csr/ruleview.aspx?document=2821>

West Virginia Department of Health and Human Services, Adult Residential Services website: Adult Family Care Homes, including links to general information, provider guidelines, and Adult Residential Services law.  
[http://www.wvdhhr.org/bcf/children\\_adult/ars/provider\\_afc.asp](http://www.wvdhhr.org/bcf/children_adult/ars/provider_afc.asp)

West Virginia Department of Health and Human Services, Office of Health Facility Licensure and Certification website: Approved Medication Assistive Personnel guidelines with links to resources and legislative rules.  
<https://ohflac.wv.gov/Programs/AM.html>

## Information Sources

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<sup>130</sup> Social Security Administration. *State Assistance Programs for SSI Recipients*, January 2011.  
[http://www.socialsecurity.gov/policy/docs/progdesc/ssi\\_st\\_asst/2011/wv.html](http://www.socialsecurity.gov/policy/docs/progdesc/ssi_st_asst/2011/wv.html). ALRs used to be called personal care homes and residential board and care, the terms used by the Social Security Administration. Current information about the amount of the supplement was not available online or from other sources. A state source said that the PNA was about \$131 a month in 2014.

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## WISCONSIN

### Licensure Terms

Assisted Living Facilities

### General Approach

The state licenses, certifies, registers, and regulates four types of assisted living settings and programs, including adult day care.<sup>131</sup> The Wisconsin Department of Health Services, Bureau of Assisted Living, Division of Quality Assurance, regulates community-based residential facilities (CBRFs), residential care apartment complexes (RCACs), and adult family homes.

CBRFs are licensed based on: (1) size--small, 5-8 beds; medium, 9-20 beds; and large, 21 or more beds; and (2) class--whether residents are ambulatory, semi-ambulatory, or non-ambulatory, and able to mentally and physically respond to an electronic fire alarm and exit the facility without assistance or verbal or physical prompting. If serving more than one resident group, an applicant for a license must provide an explanation acceptable to the Department of how the resident groups are compatible with one another.

RCACs provide each resident with an independent apartment in a setting that must be home-like and residential in character. RCACs are not licensed or monitored; they only have to register with the Department. To be reimbursed by Medicaid, RCACs must be certified as being in compliance with all applicable federal, state, and local licensing, building, zoning, and related requirements, including the requirements of the Medicaid Community Waivers Manual.

*Adult Foster Care.* The Department also licenses adult family homes, which are private residences in which the care provider--whose primary domicile is this residence--furnishes care and maintenance above the level of room and board to 3-4 adults who are not related to the licensee. Homes serving 1-2 individuals do not need to be licensed but if they want to receive public funding, they are regulated by individual county Human Services departments. No more than 7 hours per week of nursing care per resident may be provided in this setting. *Regulatory provisions for adult family homes are not included in this profile but a link to the provisions can found at the end.*

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<sup>131</sup> Wisconsin considers adult day care to be a type of assisted living.

*This profile includes summaries of selected regulatory provisions for RCACs and CBRFs. The complete regulations are available online through the links provided at the end.*

## Definitions

**Community-based residential facilities** provide care, treatment, and other services to five or more unrelated adults who need supportive or protective services or supervision because they cannot or do not wish to live independently yet do not need the services of a nursing home or a hospital. CBRFs are limited to those who do not require care above intermediate nursing care or more than 3 hours of nursing care per week, unless there is a waiver approved by the Department.

CBRFs provide a living environment that is as home-like as possible and the least restrictive of each resident's freedom, and is compatible with the resident's need for care and services. Residents are encouraged to move toward functional independence in daily living or to continue functioning independently to the extent possible.

**Residential care apartment complexes** consist of five or more independent apartments, each of which has an individual, lockable entrance and exit; a kitchen, including a stove; individual bathroom, sleeping, and living areas; and provide residents up to 28 hours per week of personal, supportive, and nursing services that are appropriate to the needs, abilities, and preferences of individual residents. RCACs operate in a manner that protects residents' rights, respects resident privacy, enhances resident self-reliance, and supports resident autonomy in decision-making, including the right to accept risk.

An RCAC does not include a nursing home or a CBRF, but may be physically part of a structure that is a nursing home or CBRF.

## Resident Agreements

**Community-Based Residential Facilities.** The resident agreement must be provided prior to move-in or within 5 days of an emergency admission. The agreement must cover the services provided; the basic daily or monthly rate; payment and refund policies; security deposits, entry fees, and bed hold fees (if any); and discharge policies.

**Residential Care Apartment Complexes.** A services agreement must include information about fees, the services that will be provided, optional services and their cost, and facility policies and procedures.

## Disclosure Provisions

**Community-Based Residential Facilities.** A program statement must disclose the facility type (size and class); services provided; facility contact; employee availability, including 24-hour staffing patterns and the availability of a licensed nurse, if any; and whether an entrance fee is required. A copy of the resident's rights and house rules must be provided prior to and upon move-in.

A licensed facility that markets or otherwise promotes itself as providing specialized services, 24 hours per day, in a specialized unit, for residents with a diagnosis of Alzheimer's disease or other dementia, must complete a disclosure form. The regulations specify individuals with dementia as one of several specific groups that may be served and requirements for serving them. As part of the licensing process, facilities serving people with dementia must prepare a full description of the special needs of the residents to be served and the care and services to be offered.

**Residential Care Apartment Complexes.** Facilities must provide prospective residents a schedule of charges and fees for rent, meals, and services; and required deposits, refund policies, and notification procedures for fee increases.

## Admission and Retention Policy

**Community-based residential facilities** can admit and provide services to individuals of advanced age, and those with dementia, developmental disabilities, mental health problems, physical disabilities, traumatic brain injury, AIDS, Alcohol and Other Drug Abuse, correctional clients, pregnant women needing counseling, and/or the terminally ill. CBRFs must ensure that residents of different ages, development levels, or behavior patterns, as identified in their assessment and individualized service plans (ISPs), are compatible.

Facilities may not admit or retain persons who: (1) are confined to bed; (2) are destructive to property or self; (3) are physically or mentally abusive to others, unless the facility has sufficient resources to care for such an individual and is able to protect the resident and others; (4) have physical, mental, psychiatric, or social needs that are not compatible with the CBRF resident group or with the care, treatment, or services offered by the CBRF; and (5) present an imminent risk of serious harm to the health or safety of the resident, other residents, or employees, as documented in the resident's record.

Facilities may not have more than four residents, or 10 percent of the licensed capacity, whichever is greater, who need more than 3 hours of nursing care per week, or who need care above intermediate level nursing care for more than 30 days, unless the facility has obtained a waiver from the Department or the Department's decision regarding the waiver request is pending.

**Residential Care Apartment Complexes.** Unless residents are admitted to share an apartment with a competent spouse or other person who has legal responsibility, facilities may not admit persons who have a court determination of incompetence and are subject to guardianship; have an activated power-of-attorney for health care; or have been found by a physician or psychologist to be incapable of recognizing danger, summoning assistance, expressing need, or making care decisions.

A facility may retain a resident who becomes incompetent or incapable of recognizing danger, summoning assistance, expressing need, or making care decisions, under the following conditions:

- Adequate oversight, protection, and services are provided.
- The resident has an appointed guardian, or an activated power-of-attorney for health care, or a durable power-of-attorney. The activated power-of-attorney for health care or durable power-of-attorney must, either singly or together, substantially cover the person's areas of incapacity.
- Both the service agreement and risk agreement are signed by the guardian and by the health care agent or the agent with power-of-attorney, if any.

Facilities may discharge residents for several reasons, including: the facility cannot meet their needs; they need more than 28 hours of services per week; their condition requires the immediate availability of a nurse 24 hours per day; their behavior poses an immediate threat to the health or safety of self or others; they refuse to cooperate in a physical examination; they refuse to enter into or revise, when needed, a negotiated risk agreement; or they are adjudicated incompetent, have an activated power-of-attorney for health care, or have been found to be incapable of recognizing danger, summoning assistance, expressing need or making care decisions by two physicians, or by one physician and one licensed psychologist who have personally examined the resident and signed a statement specifying that the person is incapable.<sup>132</sup>

## Services

**Community-based residential facilities** must provide general services, including supervision, information and referral, leisure time activities, transportation, and health monitoring; resident-specific services, including personal care, activity programming for persons with dementia,<sup>133</sup> independent living skills, behavior management, communication skills, and up to 3 hours of nursing care per week (unless hospice is involved); and medication assistance and administration.

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<sup>132</sup> Some provisions in this and the two preceding paragraphs are contradictory; the state will clarify these provisions in 2015.

<sup>133</sup> Structured activity programming must be integrated into the daily routines of residents with irreversible dementia.

**Residential care apartment complexes** must provide a minimum service package that includes housekeeping, access to medical services, personal services, including assistance with all activities of daily living; and nursing services, including health monitoring and medication administration. Services must be sufficient to meet the care needs identified in the resident service agreements, resident's unscheduled care needs, and to provide emergency services as needed 24 hours a day. The services provided--which include staff time attributable to providing or arranging supportive, personal, and nursing services, including nursing assessment, documentation, and consultation and standby assistance--cannot exceed 28 hours a week. Social, and recreational activities are not counted toward the 28-hour limit. Facilities may choose to provide services above the minimum required level and residents have the right to contract for or arrange for additional services outside the service agreement and above the 28-hour limit.

### **Service Planning**

**Community-Based Residential Facilities.** Prior to admission, CBRFs must assess each resident's needs, abilities, and physical and mental condition. Reassessments must be conducted at least annually, and when residents have a change in needs, abilities, or condition. Upon admission, the CBRF must develop a temporary service plan to meet immediate needs, and a comprehensive ISP within 30 days after admission. The plan must specify which program services will be provided to meet the resident's needs as identified by the assessment and the frequency with which each service will be provided.

**Residential Care Apartment Complexes.** Prior to admission, the facility must conduct a comprehensive assessment to inform the development of a service plan and risk agreement. The assessment covers: physical health; functional limitations and capacities; medication and the ability to self-administer; nutritional status and needs; mental and emotional health; behavior patterns; social and leisure needs and preferences; strengths, abilities, and capacity for self-care; situations or conditions that could put the resident at risk; and the type, amount, and timing of services desired by the resident.

The risk agreement identifies situations or conditions known by the facility to arise from the resident's preferences that are contrary to the facility's advice, how they will be accommodated, alternatives offered to reduce the risk, the agreed upon course of action, and the resident's understanding and acceptance of responsibility.

### **Third-Party Providers**

**Community-based residential facilities** may provide or contract for services. Residents may enter into contracts with outside providers as long as the contract agency complies with facility policies and procedures.

**Residential care apartment complexes** may provide or contract for services to meet the care needs identified in the resident service agreement. Residents may contract for additional services not included in the service agreement, as long as the providers comply with applicable facility policies and procedures. Services arranged directly by an individual resident from a provider other than the RCAC must not count toward the limit on the amount of services provided by a facility.

A facility may not limit the amount of hospice care a resident receives or the amount of unpaid services provided by the residents' family or friends. A facility may not limit the amount of recuperative care which a resident receives, provided the recuperative care will not raise the total service level above 28 hours per week for more than 90 days.

## Medication Provisions

**Community-Based Residential Facilities.** Residents may self-administer medications unless they have been found incompetent or do not have the physical or mental capacity to self-administer as determined by the resident's physician. When medication administration is supervised by a registered nurse (RN), practitioner, or pharmacist, the CBRF must ensure that these individuals coordinate, direct, and inspect the medication administration process and the medication administration system.

When medication administration is not supervised by an RN, practitioner, or pharmacist, the CBRF must arrange for a pharmacist to package and label a resident's prescription medications in unit dose. Injectables, nebulizers, stomal and enteral medications, and medications, treatments, or preparations delivered vaginally or rectally must be administered by an RN or by a licensed practical nurse (LPN) within the scope of their license, or by non-licensed employees if delegated by a licensed nurse in accordance with the state's practice standards for RNs and LPNs.

Any employee who manages, administers, or assists residents with prescribed or over-the-counter medications must complete training in medication administration and management prior to assuming these job duties.

**Residential Care Apartment Complexes.** Facilities can offer medication administration (giving or assisting residents in taking prescription and non-prescription medications in the correct dosage, at the proper time, and in the specified manner) and medication management (oversight by a nurse, pharmacist, or other health care professional to minimize risks associated with use of medications.) Medications can be administered by an RN or as a delegated task to unlicensed staff, under the supervision of a nurse or pharmacist.

## Food Service and Dietary Provisions

**Community-based residential facilities** must provide at least three nutritious meals a day and a nutritious snack that meet the recommended dietary allowances based on current dietary guidelines for Americans, and must meet residents' special dietary needs. Therapeutic diets must be provided if ordered by a physician.

**Residential care apartment complexes** must provide meals and snacks.

## Staffing Requirements

### **Community-Based Residential Facilities**

**Type of Staff.** An *administrator* must be responsible for the management and day-to-day operation of the CBRF, and is responsible for the training and ensuring the competency of all employees, including *resident care staff* who provide direct care to residents.

**Staff Ratios.** *No minimum ratios.* Facilities must provide employees in sufficient numbers on a 24-hour basis to meet residents' needs as defined in their ISPs. At least one qualified resident care staff must be on-duty whenever one or more residents are present, and at least one qualified resident care staff must be on-duty and awake if at least one resident in the CBRF needs constant or intermittent supervision or care, or if the evacuation capability of at least one resident is 4 minutes or more.

### **Residential Care Apartment Complexes**

**Type of Staff.** Each facility must have a *service manager* who is responsible for day-to-day operations, including ensuring that the services provided are sufficient to meet resident needs and are provided by qualified persons; that staff are appropriately trained and supervised; that facility policies and procedures are followed; and that the health, safety, and autonomy of the residents are protected.

**Staff Ratios.** *No minimum ratios.* The number, assignment, and responsibilities of all staff must be adequate to provide all services identified in the residents' service agreements, including assisting residents with unscheduled care needs.

## Training Requirements

**Community-Based Residential Facilities.** Before an employee performs any job duties, they must have orientation training regarding facility policies and procedures and job responsibilities. Minimum initial training consists of Department-approved training in medication management, standard precautions, fire safety, and first-aid. In addition, the facility must provide, obtain, or otherwise ensure adequate training for all employees in

a wide range of topics, including resident rights, reporting abuse, and challenging behaviors.

Resident care staff involved in certain tasks must have training in needs assessment of prospective residents, development of service plans, and provision of personal care.

The administrator and resident care staff must receive 15 hours annually of continuing education relevant to their job responsibilities. Additionally, all staff must have appropriate training about the physical, functional, and psychological characteristics of the populations they serve, including persons with dementia.

***Residential Care Apartment Complexes.*** All facility staff must have training in safety procedures, including fire safety, first-aid, universal precautions, and the facility's emergency plan; and in the facility's policies and procedures relating to resident rights. Staff providing services to residents must have documented training or experience in: (1) physical, functional, and psychological characteristics associated with aging or likely to be present in the resident population, including persons with dementia, and their implications for service needs; (2) the purpose and philosophy of assisted living, including respect for resident privacy, autonomy and independence; and (3) assigned duties and responsibilities, including the needs and abilities of individual residents for whom staff will be providing care.

## Provisions for Apartments and Private Units

***Community-based residential facilities*** have both private and double-occupancy bedrooms with shared bathrooms. Small and medium facilities must offer one bathroom and shower facility for every eight residents. Large facilities must have one toilet, bath, and shower for every eight male residents and every eight female residents. Each facility must have at least one toilet, sink, and tub or shower for ten residents.

***Residential Care Apartment Complexes.*** All units must be independent with a lockable entrance/exit. Multiple-occupancy of an independent apartment is limited to a spouse or a roommate chosen at a resident's initiative. The kitchen must be a visually and functionally distinct area of the unit. Microwave ovens may be used instead of stoves. The sleeping and living areas also have to be visually and functionally distinct but are not required to be separate rooms. Each apartment must have a bathroom that has floor-to-ceiling walls, a door, a toilet, a sink, and a bathtub or shower.

## Provisions for Serving Persons with Dementia

***Dementia Care Staff and Facility Requirements.*** *No provisions identified.*

***Dementia Staff Training.*** CBRFs that serve persons with dementia must provide training within 90 days of employment, to include but not be limited to, the characteristics of persons with dementia and their specific service, medication, and treatment needs.

## Background Checks

***Community-Based Residential Facilities.*** At the time of hire, employment, or contract and every four years after, the licensee must conduct and document a caregiver background check. A licensee must not employ or contract with any person--or permit a non-client to reside at the CBRF--if the person has been convicted of certain crimes or offenses, or has a governmental finding of misconduct, unless the person has been approved under the Department's rehabilitation process.

***Residential Care Apartment Complexes.*** Facilities must conduct a criminal record check with the Wisconsin Department of Justice, and with the registry for nurse aides, home health aides, and hospice aides for managers, service providers, and all staff who will have direct contact with residents.

## Inspection and Monitoring

***Community-Based Residential Facilities.*** Department licensing specialists inspect CBRFs every 2 years, via unannounced surveys, in response to complaints, and to determine if any noted deficiencies have been corrected.

***Residential Care Apartment Complexes.*** The Department has the authority--but is not required--to inspect registered RCACs to determine compliance with regulatory requirements. Residents in registered facilities must be notified that the Department does not regularly visit or inspect them. However, the Department inspects RCACs in response to all complaints.

The Department conducts periodic inspections of RCACs that are certified as Medicaid providers every 2 years to determine compliance with certification requirements.

## Public Financing

The Medicaid State Plan covers personal care services in certified RCACs and in CBRFs with 20 or fewer beds. The Elderly and Physically Disabled 1915(c) Waiver program, the Community Options 1915(c) Waiver program, and the Medicaid managed care 1915(b)(c) Family Care Waiver program for the aged and physically disabled cover services in RCACs, CBRFs, and adult family homes. The state-funded Community Option Program funds services only in CBRFs and adult family homes.

## **Room and Board Policy**

The state provides a monthly Supplemental Security Income (SSI) exceptional expense (SSI-E) payment of \$95.99 to an SSI recipient who needs at least 40 hours of primary long-term support services each month, whose expenses are greater than the SSI-E payment level, and who lives in a licensed or certified adult family/foster home, a CBRF of 20 beds or less, or a certified RCAC.<sup>134</sup>

The state limits the amount that can be charged for room and board to Medicaid waiver participants to the SSI federal benefit plus the SSI-E payment (if any) less a personal needs allowance of \$45 a month, which is retained by the resident.

The state agency allows family supplementation to cover room and board, a private room, or for service enhancements that are not covered by the Medicaid payment.

## **Location of Licensing, Certification, or Other Requirements**

*The following Wisconsin Department of Health website has links to all of the regulations for the two types of assisted living regulations summarized in this profile.* [January 16, 2015]

<http://dhfs.wisconsin.gov/bqaconsumer/AssistedLiving/AsLivindex.htm>

*Direct links to the regulations follow.*

*Wisconsin Statutes, Chapter 50, Subchapter 1: Care and Service Residential Facilities.*

[January 1, 2015]

<http://docs.legis.wisconsin.gov/statutes/statutes/50.pdf>

*Wisconsin Statutes, Chapter DHS 83: Community-Based Residential Facilities.* [December 2011]

[http://docs.legis.wisconsin.gov/code/admin\\_code/dhs/030/83.pdf](http://docs.legis.wisconsin.gov/code/admin_code/dhs/030/83.pdf)

*Wisconsin Administrative Code, Chapter DHS 89: Residential Care Apartment Complexes.*

[January 2012]

[https://docs.legis.wisconsin.gov/code/admin\\_code/dhs/030/89/II/24](https://docs.legis.wisconsin.gov/code/admin_code/dhs/030/89/II/24)

*Wisconsin Administrative Code, Chapter DHS 88: Licensed Adult Family Homes.* [May 2011]

[https://docs.legis.wisconsin.gov/code/admin\\_code/dhs/030/88/07](https://docs.legis.wisconsin.gov/code/admin_code/dhs/030/88/07)

*Exceptional Expense Supplement for Members of Supplemental Security Income in Wisconsin.*

[November 15, 2014]

<https://www.dhs.wisconsin.gov/ssi/ssi-e.htm>

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<sup>134</sup> The state also pays this supplement to individuals in other living arrangements.

## Information Sources

Alfred C. Johnson  
Director  
Bureau of Assisted Living  
Department of Health Services

Phoebe Hefko  
Legal Services Developer/SHIP Director  
Wisconsin Department of Health Services  
Bureau of Aging and Disability Resources

## WYOMING

### Licensure Terms

Assisted Living Facilities

### General Approach

The Department of Health, Office of Healthcare Licensing and Surveys, licenses assisted living facilities (ALFs). The rules do not specify a minimum number of residents needed to trigger licensure requirement. There are two levels of licensure: Level 1 is for ALFs that do not have a secure unit, and Level 2 is for ALFs that have a secure unit and are required to meet special staffing and staff education requirements defined under the rules. The licensing level is used for regulatory purposes only.

The state is currently revising the regulations. The process for finalizing the revisions may take several months because the state has to obtain comments on the proposed changes and if the comments lead to further revisions, the state may have to obtain a second round of comments.

*Adult Foster Care (AFC).* The state has licensure requirements for AFC homes that provide care and supervision for up to five adults who are not related to the provider by blood, marriage or adoption (except in certain circumstances), and who need long-term care in a home-like atmosphere. The AFC home must be the primary residence of the licensee. Residents in the home must have private rooms, which may be shared with spouses, and must have individual accessible bathrooms. At the current time, the state has no AFC providers. *Regulatory provisions for AFC are not included in this profile but a link to the provisions can found at the end.*

*This profile includes summaries of selected regulatory provisions for ALFs. The complete regulations are online at the links provided at the end.*

### Definitions

**Assisted living facility** means a non-institutional dwelling operated by a person, firm, or corporation engaged in providing limited nursing care, personal care, and boarding home care, but not habilitative care, for persons not related to the owner of the facility.

**Boarding home** means a non-institutional dwelling or rooming house operated by any person, firm or corporation engaged in the business of operating a home for the

purpose of letting rooms for rent and providing meals and personal daily living care, but not habilitative or nursing care, for persons not related to the owner. A boarding home does not include a lodging facility or an apartment in which only room and board is provided.

## **Resident Agreements**

A resident agreement is not required. Facilities must provide an assistance plan that specifies the type, frequency, and duration of services that will be provided and the expected outcome.

## **Disclosure Provisions**

*No provisions identified.*

## **Admission and Retention Policy**

Individuals may only be admitted if accompanied by a medical history and physical that is completed by a physician or physician extender within 90 days prior to admission.

Individuals cannot be admitted or retained if the facility cannot provide the level of care needed and cannot meet their needs, or if they need any of the following services: (1) continuous assistance with transfers and mobility; (2) total assistance with feeding, bathing, or dressing; (3) catheter or ostomy care; (4) monitoring of continuous oxygen; (5) supervision to prevent wandering that jeopardizes health and safety; (6) wound care requiring sterile dressings; (7) Stage II or higher skin care; (8) highly restrictive therapeutic diets (e.g., renal diets); and (9) incontinence care. Individuals who need limited nursing services may be served, defined as the level of care provided by a certified nursing assistant (CNA) within the scope of ALF licensure.

Residents may be discharged if they exhibit inappropriate social behavior, such as frequent aggression, abuse, or disruptive behavior; or demonstrate chemical abuse that places them or others at risk; or have a documented established pattern, in the facility, of not abiding by agreements necessary for assisted living; or engage in behavior that poses an imminent danger to self and/or to others.

Individuals may not be admitted to or retained in a secure dementia unit if they score more than 20 or less than 10 on the Mini-Mental State Exam (MMSE); if they need ongoing nursing care; or if they require more than limited assistance to evacuate the building.

## Services

Facilities must provide core services, which include: assistance with transportation; assistance with obtaining medical, dental, and optometric care, and social services; assistance in adjusting to group living activities; provision of appropriate recreational activities in and out of the facility; partial assistance with personal care (e.g., bathing, shampoos); limited assistance with dressing; minor non-sterile dressing changes; Stage I skin care; infrequent assistance with mobility (the resident may use an assistive device, such as wheelchair, walker, or cane); cuing guidance with activities of daily living (ADLs) for the visually impaired resident, or the intermittently confused and/or agitated resident requiring occasional reminders of time, place, and person; limited care to residents who can independently manage catheter or ostomy care and incontinence; and 24-hour monitoring of each resident.

To operate a secure dementia unit, ALFs must be licensed as a Level 2 facility and must meet additional Level 2 requirements. In addition to Level 1 core services, Level 2 must provide the following services: increased assistance with ADLs (dressing, grooming, bathing, mobility, toileting); assistance as needed to maintain nutrition and hydration status; services necessary to maintain the highest continence level and skin integrity; and an activity program developed by an activities professional, at least on a consultation basis, who has been trained in dementia-specific activities. The program must be evaluated and revised as needed to meet residents' needs.

### ***Service Planning***

A registered nurse (RN) must complete an assessment using a state-required screening tool (the Long-Term Care 102 Form) no earlier than 1 week prior to admission and, at a minimum, annually or upon a significant change in condition. The assessment must determine all of the individual's needs.

Assessment results are used to develop, review, and revise the resident's individualized assistance plan. The assistance plan must include information about who will provide the care/services; what, when, and how care/services will be provided; and the expected outcome.

Residents must be included in the development of their individual assistance plan to the best of their abilities; a relative or other interested party may participate. The plan must reflect assessed needs and resident decisions (including resident's level of involvement); and support the principles of dignity, privacy, choice, individuality, independence, and home-like environment.

In addition to all other required assessments, Level 2 facilities must provide an MMSE for each individual considered for admission to the secure unit, and the individual must score between 20 and 10 points. The MMSE must be performed at least annually and upon any significant change in the resident's mental or physical condition.

### ***Third-Party Providers***

Residents may receive services from an outside entity for care beyond those specified in Assisted Living Program Administration Rules. Services include, but are not limited to: hospice care, Medicare/Medicaid certified home health care, private duty care, and Medicaid waiver program services. These services must be arranged by the appropriate professional and be incorporated into the resident's assistance plan. The resident's choice of providers must be honored.

A contract between the resident, the facility, and all outside service providers must be in place prior to the time of service delivery. This contract must clearly delineate the services that will be provided, when they will be provided, and by whom they will be provided. Additionally, the service plan must include family members/significant others who participate in the delivery of services.

## **Medication Provisions**

An RN is responsible for the supervision and management of all medication administration as required by the Wyoming Nurse Practice Act, and the Wyoming Board of Nursing Rules and Regulations. An RN must review residents' medications every 2 months, whenever new medications are prescribed, and when medications are changed.

The RN must document whether a resident is able to self-administer medications. The facility staff are responsible for providing necessary assistance to residents deemed capable of self-medicating, but are unable to take oral medications because of functional limitations. Non-licensed staff can assist only with oral medications. Medication assistance may include: reminders, removing the medication from a container, assistance with removing caps, assisting with the removal of a medication from a container for residents with a disability that prevents independence in this act, and observation of the resident taking the medication

For residents unable to self-administer, medications may be administered by an RN or a licensed practical nurse (LPN).

## **Food Service and Dietary Provisions**

Facilities must provide a minimum of three balanced, palatable, properly prepared, and attractively served meals that meet the recommended dietary allowances. Special diets may be ordered by a physician or a registered dietician.

Facilities that admit residents who need therapeutic or mechanically modified diets must employ or contract with a registered dietitian who must approve written menus and dietary modifications; approve special diet needs; plan individual diets; and provide

guidance to dietary staff in areas of preparation, service, and monitoring. The frequency of visits is determined by the residents' needs and the competency of the dietary staff, but must include at least a monthly on-site review of dietary services.

## Staffing Requirements

**Type of Staff.** Facilities must designate a *manager* who is responsible for the facility's day-to-day operations and staff development and training. If the ALF does not employ a *registered nurse*, it must contract with one to provide residents' initial and updated assessments, assistance plans, periodic reviews, and medication management.

**Staff Ratios.** *No minimum ratios.* The staffing level must be sufficient to meet the needs of all residents and to ensure the appropriate level of care is provided. Facilities must have at least one staff person on duty and awake at all times. At least one RN, LPN, or CNA must be on-duty every shift.

## Training Requirements

Facilities must provide an orientation to new employees that covers resident rights and evacuation and emergency procedures, and must also provide training and competent supervision designed to improve resident care.

Administrators must complete at least 16 hours of continuing education annually.

## Provisions for Apartments and Private Units

Apartment-style units are not required. No more than two people may share a bedroom.

Two residents may, by consent of both parties, or by approval of the appropriate responsible party, be permitted to use one bed no smaller than double size, and occupy a single-bed sleeping room.

One flush toilet and sink must be provided for every two residents and one tub and shower is required for every ten residents. One half of licensed beds must be in private rooms.

In 2009, Medicaid required apartment-style living units shared only by resident choice.<sup>135</sup>

## Provisions for Serving Persons with Dementia

***Dementia Care Staff.*** A licensed nurse must be on-duty on all shifts to administer PRN medications and to perform ongoing resident evaluations in order to ensure appropriate, timely interventions. The nurse may be an LPN if an RN is available on the premises or reachable by phone. At least one staff member with specialized training (described below) must be available on the unit at all times to provide supervision and care to the residents, as well as to assist the residents to evacuate the facility.

***Dementia Staff Training.*** In addition to meeting all Level I training requirements, direct care staff in secure dementia units must receive additional documented training in the following areas:

- The facility philosophy and approaches to providing care and supervision of persons with severe cognitive impairment.
- Techniques for minimizing challenging behaviors, such as wandering and delusions.
- Therapeutic programming to support the highest level of residents' functioning.
- Promoting residents' dignity, independence, individuality, privacy, and choice.
- Identifying and alleviating safety risks to residents.
- Recognizing common side effects and reactions to medications.
- Techniques for dealing with bowel and bladder aberrant behavior.

Administrators must complete at least 16 hours of continuing education annually, at least 8 of which must pertain to caring for persons with severe cognitive impairments. Staff must complete at least 12 hours of continuing education annually related to the care of persons with dementia.

***Dementia Facility Requirements.*** Facilities with secure units must meet health care occupancy requirements.

## Background Checks

All ALF staff must successfully complete, at a minimum, a Wyoming Division of Criminal Investigation fingerprint background check and a Department of Family Services Central Registry Screening before direct resident contact.

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<sup>135</sup> Mollica, R.L. (2009). *State Medicaid Reimbursement Policies and Practices in Assisted Living*, National Center for Assisted Living, American Health Care Association. <http://www.ahcancal.org/ncal/resources/Documents/MedicaidAssistedLivingReport.pdf>. Current information about Medicaid requirements for private apartments was not available online or from other sources.

## Inspection and Monitoring

The Survey Division's designated representative performs initial and periodic surveys for licensure renewal. Facilities are surveyed at least annually and as-needed to investigate complaints. When conditions are such that residents' needs are not being met by the ALF, the Licensing Division may place a Departmental-approved monitor at the ALF owner's expense to ensure that residents' health or safety is not in jeopardy.

## Public Financing

The state covers services in both levels of ALFs through a Medicaid 1915(c) waiver program called Assisted Living Facility Home and Community-Based Services.

### ***Room and Board Policy***

In 2009, room and board charges were determined by the facility and were not capped by state policy. The state did not provide a supplement to residents of ALFs nor specify a personal needs allowance (PNA). Family supplementation was allowed to help pay for room and board costs.<sup>136</sup>

## Location of Licensing, Certification, or Other Requirements

Rules and Regulations for Licensure of Assisted Living Facilities, Chapter 4.

<http://soswy.state.wy.us/Rules/RULES/4451.pdf>

Wyoming Department of Health, Aging Division Rules for Program Administration of Assisted Living Facilities, Chapter 12. [December 12, 2007]

<http://soswy.state.wy.us/Rules/RULES/6796.pdf>

Wyoming Department of Health website: Assisted Living Facility–Wyoming Licensure Information.

[http://www.health.wyo.gov/ohls/Wyoming\\_Assisted\\_Living.html](http://www.health.wyo.gov/ohls/Wyoming_Assisted_Living.html)

Department of Health, Rules for Pilot Project–Adult Foster Care Homes, Chapter 13.

<http://soswy.state.wy.us/Rules/RULES/7158.pdf>

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<sup>136</sup> Mollica, R.L. (2009). *State Medicaid Reimbursement Policies and Practices in Assisted Living*, National Center for Assisted Living, American Health Care Association. <http://www.ahcancal.org/ncal/resources/Documents/MedicaidAssistedLivingReport.pdf>. Current information about Medicaid room and board policies, the PNA, and family supplementation policy, was not available online or from other sources.

## Information Sources

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# COMPENDIUM OF RESIDENTIAL CARE AND ASSISTED LIVING REGULATIONS AND POLICY: 2015 EDITION

## Files Available for This Report

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### SEPARATE STATE PROFILES

[**NOTE:** These profiles are available in the full HTML and PDF versions, as well as each state available as a separate PDF listed below.]

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