

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

COMPENDIUM OF RESIDENTIAL CARE AND ASSISTED LIVING REGULATIONS AND POLICY: 2015 EDITION

Files Available for This Report

FULL REPORT

Executive Summary	http://aspe.hhs.gov/execsum/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-executive-summary
HTML	http://aspe.hhs.gov/basic-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition
PDF	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition

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.]

Alabama	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-alabama-profile
Alaska	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-alaska-profile
Arizona	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-arizona-profile
Arkansas	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-arkansas-profile
California	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-california-profile
Colorado	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-colorado-profile
Connecticut	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-connecticut-profile
Delaware	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-delaware-profile
District of Columbia	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-district-columbia-profile
Florida	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-florida-profile

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Indiana	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-indiana-profile
Iowa	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-iowa-profile
Kansas	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-kansas-profile
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North Dakota	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-north-dakota-profile
Ohio	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-ohio-profile
Oklahoma	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-oklahoma-profile
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Pennsylvania	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-pennsylvania-profile
Rhode Island	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-rhode-island-profile
South Carolina	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-south-carolina-profile
South Dakota	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-south-dakota-profile
Tennessee	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-tennessee-profile
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