

## **SECTION 3.**

### **STATE SUMMARIES**

## NOTES ON STATE SUMMARIES

Each state summary includes the regulatory or statutory citation and category name and includes information on the following, when available:

- a description of the state’s approach to assisted living or board and care;
- a summary of the state’s approach to AFC;
- linkages to relevant websites;
- the term(s) used to define facilities;
- unit requirements;
- tenant admission and retention policies;
- nursing home admission criteria;
- services that may be provided and negotiated risk agreements;
- dietary provisions and policies;
- tenant agreements;
- provisions for people with dementia;
- medication assistance;
- financing, including the availability of Medicaid reimbursement for low income residents;
- staffing requirements;
- training requirements for staff;
- background checks;
- monitoring of facilities; and
- licensing fees.

The information for each state is based on statutes, regulations, and draft regulations. Information based on draft material is presented to indicate the potential direction of state policy. Final rules may vary from the source material. The Medicaid nursing home LOC criteria are included to allow comparison with admission/retention criteria and highlight the functional eligibility requirements for HCBS waivers (several states use the Medicaid state plan to pay for services in residential settings, which has different financial and functional eligibility criteria than waivers).

**[NOTE:** Links listed in the state summaries take the user to another website, and were active at the time this Compendium was written. HHS and ASPE are not responsible for the content on these other websites.]

# ALABAMA

**Citation** Assisted Living: Chapter 420-5-4, Alabama Department of Public Health  
Specialty Care Assisted Living Facilities: Chapter 420-5-20

## General Approach and Recent Developments

Sections of the regulations governing building requirements for ALFs and specialty care facilities were revised in July 2003. Revisions to incident investigations were effective in 2004. Other minor changes were made in 2005, 2006 and 2007. The regulations license three categories of facilities:

- Congregate ALFs serve 17 or more adults;
- Group ALFs serve 4-16 adults; and
- Family ALFs serve 2-3 adults.

Specialty care facilities must receive a separate certification from the Board of Health.

The state implemented a system for rating facilities in 2004. Using survey findings, facilities are rated green if they have minor deficiencies; yellow if they have a problem that could pose a substantial risk to residents; or red if the survey found serious risk to residents. Facilities rated red receive full surveys. About 10% of the facilities receive a “green” rating; 30% receive a “red” rating and require further action and the rest are rated “yellow.” Shorter surveys are conducted for facilities rated green or yellow. See sample at the end of the summary. General survey findings and a profile score are posted on the licensing agency’s website.

The Department of Health is evaluating whether the regulations adequately address safety related issues (e.g., if residents have recurring problems with falls) should the rules limit admission/retention or should the staffing and training requirements be changed. The Department, Board of Nursing and Legislature are considering proposals to allow unlicensed staff to administer medications either through nurse delegation or creation of medication technician category.

## Adult Foster Care

The Department of Human Resources, Adult Protective Services unit sets policy, standards and oversight for adult foster homes that serve one resident.

Web Address	Content
<a href="http://www.adph.org/providers/">http://www.adph.org/providers/</a>	Rules, list, application form
<a href="http://adphnotes.state.al.us/hcfweb.nsf">http://adphnotes.state.al.us/hcfweb.nsf</a>	Survey findings

Category	Supply					
	2007		2004		2002	
	Facilities	Units	Facilities	Units	Facilities	Units
Assisted living facilities	219	7,021	241	7,260	302	9,140
Specialty care facilities	88	2,488	94	2,616	25	598

## Definition

“*Assisted living facility*” means an individual, individuals, corporation, partnership, limited partnership, a limited liability company or any other entity that provides or offers to provide residence and personal care to two or more individuals who are in need of assistance with ADLs. Exceptions to this definition are: Individuals who provide residential and personal care services solely to persons to whom they are personally related, shall not be deemed to be an ALF. This exception is only for individuals, and does not apply to corporations, partnerships, limited partnerships, limited liability companies, or any other organized entity or business.

Building requirements vary for congregate ALFs (17 or more), group assisted living facilities (4-16) and family ALFs (2-3 adults).

*Specialty Care Assisted Living Facility* means a facility that meets the definition of ALF but which is specially licensed and staffed to permit it to care for residents with a degree of cognitive impairment that would ordinarily make them ineligible for admission or continued stay in an ALF.

## Unit Requirements

The regulations do not require separate living and sleeping quarters. Private bedrooms without sitting areas must provide 80 square feet, and double rooms 130 square feet. If sitting areas are included, private rooms must be 160 square feet and double rooms 200 square feet. Bathtubs or showers must be available for every eight beds; lavatories and toilets for every six beds. Lockable doors are permitted. No more than two people may share a room.

## Admission/Retention Policy<sup>1</sup>

An ALF shall not admit nor once admitted shall it retain a resident who requires medical or skilled nursing care for an acute condition or exacerbation of a chronic condition which 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.
2. The individual is incapable of performing some or all tasks related to his or her own care due to limitations of mobility or dexterity but the individual has sufficient cognitive

---

<sup>1</sup> See notes at the beginning of Section 3.

ability to direct his or her own care and the individual is able to direct others and does direct others to provide the physical assistance needed to complete such tasks, and the facility staff is capable of providing such assistance and does provide such assistance.

Facilities may not serve individuals with acute infectious pulmonary disease, such as influenza or active tuberculosis, or other communicable diseases, and individuals with infected draining wounds until the wound is sufficiently healed.

## **Nursing Home Admission Policy**

A physician must certify the need for continuing stay. Nursing care is required on a daily basis that as a practical matter can only be provided in a nursing facility on an in-patient basis. Residents must need two of the following services on a regular basis:

- Administration of a potent and dangerous injectable medication and IV medications and solutions on a daily basis or administration of routine oral medications, eye drops, or ointment.
- Restorative nursing procedures (such as gait training and bowel and bladder training) in the case of residents who are determined to have restorative potential and can benefit from the training on a daily basis.
- Nasopharyngeal aspiration required for the maintenance of a clear airway.
- Maintenance of tracheostomy, gastrostomy, colostomy, ileostomy, and other tubes indwelling in body cavities as an adjunct to active treatment for rehabilitation of disease for which the stoma was created.
- Administration of tube feedings by naso-gastric tube.
- Care of extensive decubitus ulcers or other widespread skin disorders.
- Observation of unstable medical conditions required on a regular and continuing basis that can only be provided by or under the direction of a RN.
- Use of oxygen on a regular or continuing basis.
- Application of dressing involving prescription medications and aseptic techniques and/or changing of dressing in non-infected, post-operative, or chronic conditions.
- Comatose patient receiving routine medical treatment.

## **Services**

ALFs must provide personal care for bathing, oral hygiene, hair and nail care, shaving, laundry services, personal safety and assistance making and keeping appointments. Facilities may provide for general observation and health supervision and may arrange for or assist residents in obtaining medical attention or nursing services when needed. Home health may be provided by a certified agency as long as residents do not require hospital or nursing home care. A written plan of care is required at the time of admission based on the medical examination, diagnoses, and recommendations of the resident's treating physician. It shall document the personal care and services required from the facility. Plans of care are kept current and reviewed and updated at least annually by the attending physician.

## **Dietary**

Menus must be planned and posted one week in advance. Alternate food selections must be available for residents on medically prescribed diets, including hypertension, diabetes, hyperlipdemia, and modified consistency diets. A dietician is available for residents who need special diets. Congregate ALFs must be under the direction and supervision of a full or part-time professionally qualified dietician or a consulting dietician.

## **Agreements**

Agreements must be signed prior to or at the time of admission and include: basic charges (room, board, laundry, personal care, and services); period covered; services for which there are special charges; refund policy and termination provisions; bed hold policy and process; documentation that the resident and sponsor understand that the facility is not staffed and not authorized 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 should need skilled nursing services or care for a severe cognitive impairment as a result of a condition that is expected to last for more than 90 days, that the resident will be discharged by the facility after prior written notice; and a reminder to the resident or sponsor that the local ombudsman may be able to provide assistance if the facility and the resident or family member are unable to resolve a dispute about payment of fees or monies owed.

## **Provisions for Serving People with Dementia**

The state has separate rules for specialty care facilities. No facility may serve anyone with Alzheimer's disease or dementia unless they have a specialty care facility license. Facilities are allowed to serve residents who do not have dementia if they have readily available egress from the facility. Specialty care facilities must have a medical director, at least one RN who is responsible for staff training, resident assessment, and plans of care and medication. Minimum ratios of awake staff are specified: two staff for less than 16 residents; one staff for every eight residents for facilities with 16 or more residents from 7 a.m. to 9 p.m.; three staff from 9 p.m. to

7 a.m. for facilities with 17-24 residents; and three staff plus one for every 16 residents for facilities serving 25 or more residents. Activity programs are required. Residents must have a Physical Self Maintenance Scale score of 23 or less and may not have unmanageable behavior problems.

*Continuing Education.* All staff members of a specialty care ALF shall have at least six hours of continuing education annually. All direct care staff, including the administrator, shall have initial training and refresher training as necessary. An RN shall identify staff refresher training needs and shall provide or arrange for needed training. Prior to providing any resident care, all staff shall complete the Dementia Education and Training Act Brain Series Training developed by the Alabama Department of Mental Health and Mental Retardation or equivalent training approved by the state Health Officer. In addition to the training areas for staff in ALFs, special care staff members must receive training on: resident fire and environmental safety; specialty care ALFs Chapter 420-5-20; understanding the aging mind; basic brain function; common neuropsychiatric disorders in the elderly; basic evaluation of the dementia patient; cognitive symptoms of dementia; psychiatric symptoms of dementia; behavioral problems associated with dementia; end of life issues in dementia; dementia other than Alzheimer's; research and dementia; nutrition and hydration needs of the resident with dementia to include feeding techniques; and safety needs of residents with dementia.

## **Medication Administration**

Assistance with medications is limited to reminders, reading container labels to the resident, checking the dosage, and opening containers. Licensed nurses are allowed to administer medications for residents who are not aware of their medications.

Residents who are aware of their medications may self-administer medications. A licensed nurse may administer medication to a resident who is capable of self-administration. Facility staff may assist with the self-administration of medication. Assistance includes reminding, physically assisting by opening or helping to open a container holding oral medications, offering liquids, physically bringing a container of oral medications. Assistance with medications by staff does not include giving injections, administering eye drops, ear drops, nose drops (unless the resident is aware but has dexterity limitations), inhalers, suppositories, or enemas, telling or reminding a resident that it is time to take a PRN, or as needed medication crushing or splitting, placing medications in a feeding tube, or mixing medications with food or liquids.

## **Public Financing**

A Medicaid waiver to cover people with dementia in assisted living was approved in 2003 but was not implemented due to budget limitations.

## **Staffing**

An ALF shall employ sufficient staff and ensure sufficient staff are on duty to meet the care needs of all residents 24-hours-a-day, seven days a week. This means that an ALF must not only have a sufficiently large number of staff members to meet the care needs of all residents, it must also manage and direct the activities of staff members in a manner that results in adequate care being provided. An ALF shall likewise employ sufficient staff, ensure sufficient staff are on duty, and manage and direct staff activities in a manner that results in maintenance of a neat, clean, orderly, and safe environment at all times.

## **Training**

*Administrators.* Legislation passed in 2001 creates a Board of Examiners for Assisted Living Administrators. All administrators must be licensed which includes passing an examination and meeting education and training requirements. Existing rules require that administrators have six hours of continuing education annually. Administrators who are licensed nursing facility administrators are exempt.

*Staff.* Administrators and direct care staff receive initial and refresher training on state law and rules on ALFs; identifying and reporting abuse, neglect and exploitation; special needs of the elderly, mentally ill, and mentally retarded; basic first aid; advance directives; protecting resident confidentiality; safety and nutritional needs of the elderly; resident fire and environmental safety; and identifying signs and symptoms of dementia.

## **Background Check**

Not specified. Facilities may not hire an individual whose name appears on the nurse abuse registry.

## **Monitoring**

Facilities are monitored through licensing review and periodic inspections by the Board of Health depending on funding for inspectors. Incidents are reported through a hotline. Written reports may be requested to determine the cause of an incident or if the facility acted appropriately. Facilities are currently inspected every 2-3 years. The oversight agency is seeking additional staff to permit annual inspections.

The Alabama scoring system arranges deficiencies into three categories: routine deficiencies that have limited potential for harm; systemic or substantial risk deficiencies that have a high potential for harm; and critical deficiencies that result in actual harm and lead to mandatory enforcement. Routine deficiencies present minimal risk to residents and receive a score only if more serious deficiencies are not present. Each deficiency reduces the facility's score by one point each up to a maximum of ten points. Facilities with routine deficiencies

receive a score between 90 and 100 and are coded green. Examples of deficiencies include: the facility exceeds its licensed capacity; the facility does not properly label drugs and medicines; the facility does not have sufficient staff to meet residents' needs; the facility does not provide appropriate health observation and oversight; or the facility fails to provide appropriate assistance with self-administration of medications or uses non-licensed personnel to administer medications.

Substantial risk deficiencies are scored only when actual harm deficiencies are not present. The first substantial risk deficiency receives a score of 11 and additional substantial risk deficiencies add three additional points for up to a total of four deficiencies. Facilities that score between 80 and 90 receive a deficiency report with a yellow border.

Actual harm deficiencies are noted when residents have been injured or neglected due to inappropriate or inadequate care and mandatory enforcement is required. These deficiencies result in an enforcement action. The first actual harm deficiency reduces the facility's score by 21 points. Scores are reduced by five points for each subsequent deficiency. Inspection reports that contain citations for actual harm are printed with a red border. Eight deficiencies are listed that lead to mandatory enforcement. An additional 44 deficiencies are included in the substantial risk group and may lead to mandatory enforcement if they result in actual harm.

## **Fees**

Licensure fees for ALFs and specialty-care ALFs rising to the level of intermediate care are \$200, plus \$15 per bed.

**Alabama Department of Public Health**  
Assisted Living Facility Inspection Report (Facsimile)

Facility Name:  
City:  
Administrator:  
Date of Survey:

**TOTAL SCORE**

**90 - 100**  
**Acceptable**

A score of 90-100 indicates that the facility is generally well operated but may have one or more problems that must be corrected. A report with this score has a green border.

**80 - 89**  
**Caution**

A score of 80-89 indicates that the facility has some significant problems that need correction but it does not have safety or patient care problems that pose an immediate risk threat to residents. A report with this score has a yellow border.

**Less than 80**  
**Referred for enforcement action**

A score of LESS THAN 80 IS A FAILED SCORE and indicates that the facility has significant problems that have resulted in a referral of the facility for enforcement action. A report with this score has a red border.

# ALASKA

**Citation** Assisted living homes: Alaska Statute §47.32.010 et seq.; §47.33.01 et. seq.; 7 Alaska Administrative Code §75.010 et seq.; 7 AAC 10.010; 7 ACC 43:1058(h)  
 Medicaid waivers: Amounts of reimbursement for HCBS

## General Approach and Recent Developments

A law centralizing licensing and procedures for multiple types of entities, including assisted living homes, became law in 2004. The Assisted Living Licensing Unit was transferred from the Division of Senior and Disability Services to the Division of Public Health in 2004. Changes in the safety and sanitation requirements were effective in 2006. The Alaska BCU was created in 2007 and provides centralized background check support for programs that provide for the health, safety, and welfare of persons who are served by the programs administered by DHSS.

The state continues to support the expansion of assisted living homes into rural areas. Assistance with planning and technical support is provided wherever possible.

## Adult Foster Care

Assisted living rules include adult foster homes that serve three or more residents. The term “adult foster care” is the prior name used for what is now licensed as assisted living homes. Nothing in the regulations prohibit an assisted living home that is licensed and that serves five or fewer residents from using the term “adult foster home” or “assisted living foster home.”

Web Address	Content
<a href="http://www.legis.state.ak.us/cgi-bin/folioisa.dll/aac/query=[jump!3A!27title7chap75!27]/doc/%7B@38883%7D?">http://www.legis.state.ak.us/cgi-bin/folioisa.dll/aac/query=[jump!3A!27title7chap75!27]/doc/%7B@38883%7D?</a>	Rules
<a href="http://www.hss.state.ak.us/dph/CL/ALL/forms.htm">http://www.hss.state.ak.us/dph/CL/ALL/forms.htm</a>	Provider tools, guide
<a href="http://www.hss.state.ak.us/dph/CL/forms/default.htm">http://www.hss.state.ak.us/dph/CL/forms/default.htm</a>	Forms
<a href="http://www.hss.state.ak.us/dph/CL/PDFs/ALHomes.pdf">http://www.hss.state.ak.us/dph/CL/PDFs/ALHomes.pdf</a>	List

Category	Supply					
	2007		2004		2002	
	Facilities	Units	Facilities	Units	Facilities	Units
Assisted living homes	229	1,912	162	1,650	143	1,497

## Definition

An *assisted living home* means a residential facility that serves three or more adults 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; the department shall consider a facility to be

an assisted living home if the facility provides housing and food services to its residents; offers to provide or obtain for its residents assistance with ADLs; offers personal assistance as defined in Alaska Statutes 47.33.990; or provides or offers any combination of these services. Personal assistance services includes assistance with ADLs and/or personal assistance (help with IADLs, obtaining supportive services [recreational, leisure, transportation, social, legal, etc.], awareness of the resident's whereabouts when traveling in the community, and monitoring activities).

## **Unit Requirements**

Single occupancy units must provide 80 square feet and double occupancy units, 140 square feet. No more than two residents may share a room. A facility must meet life safety code requirements applicable for buildings of its size. Homes for six or more people must meet applicable state and municipal standards for sanitation and environmental protection. Because of the size of the state and the geographic variation within it, the licensing standards are based on community and neighborhood standards rather than a statewide standard. This allows homes to be licensed that are consistent with prevailing local housing standards.

## **Admission/Retention Policy**

Residents who have exceeded the 45 consecutive day limit for receiving 24-hour skilled nursing (see below) may continue to live at the home if the home and the resident or resident's representative have consulted with the resident's physician and discussed the consequences and risks. In addition, a revised plan without 24-hour nursing must have been reviewed by a RN. Terminally ill residents may continue to reside in the residence if a physician certifies that the person's needs are being met.

Evacuation requirements are included in life safety code standards and facility procedures for emergency evacuation drills.

Since the regulations governing admission/retention are broad, waivers of the requirements are not needed. The rules do allow variances of any provision of the chapter that will promote aging-in-place and meet the goals of the rules.

## **Nursing Home Admission Policy**

Individuals meet the HCBS LOC criteria if they:

- Receive a listed nursing service daily;
- Receive a nursing service less than daily and require limited, extensive, or total assistance with two ADLs (bed mobility, transfer, locomotion, eating, toilet use, personal hygiene, walking, bathing);

- Have impaired cognition and require limited, extensive or total assistance with two ADLs; or
- Have behaviors (wandering, verbal or physical abuse, socially inappropriate) and require limited, extensive, or total assistance with two ADLs.

## **Services**

Each resident must have an assisted living plan (developed within 30 days of move-in and approved by the resident or their representative) that identifies strengths and weaknesses performing ADLs, physical disabilities and impairments, preferences for roommates, living environment, food, recreation, religious affiliation and other factors. The plan also identifies the ADLs with which the resident needs help, how help will be provided by the home or other agencies, and health-related services and how they will be addressed. Health-related services include assistance with self-administration of medication, intermittent nursing services, 24-hour skilled nursing for 45 days, and hospice services.

The plan must promote the resident's participation in the community and increased independence through training and support, in order to provide the resident with an environment suited to the resident's needs and best interests.

Negotiated risk is 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 home, the risks associated with each option when making decisions pertaining to the resident's abilities, preferences, and service needs; and recognize the right of the home to evaluate and to either consent or refuse to accept the resident's choice of risks.

The plan must also identify the resident's reasonable wants and how those will be addressed. If health-related services are provided or arranged, the evaluation must be done quarterly. If no health-related services are provided, an annual evaluation is required. Assisted living homes may provide intermittent nursing services to residents who do not require 24-hour care and supervision. Intermittent nursing tasks may be delegated to unlicensed staff for tasks designated by the Board of Nursing.

## **Dietary**

An assisted living home shall offer three balanced, nutritious meals and at least one snack daily at consistent times. A home shall ensure that the meals and snacks offered include the recommended number of servings of each food type set out in the USDA publication, *The Food Guide Pyramid*, as revised October 1996 and adopted by reference. The home shall offer a wide variety of food that includes fresh fruits and vegetables as often as possible. Additionally, the home shall consider each resident's health-related or religious restrictions, cultural or ethnic preferences in food preparation, and preference for smaller portions, as reflected in the resident's residential services contract.

## Agreements

Terms for the residential services contract are specified in statute. The contract must be signed prior to move-in that describes the services and accommodations; rates charged; rights, duties and obligations of the resident; policies and procedures for termination of the contract; amount and purpose of advance payments; and refund policy.

## Provisions for Serving People with Dementia

The rules do not include specific provisions.

## Medication Administration

Aides (home staff persons) may provide medication reminders, read labels, open containers, observe a resident while taking medication, check self-administered dosage against the label, reassure the resident that the dosage is correct, and direct/guide the hand of a resident at the resident's request. The authority for RNs to delegate tasks is contained in the nurse delegation statute and rules.

## Public Financing

A broad HCBS waiver covers services in assisted living homes for elders and adults with disabilities. The room and board payment is negotiated between the home and the resident. In a limited number of cases, room and board and some services are covered by the state's "general relief" program. The payment standard for SSI recipients is \$985 a month and the PNA is \$100 a month. Family supplementation is allowed for room and board. A new SSI payment standard is being created for assisted living homes (\$654, including a \$100 PNA).

Medicaid Participation					
2007		2004		2002	
Facilities	Participation	Facilities	Participation	Facilities	Participation
235	730	174	632	126	492

Services for Medicaid waiver certified individuals in assisted living homes are funded under the state's Choice Program, a Medicaid HCBS waiver. Rates vary by area of the state. A multiplier that ranges from 1.0 to 1.38 is applied to the rates, resulting in higher payments in rural and frontier areas (i.e., \$100 service in one region may be reimbursed at \$138 in another region). Providers receive a basic service rate that varies for AFC, adult residential I, and adult residential II. An "augmented service rate cost factor" is available for clients whose needs warrant the hiring or designating of additional staff. The "augmented care" payment recognizes the added staffing needed by homes caring for residents needing incontinent care, skin care,

added supervision, and help with medication. Some residents also attend ADC. The service rate is lower for residents attending day care at least three days a week.

Contracted homes have the option of receiving payment according to the tiers or cost-based reimbursement. About half the contracted homes have applied for cost-based reimbursement. The average cost-based rate is \$130 a day but is as high as \$234.

Medicaid Payment Rates, July 1, 2004				
Anchorage Area	ADC Basic Rate	Basic Service Rate	Augmented Factor	Basic and Augmented*
Adult foster care	\$32.93	\$44.52	\$17.37	\$70.54
Adult residential I	\$44.52	\$56.10	\$17.37	\$82.13
Adult residential II	\$56.10	\$67.68	\$17.37	\$93.70

\* Total rate includes an \$8.65 daily service rate. See <http://www.hss.state.ak.us/dsds/pdfs/ChoiceRSLRate20046-30-04.pdf>.

## Staffing

*Administrators* must be 21 years of age or older and have sufficient experience, training, or education to fulfill the responsibilities of an administrator. Administrators in homes with ten or fewer units must fulfill at least one of the following requirements: complete an approved management or administrator training course and one year of documented experience relevant to population to be served, or complete a CNA training program and have at least one year of documented experience relevant to the population to be served, or two years of documented care experience relevant to the population to be served.

*Staff.* Homes must have the type and number of staff needed to operate the home and must develop a staffing plan that is appropriate to provide services required by resident care plans. Staff must pass a criminal background check.

## Training

Regulations require that administrators receive 18 hours of training annually, direct care staff, 12 hours annually. Staff providing direct care without supervision must have sufficient language skills to meet the needs of residents. Staff must receive orientation that covers emergency procedures, fire safety, resident rights, universal precautions, resident interaction, house rules, medication management and security, physical plant layout, and reporting responsibilities.

## Background Check

No person may be employed who has been convicted of crimes listed in the regulations. Administrators and staff must provide a sworn statement regarding conviction of listed crimes, the results of a name check criminal background check initially and every two years, and a national criminal history check based on fingerprints and conducted by the Alaska Department of Public Safety initially and every six years.

## **Monitoring**

Both DHSS and the Division of Senior and Disabilities Services are responsible for screening applicants, issuing licenses, and investigating complaints. The departments may delegate responsibility for investigating and making recommendations for licensing to a state, municipal, or private agency. Homes must submit an annual self-monitoring report on forms provided by DHSS. Case managers monitor Choice waiver participants monthly.

Regulations require an annual monitoring visit or self-monitoring report filed by the facility. The licensing agency may impose a range of sanctions: revoking or suspending the license, denying renewal, issuing a probationary license, restricting the type of care provided, banning or imposing conditions on admissions, or imposing a civil fine.

The state describes its oversight and monitoring process as consultative. The state acts as a licensing body first, but also sees itself as educators and teachers. If violations are found through the inspection and monitoring process, the state will hand out notices of violation, but will provide education regarding how to improve care, or address the violation.

Currently, the state has limited staff resources to provide as much education and training, as they would like. When a pattern of violations is identified, a more industry-wide, versus a one-on-one, training approach is implemented. The state still holds planned orientations for new or potentially new assisted living homes every three months, but training can be extended out to six months if there is not staff available to conduct formal orientation training.

Licensing staff currently monitor homes as well as provide consultation through education and teaching. After the consolidation of Assisted Living Licensing with Public Health this process may change at some point in the future. They envision possibly rearranging, or reassigning existing staff to perform separate functions.

## **Fees**

Voluntary license: \$25 per resident. License for 3-5 residents -- \$75, six or more residents -- \$150, plus \$25 per resident over three residents.

# ARIZONA

**Citation**      Assisted living facilities: Comprehensive administrative rules and regulations §R9-10-701 et seq.

## General Approach and Recent Developments

The Governor issued an Executive Order in January 2007 directing state agencies to develop a comprehensive three year strategy to improve quality of care in nursing homes, ALFs and community settings. Most of the focus is on nursing homes. The licensing rules, established in 1998, set requirements based on the size of the facility along with supplemental requirements depending on the level of service provided. A “rules committee” that includes stakeholders may be formed early in 2008 to review changes to the regulations that are still being developed. The core requirements address facilities serving ten or fewer residents, 11 or more residents, and adult foster homes which serve 1-4 residents. Facilities are licensed to provide one of three levels of care (supervisory care services, personal care services, and directed care services) and must meet supplemental requirements.

The directed care level serves people with Alzheimer’s disease or dementia who cannot self-direct their care (e.g., cannot recognize danger, summon assistance, express need, or make basic decisions). Legislation expanding the Department of Health Services’ enforcement authority for overseeing training programs passed in 2005 that allows the Department to grant, deny, suspend or revoke the approval of training programs and to impose civil penalties for violations of the training requirements.

## Adult Foster Care

AFC is regulated under the assisted living rules.

Web Address	Content
<a href="http://www.azdhs.gov/als/hcb/index.htm">http://www.azdhs.gov/als/hcb/index.htm</a>	Rules, guide, list, provider
<a href="http://www.azhdhs.gov/als/enforce/index.htm">http://www.azhdhs.gov/als/enforce/index.htm</a>	Enforcement actions

Category	Supply					
	2007		2004		2002	
	Facilities	Units	Facilities	Units	Facilities	Units
Assisted living home: <10	1,951	27,000	1,509	24,500	1,077	8,616
Assisted living centers: 11+					196	14,384
Adult foster care: 1-4					251	1,041

## **Definition**

*Assisted living facility* means a residential care institution, including AFC, that provides or contracts to provide supervisory care services, personal care services, or directed care services on a continuing basis.

*Supervisory care services* mean general supervision, including daily awareness of resident functioning and continuing needs, the ability to intervene in a crisis, and assistance in the self-administration of prescribed medications.

*Personal care services* mean assistance with ADLs that can be performed by persons without professional skills or professional training and include the coordination or provision of intermittent nursing services and the administration of medication and treatments by a nurse who is licensed pursuant to Title 32, Chapter 15, or as otherwise provided by law.

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

Assisted living homes serve ten or fewer residents and assisted living centers serve 11 or more residents. The Arizona Long-Term Care Systems (ALTCS) Program contracts with AFC (four or fewer in which the provider lives in the home), assisted living homes (ten or fewer, owner is not a resident), and assisted living centers.

## **Unit Requirements**

Assisted living centers (11+ residents) may provide residential units or bedrooms. Residential units must have at least 220 square feet of floor space (excluding bathroom and closet) for one person, with an additional 100 square feet for a second person. 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.

Assisted living centers and homes providing bedrooms must have 80 square feet in single rooms and 60 square feet per resident in double rooms. No more than two residents may share a room. Rooms occupied by residents receiving personal care services or directed care services must have a bell, intercom, or other mechanical means to contact staff. At least one toilet, sink, and shower is required for every eight residents.

## **Admission/Retention Policy**

ALFs providing supervisory care services may serve residents who need health or health-related services if these services are provided by a licensed home health or hospice agency.

ALFs with a personal care service license may not accept or retain any resident who is unable to direct self-care; requires continuous nursing services unless the nursing services are provided by a licensed hospice agency or a private duty nurse; residents with a Stage III or IV pressure sore, or someone who is bed bound due to a short illness unless the primary care physician approves, the resident signs a statement, and the resident is under the care of a nurse, a licensed home health agency, or a licensed hospice agency.

ALFs licensed to provide directed care services may admit residents who are bedbound, need continuous nursing services, or have a Stage III or IV pressure sore if the requirements for facilities providing personal care services are met.

A copy of the resident agreement, resident rights, and consumer resources must be provided to residents upon move-in.

## **Nursing Home Admission Policy**

Assessment information in three categories is scored: functional, emotional and cognitive, and medical. Functional areas include ADLs (i.e., bathing, dressing, grooming, eating, mobility, transferring, and toileting), communication and sensory skills, and continence. Emotional and cognitive information is obtained on orientation and behavior (i.e., wandering, self-injurious behavior, aggression, suicidal behavior, and disruptive behavior). Medical information is collected on conditions and their impact on ADLs, conditions requiring medical or nursing services and treatment, medication, special services and treatments needed, and physical measurements, history, and ventilator dependency.

Each score is weighted and totaled. The weighted functional score (ADLs and cognition) can range from 0-15 on each item, and the maximum total is 141. Applicants are grouped into two medical groups based on their conditions. Applicants in either medical group with a total score of 60 or over and those in groups 1 and 2, whose total scores are less than 60 but exceed a specified numerical threshold in each component, are eligible.

## **Services**

Residents must receive an assessment and a service plan within 14 days of acceptance. Plans must be reviewed every 12 months for residents receiving supervisory care services, every six months for residents receiving personal care services, and every three months for residents receiving directed care services. Services must meet scheduled and unscheduled needs. Facilities must provide general supervision; promote resident independence; autonomy; dignity; choice; self-determination; and the resident's highest physical, cognitive, and functional capacity; help utilize community resources; encourage residents to preserve outside supports; and offer individual attention and social interaction and activities.

Facilities providing personal care services also provide skin maintenance, sufficient fluids to maintain hydration, incontinence care, and an assessment by a primary care provider for residents needing medication administration or nursing services.

Facilities providing directed care must provide cognitive stimulation and activities to maximize functioning; encouragement to eat meals and snacks; and an assessment by a primary care provider.

Hospice care may be provided by a licensed hospice agency.

## **Arizona Long-Term Care Systems (ALTCS)**

An interdisciplinary team (manager, staff, RN [if nursing services are provided], resident and/or representative, and case manager, if applicable) conducts an assessment within 12 days of enrollment and every 90 days, or as needed, thereafter. A plan of care is developed with the resident or their representative that identifies the services needed, the person responsible for providing the service, the method and frequency of services, the measurable resident goals, and the person responsible for assisting the resident in an emergency.

## **Dietary**

Facilities must provide three meals a day and one snack to meet nutritional needs based on resident health and age. Menus must be based on the Food Guide Pyramid, USDA Center for Nutrition Policy and Promotion, Home and Garden Bulletin Number 252. If therapeutic diets are offered, a manual must be available for use by employees. Diets must be consistent with physicians' orders or as prescribed by law. Provisions for the storing and preparation of food are included. Nutrition, hydration, food preparation, service, and storage are part of the orientation and training requirements.

## **Agreements**

Resident agreements that include the following must be signed upon move-in: terms of occupancy; services to be provided; amount and purpose of fees, charges, and deposit (including fees/charges for days the resident is absent); services available for additional charges; refund policy; responsibility to provide 30 days notice of any fee changes (unless there is a change in acuity); policy and procedures for termination of residency; and the grievance procedure.

## **Provisions for Serving People with Dementia**

The rules contain specific provisions for facilities serving people with dementia. A minimum of four hours of training in dementia care must be provided to staff each year. Direct supervision must be available and facilities must provide cognitive stimulation and activities to

maximize functioning. Facilities must have egress controls and access to secure outside areas for residents who wander.

## Medication Administration

Facilities must have policies and procedures governing the procurement, administration, storing, and disposal of medications. Trained caregivers may supervise self-administration by opening bottle caps, reading labels, checking the dosage, and observing the resident taking the medication. Medications which cannot be self-administered must be administered by an RN or “as otherwise permitted.” The phrase *as otherwise permitted* was included to accommodate any future statutory changes in the state’s Nurse Practice Act. Medication organizers can be prepared a month in advance by an RN or family member. Rules governing assistance with medications are contained in the licensing rules.

## Public Financing

Services in ALFs are covered through the ALTCS program which operates under a §1115 waiver. Program administrators originally used rates set for AFC, nursing facilities, the Oregon ALP, and the Arizona HCBS program as guidelines in setting the rates. Three classes of rates are negotiated based on the LOC: low, intermediate, and high skilled. The rates include room and board which is paid by the resident. The monthly room and board amount is the resident’s “alternative share of cost” (spend-down) or 85% of the current SSI payment, whichever is greater. For residents who receive SSI, the payment rate is \$623.00 a month of which \$512.55 is paid to the residence to cover room and board charges and \$90.45 is retained by the resident as a PNA. Rates are presented in the table below. The weighted average reflects participation among the program contractors by level.

Arizona allows third-party supplementation for room upgrades that are not part of the Medicaid payment. A family member could pay the difference in the rate if someone wanted their parent to live in a one-bedroom unit of an assisted living center rather than the standard efficiency type unit. Level III rates can vary greatly because they can include specialty care services (e.g., behavioral management).

Medicaid Participation					
2007		2004		2002	
Facilities	Participation	Facilities	Participation	Facilities	Participation
866	4,034	NA	3,076	NA	2,300

Medicaid Payment Rates by Program Contractor (Daily)									
	Level I			Level II			Level III		
	AFC	AL Homes	AL Centers	AFC	AL Homes	AL Centers	AFC	AL Homes	AL Centers
Program A	NA	\$58.55	\$75.89	NA	\$62.00	\$95.15	NA	\$67.00	\$97.17
Program B	NA	\$63.03	\$64.57	NA	\$66.10	\$74.49	NA	\$108.37	\$95.86
Program C	\$51.00	\$49.00	\$59.00	\$51.00	\$55.00	\$62.50	\$51.00	\$143.75	\$79.00
Program D	\$52.61	\$51.87	\$70.84	\$52.61	\$68.38	\$71.24	\$52.61	\$126.60	\$114.73
Program E	\$70.11	\$58.64	\$72.35	\$70.11	\$66.85	\$91.91	\$70.11	\$90.89	\$111.09
Program F	NA	\$52.13	\$62.89	NA	\$66.11	\$71.73	NA	\$80.66	\$90.01
Program G	\$51.89	\$47.50	\$70.34	\$51.89	\$55.00	\$80.46	\$51.89	NA	\$91.46
Program H	\$41.23	\$52.17	\$56.84	\$49.79	\$59.99	\$65.87	\$58.40	\$66.96	\$80.77

## Staffing

Facilities are required to ensure that sufficient staff are available to provide: services consistent with the LOC for which the facility is licensed; services established in a service plan; services to meet resident needs for scheduled and unscheduled needs; general supervision and intervention in a crisis 24-hours a day; food services; environmental services; safe evacuations; and on-going social and recreational services.

## Training

*Managers* must be 21 years old, certified, and have a minimum of 12 months of health-related experience.

*Staff* must complete an orientation that includes the characteristics and needs of residents; the facility's philosophy and goals; promotion of resident dignity, independence, self-determination, privacy, choice and resident rights; the significance and location of service plans and how to read and implement a service plan; facility rules, policies, and procedures; confidentiality of resident records; infection control; food preparation, service, and storage if applicable; abuse, neglect, and exploitation; accident, incident, and injury reporting; and fire, safety, and emergency procedures.

*Managers and staff* must complete 12 hours of on-going training annually covering the promotion of resident dignity; independence; self-determination; privacy; choice; resident rights; fire, safety, and emergency procedures; infection control; and abuse, neglect, and exploitation. Staff in facilities licensed to provide directed care services must also receive a minimum of four hours of training in providing services to residents.

In addition to the above topics, training may include providing services to residents; nutrition, hydration, and sanitation; behavioral health or gerontology; social, recreational, or rehabilitative services; personnel management, if applicable; common medical conditions, medication procedures, medical terminology, and personal hygiene; service plan development, implementation, or review; and other needs identified by the facility.

*Staff* must also maintain current CPR certification and complete six hours of continuing education annually pursuant to §36-448.11(D). Nurses aides in good standing may be deemed to meet the initial training requirements.

*Certificate of training.* Caregiving staff must obtain a certificate of training. Facilities may develop their own training and certificate program with approval from the department. Department approved training programs have requirements for instructors and the method of instruction. The competency-based approach sets standards for supervisory care services, personal care services, directed care services, and manager training.

*Supervisory care services.* 20 hours or the amount of time needed to verify a person demonstrates skills and knowledge in assisted living principles; communication; managing personal stress; preventing abuse, neglect, and exploitation; controlling the spread of disease and infection; documentation and record keeping; implementing service plans; nutrition, hydration, and food services; assisting with self-administration of medications; providing social, recreational, and rehabilitative activities; and fire, safety, and emergency procedures.

*Personal care services.* 30 hours (50 total) or the amount of time needed to verify a person demonstrates skills and knowledge in additional skills areas such as the aging process, common medical conditions associated with aging or physical disabilities, and medications; assisting with ADLs; and taking vital signs.

*Directed care services.* 12 hours (62 total) or the amount of time needed to verify a person demonstrates skills and knowledge of Alzheimer's disease and related dementia; communicating with residents who are unable to direct care; providing services including problem solving, maximizing functioning, and life skills training for those unable to direct care; managing difficult behaviors; and developing and providing social, recreational, and rehabilitative activities for such persons. Four hours per year of on-going training is required.

## **Background Check**

Managers and staff must comply with fingerprint requirements under A.R.S. 36-411.

## **Monitoring**

The licensing agency conducts annual renewal inspections. Licenses may be renewed for two years for facilities that are free of deficiencies. Penalties for violations may include civil money penalties, provisional licensing, and restricted admissions.

Facilities that contract with ALTCS are monitored by ALTCS program contractors and the Department of Health Services. During the pilot phase of the waiver, program contractors monitored resident care on a quarterly basis, provided technical assistance, and conducted meetings of providers to obtain feedback on the program. With statewide expansion, participants are visited at least quarterly by their ALTCS case manager. Annual operating and financial

reviews of ALTCS contractors (health maintenance organizations) are conducted annually by the Arizona Health Care Cost Containment System (AHCCCS). The reviews also include case management and provider records and claims data. AHCCCS also reviews a random sample of residents, including assisted living residents, to evaluate the appropriateness and quality of care. The review found no unmet needs or quality of care problems.

## **Fees**

There is a \$50 application fee. Facilities with 1-59 beds pay an additional fee of \$100 plus \$10 per bed; 60-99 beds: \$200 plus \$10 per bed; 100-149: \$300 plus \$10 per bed; 150+: \$500 plus \$10 per bed.

# ARKANSAS

**Citation**      Assisted living facilities: Arkansas Annotated Code §§20-10-1701  
 Residential long-term care facilities: Arkansas Annotated Code §§20-76-201(b)(3), 20-10-203, and 20-10-224

## General Approach and Recent Developments

Regulations establishing two levels of ALFs were finalized in 2002 and updated in 2003 and require that any newly-constructed Level II facility must comply with the requirements for I-2 Groups as specified in the International Building Code (IBC) 2000, with exceptions as listed. This regulation formerly required “I-1 Groups” compliance.

ALFs in 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.

The state continues to explore the adoption of nursing home SCU requirements for all ALFs, particularly as it relates to staffing. Currently, the ALF regulations require separate staff for SCUs. In nursing facilities, SCUs require sufficient staff across the entire facility to meet resident needs. The state Assisted Living Association is pushing to eliminate the RCH regulations, and create one set of rules for ALFs. Providers are discussing adoption of the “green house” model which would require some modifications to the staffing requirements.

## Adult Foster Care

AFC is not currently licensed in Arkansas.

Web Address	Content
<a href="https://www.medicaid.state.ar.us/InternetSolution/General/units/oltc/facltc.aspx">https://www.medicaid.state.ar.us/InternetSolution/General/units/oltc/facltc.aspx</a>	Rules, provider
<a href="https://www.medicaid.state.ar.us/InternetSolution/General/units/oltc/factypes.aspx">https://www.medicaid.state.ar.us/InternetSolution/General/units/oltc/factypes.aspx</a>	
<a href="http://www.state.ar.us/dhs/aging/assistedliving.html">http://www.state.ar.us/dhs/aging/assistedliving.html</a>	Provider

Category	Supply					
	2007		2004		2002	
	Facilities	Units	Facilities	Units	Facilities	Units
Assisted living Level I	10	508	1	54	NA	NA
Assisted living Level II	17	894	5	221	NA	NA
Residential care	92	3,616	111	4,369	122	4,647

The Living Choices Assisted Living 1915(c) Waiver Program was implemented in 2002. Legislation revising Alzheimer’s special care standards passed (HB 1407) in 2001. Personal care services are covered under the state plan for Medicaid beneficiaries.

## **Definition**

*Residential care facility* means a building or structure which is used or maintained to provide, for pay 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 ADLs.

An *assisted living facility* is any building or buildings, section, or distinct part of a building, boarding home, home for the aged, or other residential facility whether operated for profit or not that undertakes through its ownership or management to provide assisted living services for a period exceeding 24 hours to more than three adult residents of the facility who are not relatives of the owner or administrator. ALF means facilities in which assisted living services are provided either directly or through contractual arrangements or in which contracting in the name of residents is facilitated. An ALF provides, at a minimum, services to assist residents in performing all ADLs on a 24-hour basis.

An *Alzheimer's special care unit (ASCU)* is 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 related dementia, and that advertises, markets, or otherwise promotes the facility as providing specialized Alzheimer's or related dementia care services.

## **Unit Requirements**

*Residential care facility.* A minimum of 100 square feet is required for single rooms and 80 square feet per resident in shared rooms. Rooms may be shared by two residents. A minimum of one toilet/lavatory is required for every six residents and one tub/shower for every ten residents. Need to make decision about hyphen for long-term care

*Assisted living facility.* 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 shall be accessible to and useable by residents who use a wheelchair or other mobility aid consistent with the accessibility standards. Each apartment must have a lockable door. Separate bathroom and kitchen areas are required. Single occupancy apartments must be at least 150 square feet excluding entryway, bathroom and closets, and 230 square feet for two persons. Apartments may not be occupied by more than two persons. Each unit must provide for a small refrigerator as well as a microwave oven, except as may be otherwise provided in the regulations, and a call system monitored 24-hours a day by staff.

## **Admission/Retention Policy**

*Residential long-term care facility.* Tenants must be 18 or older; independently mobile (physically and mentally capable of vacating the facility within three minutes); able to self-administer medications; be capable of understanding and responding to reminders and guidance from staff; do not have a feeding or IV tube; are not totally incontinent of bowel and bladder; do not have a communicable disease that poses a threat to the health or safety of others; do not need nursing services which exceed those that can be provided by a certified home health agency on a temporary or infrequent basis; do not have a level of mental illness, retardation, or dementia or addiction to drugs or alcohol that requires a higher level of medical, nursing, or psychiatric care or active treatment than can safely be provided in the facility; does not require religious, cultural, or dietary regimens that cannot be met without undue burden; and do not require physical restraints or have current violent behavior.

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 of Long-Term Care to determine if a nursing home placement is needed.

*Level I assisted living facilities* cannot serve nursing home eligible residents or residents who 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; are bedridden; have transfer assistance needs that the facility cannot meet, including assistance to evacuate the building in case of an emergency; present a danger to self or others; and require medication administration performed by the facility.

*Level II facilities* are allowed to serve nursing home eligible residents but cannot serve residents who need 24-hour nursing services; are bedridden; have a temporary (more than 14 consecutive days) or terminal condition unless a physician or advance practice nurse certifies the resident's needs may be safely met by a service agreement developed by the ALF, the attending physician or advance practice nurse, a RN, the resident or his or her responsible party if the resident is incapable of making decisions, and other appropriate health care professionals as determined by the resident's needs; have transfer assistance needs, including but not limited to assistance to evacuate the facility in case of emergency, that the facility cannot meet with current staffing; present a danger to self or others or engage in criminal activities.

## **Nursing Home Admission Policy**

To be determined a functionally disabled individual, the individual must meet at least one of the following three criteria as determined by a licensed medical professional:

1. The individual is unable to perform either of the following:
  - At least one of the three ADLs of transferring/locomotion, eating, or toileting without extensive assistance from or total dependence upon another person; or
  - At least two of the three ADLs of transferring/locomotion, eating, or toileting without limited assistance from another person.

2. The individual has a primary or secondary diagnosis of Alzheimer's disease or related dementia and is cognitively impaired so as to require substantial supervision from another individual because he or she engages in inappropriate behaviors which pose serious health or safety hazards to himself or others.
3. The individual has a diagnosed medical condition which requires monitoring or assistance at least once a day by a licensed medical professional and the condition, if untreated, would be life threatening.

## Services

*Residential long-term care facility.* 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 staff 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 transportation (this does not include the provision of transportation); linen service; three meals a day; and medication assistance. Other services include attendant care, homemaker, and medication oversight. Level I facilities may provide occasional guidance, direction or monitoring, or assistance with ADLs and social activities and transportation.

Level II facilities offer services that directly help a resident with certain routines and ADLs such as assistance with mobility and transfers; hands-on assistance to resident 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. The assessment for residents with health needs must be completed by an RN.

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

The regulations provide for negotiation of a compliance agreement to deal with risk of an adverse outcome. In the agreement, the facility identifies the specific concern(s); provide clear, understandable information about the possible consequences of his or her choice or action; negotiates a compliance agreement with the resident or his or her responsible party that will

minimize the possible risk and adverse consequences while still respecting the resident's preferences.

The compliance agreement must address any situation or condition that is or should be known to the facility that involves risk; the probable consequences; the resident or his or her responsible party's preference concerning how the situation 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.

## **Dietary**

*Residential long-term care facility.* Facilities must provide three balanced meals a day and make snacks available, served at about the same time each day, not more than five hours apart between breakfast and lunch and between lunch and the evening meal, and no more than 14 hours between breakfast and the evening meal. Facilities must notify the physician if a resident does not eat meals for more than two consecutive days. State, county, and local health departments may have rules that deal with sanitation, safety, and health. Recommended daily allowances are established in the regulations. In large facilities (>17), staff involved in food and dietary services cannot perform other duties on the same shift.

*Assisted living facilities.* Three balanced meals, snacks, and fluids are required.

## **Agreements**

*Residential long-term care facility.* Residents must receive a copy of the resident agreement at or prior to moving in that covers: services, materials and equipment, and food to be included in the basic charge; additional services and charges to be provided; residency rules; conditions and rules for termination; provisions for changing the charges; and refund policy.

*Assisted living facilities.* Covers core services (24-hour staff supervision by awake staff; assistance obtaining emergency care; assistance with social, recreational, and other activities; assistance with transportation; linen service; three meals a day; medication assistance); additional services; health care services available through home health agencies; parameters for pets; current statement of all fees and daily, weekly, or monthly charges; 30-day notice of changes in charges; identification of the party responsible for payment; refund policy; procedures for nonpayment; policy on acceptance of responsibility for personal funds and valuables; responsibility for medication; a copy of facility rules; provisions for emergency transfers; and conditions of termination of the occupancy agreement.

## **Provisions for Serving People with Dementia**

*Residential long-term care facility.* The admission and retention rules limit a facility's ability to serve anyone with dementia.

*Assisted living facilities.* Facilities must provide a disclosure statement that describes: the philosophy of how care and services are provided to the residents; the pre-admission screening process; the admission, discharge and transfer criteria and procedures; training topics, amount of training time spent on each topic, and the name and qualification of the individuals used to train the direct care staff; the minimum number of direct care staff assigned to the ASCU each shift; and a copy of the Residents' Rights; assessment; individual support plan and implementation; activities; and the stages for which care is provided.

The licensing rules include program requirements that provide 24-hour care; promote social, physical, and mental well-being and protect resident rights. Nursing, direct care, and personal care staff cannot perform the duties of cooks, housekeepers, or laundry staff during their direct care shifts. An individual support plan must be prepared. Standards for the physical design of the unit are described. Policies are required for egress control and standards for locking devices are specified. Staff must have 30 hours of training on policies (one hour); etiology, philosophy, and treatment of dementia (three hours); stages of Alzheimer's disease (two hours); behavior management (four hours); use of physical restraints, wandering, and egress control (two hours); medication management (two hours); communication skills (four hours); prevention of staff burn-out (two hours); activities (four hours); ADLs and individual centered care (three hours); and assessment and Individual Service Plans (three hours). Staff must receive two hours of on-going training each quarter.

## **Medication Administration**

*Residential long-term care facility.* 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. The state does not have provisions for nurse delegation.

*Assisted living facilities.* Staff of Level I facilities may assist with self-administration of, but cannot administer, medications. Staff of Level II facilities may administer medications. A pharmacy consultant is required.

## **Public Financing**

The state implemented the Living Choices not italics Assisted Living HCBS Waiver Program in January 2002. Waiver "assisted living services" providers must be licensed as a Level II ALF or a licensed Class A Home Health Agency who has a contract with a licensed Level II ALF to provide waiver services and pharmacy consultant services.

The assisted living waiver program serves clients who are age 65 and over, or who are 21 years of age or over and blind or disabled. A Division of Medical Services, Office of Long-Term Care RN determines LOC eligibility. A Division of Aging and Adult Services assisted living waiver RN completes the comprehensive assessment and establishes the tier of need, and completes the service plan upon admission to the program, and annually or at times of significant change.

Services provided under the waiver include attendant care (assistance with ADLs); therapeutic social and recreational activities; medication oversight to the extent permitted by law; medication administration; periodic nursing evaluations; LNS; and non-medical transportation as specified in the plan of care. A diagnosis of Alzheimer’s or dementia alone does not disqualify an individual from placement at an ALF.

As of January 2006, an amendment made to Medicaid modified the waiver prohibiting the coverage of pharmaceutical drugs already covered under Medicare Part D.

Personal care services are reimbursed as a state plan service under Medicaid based on a plan of care. RCFs are reimbursed on a fee-for-service basis. A maximum of 64 hours of care per month at \$13.84 an hour (maximum payment of \$885.76) may be covered without prior authorization. Services may exceed the cap if approved. Approximately 1,155 residents living in residential long-term care facilities receive personal care services under the Medicaid state plan. The state uses a presumptive eligibility process to expedite determinations.

Medicaid Participation						
Source	2007		2004		2002	
	Facilities	Participation	Facilities	Participation	Facilities	Participation
State plan	NR	NR	NA	1,155**	NA	1,178**
Waiver	15	211	5	50	NA	NA

\*\* Unduplicated number of residents in residential long-term care facilities.

Medicaid reimbursement under the Living Choices waiver is determined through the comprehensive assessment and a four-tier method of need (see table below). The daily rate pays for all direct services in the participant’s plan of care. Pharmacy consultant services are a daily rate. The waiver pays for three prescription drugs beyond the Medicaid State Plan Prescription Drug Program’s monthly benefit limit.

Persons receiving assisted living waiver services may not receive Medicaid State Plan Personal Care. Reimbursement is for services only and may not pay for room and board. The room and board rate in 2007 is \$566.00.

Based on the level of assistance, scores are assigned for ADLs (eating [2], toileting [2], ambulation [2], bathing [2], transfer [1], and body care [1]); medication assistance; sensory ability; and psycho-social/cognitive ability. Points are awarded for ADLs for people who need substantial supervision, physical assistance, or total assistance. Points for medication assistance vary with the type of assistance multiplied by the number of medications (see table).

## **Staffing**

*Residential long-term care facility.* Ratios for the number of direct care staff varies by the time of day (daytime, evening, and night) and the number of residents. Staffing must be sufficient to meet the needs of residents.

*Assisted living facilities.* Administrators must be certified as an ALF, RCF, or Nursing Home administrator. Staffing sufficient to meet the needs of residents is required according to staff ratios that vary by facility size and shift.

*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 RN. 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. The assisted living Level II RN is responsible for the preparation, coordination, and implementation of the direct care services plan portion of the resident's occupancy admission agreement. The Living Choices waiver plan of care developed by the Division of Aging and Adult Services assisted living waiver RN is to be filed in the resident's occupancy admission agreement with the ALF's direct services plan of care. The ALF RN, in conjunction with the physician, shall be responsible for the preparation, coordination, and implementation of the health care services plan portion of the resident's occupancy admission agreement and shall review and oversee all LPN, CNA, and PCA staff. Level II facilities must employ a consulting pharmacist. The ALF RN need not be physically present at the facility, but must be available to the facility by phone or pager.

## **Training**

*Residential long-term care facility administrators* must have a current certification as a RCF administrator or complete a course of instruction and training prescribed by the Department or Human Services.

*Residential long-term care facility staff.* An orientation covering, at a minimum, job duties, resident rights, abuse/neglect reporting requirements, and fire and tornado drills is required. For direct care staff, four hours of in-service training or continuing education must be provided on a quarterly basis covering residents' rights, evacuation of a building, safe operation of fire extinguishers, incident reporting, and medication supervision.

*Assisted living facilities.* Staff must receive orientation on the following topics: philosophy of independent living in an ALR; residents' rights; abuse, neglect, and exploitation; safety and emergency procedures; communicable diseases; communication skills; review of the aging process; dementia/cognitive impairment; resident health and related problems; job requirements; medication supervision/management, and incident reporting. A minimum of six hours of on-going training a year is required. As of June 2006, the number of training hours for

CNAs increased from 75 hours to 90 hours with the requirement that the additional 15 hours be spent focusing on the issues that relate to caring for persons suffering from Alzheimer’s and related dementia.

## Background Check

*Residential long-term care and assisted living administrators* may not have any prior conviction pursuant to Arkansas Code Annotated §20-10-401 or relating to the operation of a long-term care facility nor any conviction for abusing, neglecting, or mistreating individuals. Administrators must also successfully complete a criminal background check pursuant to Arkansas Code Ann. §20-33-201, *et seq.* Criminal background checks are required for all employees. Checks include the Adult Abuse Registry.

## Monitoring

Written policies and procedures for monitoring quality of care are required. Remedies for violations include Civil Money Penalties, denial of admissions, directed in-service training, directed plan of correction, state monitoring, temporary administrator, temporary license, and transfer of residents.

*Assisted Living Facilities.* The state provides more education than consultation in their oversight and monitoring processes. This process has been very successful. With newly licensed facilities, the state will conduct mock surveys to educate the facility about the process and expectations. This has become more of a teaching/learning model regarding the interpretation of the regulations.

Education is provided on an industry-wide level versus facility-based consultation. The education is typically provided through the assisted living association. Survey nurses do not provide consultation and training. There are separate staff to perform each individual function.

## Fees

Residential long-term care facility: \$5 per bed. Assisted living: The annual application fee is \$250 plus \$10 per bed.

Medicaid Payment Rates (2007)		
Tier 1	0-5 total ADL points and 0-39 total other points	\$43.19/day
Tier 2	0-5 total ADL points and 4-60 total other points or 6-10 total ADL points and 0-39 total other points	\$46.81/day
Tier 3	0-5 total ADL points and 61 or more total other points or 6-10 total ADL points and 40-69 total other points	\$51.87/day
Tier 4	6-10 total ADL points and 70 or more total other points	\$54.61/day

<b>Tier Calculation Point Scale (2007)</b>	
<b>Task</b>	<b>Points</b>
Eating	2 points
Toileting	2 points
Ambulation	2 points
Bathing	2 points
Transfer	1 point
Body care	1 point
Medication reminding/monitoring	0.5 times number of medications
Needs RX assistance	0.75 times number of medications
Dosage prep	1 times number of medications
Needs administration	2 times number of medications
Speech not understandable, unable to speak, unable to communicate	10 points
Sight: Legally blind with corrective lenses/blind	10 points
Hearing: Must be loud even with aides; unable to hear	10 points
Disorientation	12 points
Memory impairment	16 points
Impaired judgment	17 points
Wandering	15 points
Disruptive behavior	20 points

# CALIFORNIA

**Citation** Residential care facilities for the elderly (RCFEs): Title 22, Division 6, Chapter 87100-87730

## General Approach and Recent Developments

AB 609 was enacted into law in 2006 and requires additional training on assistance with self-administration of medications that will take effect in 2008. A series of changes are being implemented following passage of several bills by the legislature. The changes replace the exceptions requirements for facilities serving people with health conditions with requirements for documentation, staff training and oversight, add requirements for special care facilities, and admissions agreements.

The Department of Health Services implemented a pilot program to test two models for covering assisted living services under a Medicaid HCBS waiver. One model covers services in licensed RCFEs and the second delivers services in elderly housing settings.

The Community Care Licensing Division plans to revise and post technical guides on their website. The website includes a manual that interprets regulations and gives guidance to facilities about how to apply the rules.

## Adult Foster Care

No requirements were reported.

Web Address	Content
<a href="http://www.dss.cahwnet.gov/ord/CCRTitle22_715.htm">http://www.dss.cahwnet.gov/ord/CCRTitle22_715.htm</a>	Rules
<a href="http://www.cclid.ca.gov/docs/cclid_search/cclid_search.aspx">http://www.cclid.ca.gov/docs/cclid_search/cclid_search.aspx</a>	List
<a href="http://www.cclid.ca.gov/PG832.htm">http://www.cclid.ca.gov/PG832.htm</a>	Provider

Category	Supply					
	2007		2004		2002	
	Facilities	Units	Facilities	Units	Facilities	Units
Residential care facilities for the elderly	7,471	161,586	6,543	154,830	6,207	147,580

## Definition

*Residential Care Facility for the Elderly* means a housing arrangement chosen voluntarily by the resident, the resident's guardian, conservator or other responsible person; where 75% of the residents are 60 years of age or older and where varying levels of care and supervision are provided, as agreed to at time of admission or as determined necessary at subsequent times of reappraisal. Any younger residents must have needs compatible with other residents.

## **Unit Requirements**

Occupancy is limited to two residents per bedroom, which must be large enough to accommodate easy passage between beds, required furniture, and assistant devices such as wheelchairs or walkers. One toilet and sink is required for every six residents and a bathtub or shower for every ten residents.

## **Admission/Retention Policy**

Facilities may admit or retain residents who are capable of administering their own medications; receive medical care and treatment outside the facility or from a visiting nurse; repeat persons who because of forgetfulness or physical limitations need only be reminded or to be assisted to take medication usually prescribed for self-administration; persons with problems including, but not limited to, forgetfulness, wandering, confusion, irritability, and inability to manage money; and people with mild dementia or mild temporary emotional disturbance resulting from personal loss or change in living arrangement.

Facilities may not admit or retain anyone with a communicable disease; anyone who requires 24-hour skilled nursing or intermediate care or residents whose primary need for care and supervision results from either an on-going behavior, caused by a mental disorder, that would upset the general resident group; or dementia, unless certain requirements (Section 87724) are met or the resident is bedridden. The regulations allow residents with health conditions requiring incidental medical services which are specified in the rules (e.g., administration of oxygen, catheter care, colostomy/ileostomy care, contractures, diabetes, enemas, suppositories, and/or fecal impaction removal, incontinence of bowel and/or bladder, injections, intermittent positive pressure breathing machine, and Stage I and II dermal ulcers) to be admitted and retained if the resident can perform the care or a licensed professional provides care. Facilities may not serve people who require care for Stage III and IV dermal ulcers, gastrostomy care, naso-gastric tubes, tracheostomies, staph infection or other serious infection, and/or who depend on others to perform all ADLs.

Residents who will be bedridden more than 14 days may be retained if the facility notifies the Department of Social Services that the condition is temporary.

## **Nursing Home Admission Policy**

Beneficiaries must have a medical condition that requires an out-of-home protective living arrangement with 24-hour supervision and skilled nursing care or observation on an on-going intermittent basis to abate health deterioration.

## **Services**

Services are divided into: (1) basic services; and (2) care and supervision. Basic services include safe and healthful living accommodations; personal assistance and care; observation and supervision; planned activities; food service; and arrangements for obtaining incidental medical and dental care. Care and supervision covers assistance with ADLs and assumption of varying degrees of responsibility for the safety and well-being of residents. Tasks include assistance with dressing, grooming, bathing, and other personal hygiene; assistance with self-administered medications; and central storing and distribution of medications.

Legislation enacted a few years ago requires that RCFEs inform residents that they have the right to have an advance directive. A brochure explaining advance directives was developed for care providers to give residents.

Legislation enacted in 1994 allows hospice care provided the resident contracts individually with a hospice agency. Facilities must request a waiver to allow hospice care and be able to meet the resident's needs when the hospice agency is not present. If the resident shares a room, the other party needs to agree to allow hospice care in the shared living space.

## **Dietary**

The total daily diet must meet the recommended dietary allowances of the Food and Nutrition Board of the National Research Council. At least three meals and snacks must be provided in facilities that have responsibility for all food arrangements. Meals must include an appropriate variety of foods, planned in consideration of cultural and religious backgrounds and resident preferences. Modified diets prescribed by physicians are provided. Facilities with 16-49 residents must designate one person with appropriate training to be responsible for food planning, service, and preparation. Staff must have training or related experience on the assigned job tasks.

## **Agreements**

Admission agreements must be signed within seven days of admission and include provisions for: the basic services available; optional services; payment provisions (i.e., basic rate, optional service rate, payer, due date, funding source); process for changing the requirements and a 60-day notice; and refund; that the Department or licensing agency has the authority to examine residents' records as a part of their evaluation of the facility; general facility policies which are for the purpose of making it possible for residents to live together; actions, circumstances, or conditions which may result in the resident's eviction from the facility; the facility's policy concerning family visits and other communication with residents; and other conditions under which the agreement may be terminated.

## **Provisions for Serving People with Dementia**

RCFEs that serve people with dementia must have adequate staff to support each resident's physical, social, emotional, safety and health care needs. Staff must have additional training on dementia care (knowledge about hydration, skin care, communication, therapeutic activities, behavioral challenges, the environment and assisting with ADLs); recognizing symptoms that create or aggravate dementia behaviors; and recognizing the effects of dementia.

RCFEs that market themselves as special care facilities must include in their plan of operation a description of the philosophy of the program, preadmission assessment, admission information (areas where special care is provided, services available, and procedures to review the plan of operation), assessment, activity programs, staff qualifications and staff training, the physical environment, procedures to follow when there is a change in a resident's condition and procedures to review the program's effectiveness. Staff training includes six hours of orientation and eight hours in-service training on topics related to serving people with dementia. At least two of the following topics must be covered each year and all within three years: the effects of medication on the behavior of residents; common problems (wandering, aggression, and inappropriate sexual behavior); positive therapeutic interventions; communication skills; promoting resident dignity, independence, privacy and choices; and end of life issues.

## **Medication Administration**

Facility staff may assist with self-administration of medications and, if authorized by law, administer injections. Medications may also be administered by licensed home health agency personnel. Beginning January 2008, the new law requires direct care staff in RCFEs, excluding licensed medical professionals, to meet specified training requirements, including passing an examination, in order to be able to assist residents with the self-administration of medications. It does not authorize unlicensed personnel to directly administer medications. This law requires 16 hours of initial training on specified topics relating to medications (including eight hours of hands-on shadowing and eight hours of other training or instruction) for staff who assist residents with the self-administration of medications in facilities licensed with a capacity of 16 or more residents, and six hours (including two hours of hands-on shadowing and four hours of other training or instruction) for staff in facilities with a licensed capacity of 15 or fewer residents. The training material and exam for all RCFEs must be developed by, or in consultation with, a licensed nurse, pharmacist or physician. Each employee who received the initial training and passed the required exam, and who continues to assist with the self-administration of medications, must also complete four hours of in-service training on medication-related issues in each succeeding 12-month period.

## **Public Financing**

The California Department of Health Services developed an Assisted Living Waiver Pilot Project (ALWPP) in three counties: Sacramento, San Joaquin and Los Angeles, and serve 1,000 people over three years in two different settings -- licensed RCFEs and conventional elderly housing sites. The legislature wanted to test ALPs as an effective alternative to long-term placement in a nursing home. In RCFEs, services are delivered to participants by staff and in

elderly housing sites, services are delivered by home health agency staff. In the summer of 2007, there were 20 licensed ALFs participating in the pilot program serving 205 participants.

The pilot requires private occupancy, with shared occupancy only by residents' choice. Units will have a kitchen area equipped with a refrigerator, a cooking appliance (microwave is acceptable), and storage space for utensils and supplies.

The project developed a four-tiered payment methodology based on the tiers used in Arkansas. The bundled rate includes payment for the following services: 24-hour awake staff to provide oversight and meet the scheduled and unscheduled needs of residents; provision and oversight personnel and supportive services (assistance with ADLs and IADLs); health-related services (e.g., medication management services); social services; recreational activities; meals; housekeeping and laundry; and transportation. The SSI/SSP standard in licensed facilities is \$1,035 a month with a PNA of \$119. The SSP is \$412. The payment standard includes the following components: room and board, \$444; care and supervision, \$472; and up to \$916 for basic services.

Medicaid Payment Rates -- Waiver Pilot Services (2007)	
Assisted living services	
Tier 1	\$52 per day
Tier 2	\$62 per day
Tier 3	\$71 per day
Tier 4	\$82 per day
Care coordination	\$200 per month
Nursing home transition coordination	\$1,000
Consumer education -- up to 10 hours in 1 <sup>st</sup> year	\$22 an hour
Interpretation/translation -- 4 hours per year	\$59 an hour

## Staffing

Administrators of facilities with 16-49 beds must have 15 college credits and in facilities with 50 or more units, two years of college or three years of experience or equivalent education and experience. Administrators who do not have a license must complete a certification program and 12 hours of classroom training.

Sufficient staff must be employed to deliver services required by residents. On-the-job training or experience is required in the principles of nutrition, food storage and preparation, housekeeping, and sanitation standards; skill and knowledge to provide necessary care and supervision; assistance with medications; knowledge to recognize early signs of illness; and knowledge of community resources.

Requirements for awake staff vary by the size of the facility. For 16 or fewer, staff must be available in the facility; 16-100, at least one awake staff; 101-200, one on call and one awake, with an additional awake staff for each additional 100 residents.

## Training

*Administrators.* Individuals shall complete an approved certification program prior to being employed as an administrator. The program must include 40 hours of classroom training which covers laws, rights, regulations, and policies (eight hours); business operations (three hours); management and supervision (three hours); psycho-social needs of the elderly (five hours); physical needs of the elderly (five hours); community and support services (two hours); use, misuse, and interaction of drugs (five hours); admission, retention, and assessment procedures (five hours) and four hours in the care of residents with Alzheimer's Disease and other dementias. All administrators shall be required to complete at least 20 clock hours of continuing education per year in areas related to aging and/or administration.

*Staff.* All personnel must be given on-the-job training or have related experience in: the principles of good nutrition, good food preparation and storage and menu planning; housekeeping and sanitation procedures; skill and knowledge required to provide necessary resident care and supervision including the ability to communicate with residents; knowledge required to safely assist with prescribed medications which are self-administered; knowledge necessary in order to recognize early signs of illness and the need for professional help; and knowledge of community services and resources. All RCFE staff who assist residents with personal ADLs shall receive at least ten hours of initial training within the first four weeks of employment and at least four hours annually. The training shall include, but not be limited to, the following: the aging process and physical limitations and special needs of the elderly; the importance and techniques of personal care services, including but not limited to, bathing, grooming, dressing, feeding, toileting, and universal precautions (at least three of the required ten hours shall cover this subject; residents' rights; policies and procedures regarding medications (at least two of the required ten hours shall cover this subject); psycho-social needs of the elderly, such as recreation, companionship, independence, etc.; and recognizing signs and symptoms of dementia in individuals.

Facilities licensed for 16 or more must have a planned on-the-job training program in the above areas including orientation, skill training, and continuing education.

## **Background Check**

The licensing agency conducts a criminal background check of officers of the organization, staff responsible for administration and direct supervision, persons providing direct care, and employees having frequent contact with residents and others and may approve or deny a license or employment based on its findings. A fingerprint clearance shall 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.

## Monitoring

Facilities are inspected on a rotating basis. Facilities are inspected on a random sample basis, but at least once every five years. Facilities that require “targeted visits” will be visited on an annual basis. These consist of facilities that need closer attention because of their compliance histories. Three levels of penalties are allowed for violations with an: (A) immediate, (B) potential, and (C) technical impact. Fifty dollars per day civil penalties are allowed for A and B violations increasing to \$100 per day if the same violation is repeated three times in a 12-month period. Consultation is provided for Type C violations. The licensing agency is mandated to conduct an investigation within ten days on any complaint received against a facility.

## Fees

Licensing fees required at initial licensure and annually thereafter are adjusted by facility size.

Licensing Fees (June 2005)		
Capacity	Application	Annual
1-3	\$375	\$375
4-6	\$750	\$375
7-15	\$1,126	\$563
16-30	\$1,500	\$750
31-49	\$1,876	\$938
50-74	\$2,252	\$1,126
75-100	\$2,628	\$1,314
101-150	\$3,004	\$1,502
151-200	\$3,502	\$1,751
201-250	\$4,000	\$2,000
251-300	\$4,500	\$2,250
301-350	\$5,000	\$2,500
351-400	\$5,500	\$2,750
401-500	\$6,500	\$3,250
501-600	\$7,500	\$3,750
601-700	\$8,500	\$4,250
701+	\$10,000	\$5,000

# COLORADO

**Citation** Assisted living residences: Chapter VII, §1.1 et seq.

## General Approach and Recent Developments

Significant revisions to the regulations were adopted in 2005 and additional changes were approved in 2006. The revisions changed the licensing category to ALRs and added intermediate sanctions. Additional attention may focus on the qualifications for administrators, the high percentage of residents in some facilities that receive hospice services and staffing.

The Department of Public Health website has links to interpretive guidelines, the survey protocol, and a consumer comparison checklist that covers provider agreements, license/certification, Medicaid participation, space, safety, care plans, personal services, staff, meals, socialization, communication, and facility tour/observations. It also posts the ten most commonly cited deficiencies for each quarter.

## Adult Foster Care

AFHs serving three or more individuals are covered by the ALR licensing regulations. Homes serving one or two individuals are not required to obtain a license.

Web Address	Content
<a href="http://www.cdphe.state.co.us/hf/alr/index.html">http://www.cdphe.state.co.us/hf/alr/index.html</a>	Rules, lists, consumer, provider

Category	Supply					
	2007		2004		2002	
	Facilities	Units	Facilities	Units	Facilities	Units
Assisted living residences	495	14,237	525	13,779	538	14,291

## Definition

The regulations define *assisted living residence* or *residence* as a residential facility that makes available to three or more adults not related to the owner of such facility -- either directly or indirectly -- through a resident agreement with the resident, room and board and at least the following services: personal services; protective oversight; social care due to impaired capacity to live independently; and regular supervision that shall be available on a 24-hour basis, but not to the extent that regular 24-hour medical or nursing care is required. The definition includes residential treatment facilities (RTFs) for individuals with mental illness that serve no more than 16 people. The term "assisted living residence" does not include any facility licensed in this state as a RCF for individuals with developmental disabilities, or any individual residential support

services that are excluded from licensure requirements pursuant to rules adopted by the department.

## **Unit Requirements**

The rules allow no more than two people to share a room for facilities built after July 1, 1986. Single occupancy rooms must have at least 100 square feet and double occupancy rooms at least 60 square feet per person. One full bathroom is required for every six residents. Cooking is not allowed in bedrooms, and facilities provide access to a food preparation area for heating or reheating food or making hot beverages subject to “house rules.” Cooking may be allowed in facilities that provide apartments rather than bedrooms. Facilities that are Medicaid certified are prohibited from cooking. However, microwaves can be used if the facility has assessed the resident for his or her ability to safely use the appliance.

## **Admission/Retention Policy**

ALRs may not admit or retain residents who are:

- Consistently, uncontrollably incontinent unless the resident or staff is able to prevent it from becoming a health hazard;
- Totally bedridden with limited potential for improvement;
- In need of 24-hour nursing or medical service;
- In need of restraints;
- Have a communicable disease; or
- Has a substance abuse problem unless it is no longer acute.

A facility may keep a resident who becomes bedridden if a physician describes the services needed to meet the health needs of the residents, there is an on-going assessment and monitoring by a licensed home health agency or hospice service that ensures that the resident’s physical, mental and psychological needs are met, and there is adequate staff trained in the needs of bedridden residents.

Additional criteria are applied to facilities contracting with Medicaid as ACFs. ACFs may not admit or retain anyone needing more than intermittent skilled services; who has an acute illness that cannot be managed through medications or therapy; is unable or unwilling to meet his or her own personal hygiene needs under supervision; has ambulation limitations, unless compensated by assistive devices or staff; is consistently disoriented to the extent that he or she poses a danger to themselves or others; requires tray food service on a continuous basis; or is consistently unwilling to take prescribed medication.

Residents may be allowed to receive hospice care if they are long-term residents (i.e., the facility has been their home), the facility can continue to meet the needs of the other residents, and staff are trained and are not doing things outside their scope of practice. Residents requiring hospice care upon admission would not be accepted.

## **Nursing Home Admission Policy**

Medical eligibility is determined by local Utilization Review Contractors according to guidelines based on a functional needs assessment of the following areas: confusion or contact with reality; behavior; communication; mobility; bathing; dressing; eating/feeding; bowel continence; bladder continence; skin care; vision; hearing; need for supervision and observation; and living skills (i.e., cooking, shopping, laundry, etc.). Residents must need skilled or maintenance services at least five days a week. Skilled and maintenance services are performed in the following areas: skin care; medication; nutrition; ADLs; therapies; elimination; and observation and monitoring.

[NOTE: The determinations were formerly made by the statewide Peer Review Organization.]

The scores in each of the functional areas are based on a set of criteria and weights which measures the degree of impairment in each of the functional areas. When the combined score in each of the functional areas exceeds 19 points, the nurse reviewer may certify that the person being reviewed is eligible for placement in a nursing facility. If the score is less than 20 points, a physician advisor may use professional judgment to determine the individual's need for the level of services provided in a nursing facility.

## **Services**

Facilities must provide a physically safe and sanitary environment, room and board, personal services (i.e., transportation, assistance with ADLs and IADLs, individualized social supervision), social and recreational services, protective oversight, and social care. Written care plans, which must be reviewed at least annually, are required for each resident and include a comprehensive assessment of physical, health, behavioral and social needs and capacity for self-care, a list of current prescribed medications (i.e., dosage, time and route of administration, whether self-administered or assisted), dietary restrictions, allergies, and any physical or mental limitations or activity restrictions. Nursing and therapies may be received if provided by a home health agency.

## **Dietary**

Three nutritionally balanced meals using a variety of foods from the basic food groups and snacks of nourishing quality are required. Therapeutic diets prescribed by a physician are provided, and the recipes are available for review. Meals cannot be routinely provided in resident rooms unless indicated on the care plan. Staff must receive on-the-job training or have experience in the tasks assigned to them.

## **Agreements**

A copy of the resident agreement must be provided upon move-in. The agreement must include: charges, refunds and deposit policies; services included in the rates and charges, including optional services for which there will be an additional, specified charge; types of services provided by the facility, those services which are not provided, and those which the facility will assist the resident in obtaining; bed hold fees; transportation services; therapeutic diets; and whether the facility will be responsible for providing bed and linens, furnishing and supplies. There must also be written evidence that the facility has disclosed the policies and procedures (e.g., admissions; discharges; emergency plan and fire escape procedures; illness, injury or death; resident rights; smoking; management of residents' funds; internal grievance process; investigation of abuse and neglect allegations; and restrictive egress devices); method of determining staffing levels and the extent to which certified or licensed health professionals are available on-site; whether the facility has an automatic sprinkler system; if the facility uses restrictive egress alert devices and the types of behavior exhibited by persons needing such devices. An addendum to the agreement includes the care plan and house rules.

## **Provisions for Serving People with Dementia**

Facilities must disclose that they operate a secure environment, information about the type of diagnosis or behaviors served and for which staff are trained. Facilities serving people whose right to move outside the environment is limited must have a secured environment. For a facility to serve a resident in a secured environment, legal authority must be established by guardianship, court order, health care proxy, or durable power of attorney. Assessments that evaluate (by a qualified professional) the need for a secured environment must be completed. Reassessments must be completed within ten days of a significant change to determine whether placement is appropriate. Staff and the owner/operator must have appropriate training. Facilities with secured environments must establish a forum that meets at least quarterly for family members to make suggestions, and express concerns and grievances. Families meet with the administrator and a staff representative. Suggestions must be responded to in writing.

In addition to the interior common areas required, the facility shall provide a safe and secure outdoor area for the use of residents year round. Fencing or other enclosures may be installed around secure areas. Residents must be able to access the secure areas in facilities establishing a secured environment.

## **Medication Administration**

Most larger facilities have hired LPNs to administer or manage medications and ensure that physicians' orders have been received and recorded. Staff who have completed a medication training course given by a licensed nurse, physician, physician's assistant, or pharmacist and who have passed a competency test may assist with and administer medications (except injections).

Changes adopted in 2006 allow ALRs to establish a policy, that meets the criteria in the regulations, to accept donated medications to be re-dispensed by a pharmacist.

## Public Financing

Services in “alternative care facilities,” the Medicaid term for assisted living, have been covered since 1984 under a 1915(c) waiver for elders, people with disabilities, MR/DD, and people with mental illness. Medicaid rules limit room and board charges for Medicaid recipients to \$571 a month. The Medicaid rate for services is \$47.58 a day. The rate covers oversight, personal care, homemaker, chore, and laundry services. A pilot program tested the impact of an enhanced rate to create incentives to retain people as their needs increased and to accept residents with greater needs from nursing homes and hospitals. An additional \$400 per month was available for residents who have enhanced needs in three of four areas: personal care, mobility, incontinence, and behavior/confusion. A tiered rate methodology was developed but has not yet been adopted.

The SSI payment is \$668 includes a state supplement. The amount remaining for personal needs after room and board is \$97 a month.

Medicaid Payment Rates 2007 (31 day month)	
Room and board	\$571.00
Service	\$1,474.98
Total	\$2,045.98

Medicaid Participation					
2007		2004		2002	
Facilities	Participation	Facilities	Participation	Facilities	Participation
281	3,800	273	3,804	266	3,773

Family members are allowed to supplement resident income for items that are not covered in the Medicaid rate. Most supplementation allows residents to move from a semiprivate to private unit. Medicaid allows residents up to 42 days “leave” per year for non-medical purposes. Facilities receive the Medicaid payment during this period.

## Staffing

Facilities must employ sufficient staff to ensure provision of services necessary to meet resident needs including services provided under the care plan and services provided under the resident agreement. Facilities contracting with Medicaid must maintain a 1:10 staff ratio during the day and a 1:15 ratio from 7 p.m. to 6 a.m., unless a lower ratio that does not jeopardize the health and safety of residents can be documented. Facilities that are Medicaid certified and provide a secure environment must have a 1:6 ratio and awake staff at all times.

## **Training**

*Administrators* must meet the minimum education, training, and experience requirements by successfully completing a program approved by the department. Acceptable programs may be conducted by an accredited college; university or vocational school; or a program, seminar, or in-service training program sponsored by an organization, association, corporation, group, or agency with specific expertise in that area. The curriculum includes at least 30 actual clock hours of which at least 15 consist of a discussion of each of the following topics: resident rights; environment and fire safety, including emergency procedures and first aid; assessment skills; identifying and dealing with difficult behaviors; and nutrition.

The remaining 15 hours shall provide emphasis on meeting the personal, social, and emotional care needs of the resident population served.

Administrators of facilities contracting with Medicaid must complete training on rules and regulations for ACFs.

*Staff.* All staff, including volunteers, must be given on-the-job training or have related experience in the job assigned to them and shall be supervised until they have completed on-the-job training appropriate to their duties and responsibilities or have had previous related experience evaluated. Training and orientation in emergency procedures shall be provided to each new staff member, including volunteers, within three days of employment.

Staff members not serving as an operator of the facility who have direct responsibility for the provision of personal care (i.e., hygiene) of residents or for the supervision or training of residents in the residents' own personal care, shall provide documentation of either successful completion of course work in the provision of personal care or previous and related job experience in providing personal care to residents.

Before providing direct care, staff must receive training specific to the needs of the population served, resident rights, environment and fire safety, first aid and injury response, the care and services of current residents, and the facility's medication administration program.

The facility shall provide adequate training and supervision for staff comprising a discussion of each of the following topics: resident rights, environment and fire safety, including emergency procedures and first aid; assessment skills; and identifying and dealing with difficult situations and behaviors.

ACF staff must be trained in the needs of the population served.

## **Background Check**

The owner or licensee may have access to and shall obtain any criminal history record information from a criminal agency for all persons responsible for the care and welfare of residents. Owners and administrators must undergo a finger print check. Owners are responsible

for obtaining a criminal background check of administrators to determine whether they have been convicted of a felony and misdemeanor that could pose a risk to the health, safety and welfare of residents.

## **Monitoring**

The regulations require that facilities provide the ombudsman program with access to the facility and residents at reasonable times. Remedies include requiring written plans to correct violations found as a result of inspections; retaining a consultant to address corrective measures; monitoring by the department for a specific period; providing additional training to employees, owners, or operators of the residence; complying with a directed written plan to correct the violation; or paying a civil fine not to exceed \$2,000 in a calendar year.

Civil fines are used for expenses related to continuing monitoring; education to avoid restrictions or conditions or to facilitate the application process or the change of ownership process; education for residents and their families about resolving problems with a residence, rights of residents, and responsibilities of residences; providing technical assistance to any residence for the purpose of complying with changes in rules or state or federal law; relocating residents to other facilities or residences; maintaining the operation of a residence pending correction of violations; closing a residence; or reimbursing residents for personal funds lost.

## **Fees**

The statute requires an application fee of \$150, plus \$23 per bed. Fees for facilities with a high percentage of Medicaid beneficiaries (over 35% of the residents) pay \$15 per bed. Fees for new construction are \$5,000. Facilities pay a fee of \$2,500 to reissue a license due to a change in ownership. Facilities with secure environments are assessed a fee of \$1,150.

The rules establish fees for reviewing construction plans: new construction or remodeling of 2,000 square feet or less, \$500; and \$0.25 per additional square foot over 2,000. Remodeling limited to installation or renovation of fire suppression systems: 3-16 beds, \$500; 17-40 beds, \$750; 41-60 beds, \$1,000; and 61 or more beds, \$1,250. Fees cannot exceed \$2,000.

# CONNECTICUT

**Citation** Assisted living services agency: Connecticut General Statutes §19a-490  
 Connecticut Department of Public Health, Public Health Code §19-13-D105  
 Residential care homes (homes for the aged, rest homes): §19-13-D-6

## General Approach and Recent Developments

Assisted living regulations issued by the health department were last revised in June 2001. The 2007 legislature considered but did not pass changes to the state’s approach which would license both the service and the setting. The current regulations take a unique approach by allowing “managed residential communities” (MRCs) to offer assisted living services through ALSAs. MRCs may obtain a license to also serve as an ALSA. Rules governing medication administration in RCHs were revised in March 2002. A workgroup will be established to revise the regulations.

State policymakers and legislators are concerned about aging-in-place, medication administration and the needs of individuals with dementia. “Scheduling” services is not as responsive to people with dementia and higher levels of impairment. Since the regulations went into effect, residents have aged in place, and the state wants to ensure that residents are receiving the right amount of services. The state encourages aging-in-place, but as the regulatory body, needs to ensure that services are available to meet resident needs.

## Adult Foster Care

Adult Family Living, which is regulated by the Department of Social Services, is an AFC 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 when needed and assistance with ADLs, housekeeping, shopping and meals.

Web Address	Content
<a href="http://www.dph.state.ct.us/phc/docs/50_Assisted_Living_Services.doc">http://www.dph.state.ct.us/phc/docs/50_Assisted_Living_Services.doc</a>	Rules
<a href="http://www.dph.state.ct.us/phc/docs/39_Long-term_Hospitals.doc">http://www.dph.state.ct.us/phc/docs/39_Long-term_Hospitals.doc</a>	RCH rules (D6)

Category	Supply							
	2007		2004		2002		2000	
	Facilities	Units	Facilities	Units	Facilities	Units	Facilities	Units
Assisted living services agencies	63	NA	65	NA	63	NA	48	NA
Managed residential communities	100*	NA	104	NA	NA	NA	NA	NA
Residential care homes	100	2,808	100	2,753	109	2,949	113	NR
* NOTE: Some ALSAs serve more than one MRC.								

The ALSA regulations focus on the licensing of agencies to provide services rather than the licensing of building and services as an entity. MRCs have to notify the health department of their intention to provide assisted living services and present specified information and assurances to the department. The ALSA, either the MRC or another agency, must be licensed by the Department of Public Health to provide services. The MRC is not licensed by the Department of Public Health. MRCs must show evidence of compliance with local zoning ordinances and building codes.

A pilot program to build 300 units to serve low income residents has been implemented jointly by the Department of Social Services, Department of Economic Development, Department of Public Health, Office of Policy and Management and the Connecticut Housing Finance Authority.

## **Definition**

An *assisted living services agency* means an institution that provides, among other things, nursing services and assistance with ADLs to a population whose conditions are chronic and stable.

*Assisted living services* means nursing services and assistance with ADLs provided to clients living within a managed group-living environment having supportive services that encourage clients primarily age 55 or older to maintain a maximum level of independence. Routine household services may be provided as assisted living services or by the managed residential community (MRC). These services provide an option for elderly persons who require some help or aid with ADLs and/or nursing services.

A *managed residential community* means a facility consisting of private residential units that provides a managed group living environment, including housing and services primarily for persons age 55 or older.

*Residential care home* means an institution having facilities and all necessary personnel to furnish food, shelter and laundry for two or more persons unrelated to the proprietor and in addition, to provide services of a personal nature which do not require the training or skills of a licensed nurse. Additional services of a personal nature may include assistance with bathing, help with dressing, preparation of special diets and supervision over medications which are self-administered.

## **Unit Requirements**

*Managed residential communities.* To qualify as a MRC and a setting in which assisted living services may be provided, units are defined as a living environment belonging to a tenant(s) that includes a full bathroom within the unit including water closet, lavatory, tub or shower bathing unit, and access to facilities and equipment for the preparation and storage of

food. MRCs may not require tenants to share units. Sharing of a unit shall be permitted solely upon the request and mutual consent of tenants.

*Residential care homes.* Single rooms must have a minimum of 150 square feet, excluding closets, toilet rooms, lockers or wardrobes and vestibule. Multiple bed rooms must have a minimum of 125 square feet per bed. A resident unit shall be 25 beds. No resident room shall be designed to permit more than two beds. Baths must have one separate shower or bathtub for every eight residents. There must be one separate shower and one separate bathtub per resident unit. One toilet may serve two resident rooms, but no more than four residents.

## **Admission/Retention Policy**

*Assisted Living Service Agencies.* Each ALSA agency will develop its own admission and discharge criteria but the regulations do not allow the ALSAs to impose unreasonable restrictions and screen out people whose needs may be met by the ALSA. 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.

Discharge policies must include categories for the discharge of clients, which include but are not limited to change in resident's condition; routine discharge; emergency discharge; financial discharge; and premature discharge.

## **Nursing Home Admission Policy**

The state requires that residents have uncontrolled and/or unstable and/or chronic conditions requiring continuous skilled nursing services and/or nursing supervision or have chronic conditions requiring substantial assistance with personal care on a daily basis.

## **Services**

*Assisted Living Service Agencies.* Core services provided by MRCs include three meals a day; laundry; scheduled transportation; housekeeping; maintenance services including chore services for routine domestic tasks that the tenant is unable to perform; and social and recreational services. In addition, 24-hour a day security and emergency call systems in each unit are required. Communities must have a service coordinator who assists tenants and acts as a liaison with the ALSA. Service coordinators ensure that all core services are provided to or are made available to residents, assist residents in making arrangements to meet their personal needs, establish collaborative relations with provider agencies, support services and community resources, establish a resident council, and ensure that a resident information system is in place.

The MRC, through its service coordinator or any other representative, may not provide health services, including but not limited to the provision of rehabilitative therapy, administration or supervision of the self-administration of medications, nursing care or medical treatment,

unless it has been licensed as an ALSA. It may contract with one or more ALSAs, home health care agencies, or other appropriately licensed health care providers to make available health services for tenants provided by such licensed persons or entities.

The state expects to require a standardized assessment instrument to establish a consistent approach to assessing residents, to simplify oversight and to improve quality of care.

Trained aides may provide assistance with ADLs; assistance with exercise, ambulation, transfer, and self-administration of medications; and routine household tasks.

Nursing services may only be provided by licensed ASLAs or other appropriately licensed agencies or individuals. Nursing services include client teaching, wellness counseling, health promotion and disease prevention, medication administration and delegation of supervision of self-administered medications, and provision of care and services to clients whose conditions are chronic and stable.

RNs may also perform quarterly assessments, coordination, orientation, training, and supervision of aides.

*Residential care homes.* Services provided include recreational activities, laundry, housekeeping, and maintenance services.

## **Dietary**

*Assisted Living Service Agencies.* Managed residential communities must offer three meals a day. Other aspects of food service are not specified in the ALSA regulations.

*Residential care homes.* Menus shall be prepared, posted and filed and shall meet state department of health requirements for basic nutritional needs.

## **Agreements**

*Assisted Living Service Agencies.* A “bill of rights” must be developed and signed for each resident upon move-in. The agreement includes: services available, charges and billing mechanisms; 15-day notice of changes; criteria for admission to service; rights to participate in service planning; client responsibilities; information about the complaint process; circumstances for discharge; description of Medicare-covered services and billing and payment for such services and other rights.

*Residential care homes.* Agreements are not required for RCHs.

## Provisions for Serving People with Dementia

Not specified.

## Medication Administration

*Assisted Living Service Agencies.* The regulations allow for administration of medications by licensed staff. Assisted living aides may supervise the self-administration of medications which includes reminding, verifying, and opening the package. All medications must be stored in the resident's unit.

*Residential care homes.* Residents of licensed RCHs may self-administer medications, and may request assistance from staff with opening containers or packages and replacing lids. Unlicensed personnel who administer medications must be certified.

Prior to the administration of any medication by program staff members, the program staff members who are responsible for administering the medications shall first be trained by a registered pharmacist, physician, physician assistant, advanced practice RN or RN in the methods of administration of medications and shall have successfully completed a written examination and practicum administered by the Connecticut League For Nursing or other department-approved certifying organization.

## Public Financing

The state provides assisted living services through ALSAs to elders in 16 state-funded congregate housing projects and three HUD facilities that have been approved as MRCs. State general revenue and Medicaid waiver funds were made available January 1, 2003, for a pilot program that serves 75 people in private ALFs. State funds are available to residents who do not meet Medicaid financial eligibility standard or functional criteria for the HCBS waiver.

Medicaid Participation					
2007		2004		2002	
Facilities	Participation	Facilities	Participation	Facilities	Participation
25	439	34	65	NA	NA

A Request for Proposal (RFP) was issued in 1999 by the Connecticut Housing Finance Authority "to test the extent to which subsidized assisted living communities are a viable and cost effective response for frail seniors facing inappropriate nursing facility admission." The Assisted Living Demonstration Project began in September 2004. The project is a result of collaboration between key agencies such as the Connecticut Housing Finance Authority, the Department of Economic and Urban Development, Office of Policy and Management and, the Department of Social Service. The resulting program created four affordable living projects where clients pay the room and board and Connecticut Home Care Program provides the personal care services. Two hundred nineteen (219) subsidized units have been selected thus far.

At least 40% of the units must be occupied by residents with less than 50% of the median income.

Services for eligible low income residents (less than \$1,869 per month income or 300% of the federal SSI benefit) are covered by the state's home care and Medicaid waiver programs. Tenants may retain a PNA of \$164.10. Residents pay a share of the rent and \$330 a month for meals. The income disregard depending on living arrangement is either \$207 for a single person or \$279 for a couple. Shelter costs are capped at \$400. Any remaining income is applied to the cost of the Medicaid, or state-funded, services. Family supplementation is allowed.

Reimbursement for core services (i.e., housekeeping, laundry, maintenance/chore, recreation, medical and non-medical transportation, emergency response, and service coordination) is \$8 per day. Meals are billed to the client. Per diem payments for four levels of personal assisted living services are reimbursed as follows:

- Occasional personal services: 1-4 hour per week, including nursing supervision as needed: \$27.33 per day.
- Limited personal services: 4-8 hours per week of personal services plus nursing visits as needed: \$42.27 per day.
- Moderate personal services: 9-15 hours per week of personal services plus nursing visits as needed: \$57.79 per day.
- Extensive personal services: 15-25 hours per week of personal services plus nursing visits as needed: \$73.19 per day.

Under the Demonstration project described above, each project sets its own rates for each LOC but cannot exceed a maximum amount for each level. For the other assisted living initiatives the state is sponsoring, the rate for each LOC is set by the state.

## **Staffing**

*ALSAs* must have at least one RN in addition to an on-site supervisor. 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 for every 20 licensed nurses or aides. A sufficient number of aides must be available to meet residents' needs. All aides must be CNA or home health aides and must complete ten hours of orientation and one hour of in-service training every two months.

Twenty-four hour awake staff are not required since the needs vary among MRCs. However, 24-hour staffing could be required if indicated by resident plans of care. An RN must be available on-call, 24-hours-a-day.

*Residential care homes.* There must be at least one attendant on duty at all times for every 25 residents.

## **Training**

Each ALSA must have a ten hour orientation program for all employees which shall include but not necessarily be limited to the following:

- Organizational structure of the agency and philosophy of assisted living services;
- Agency client services policies and procedures;
- Agency personnel policies; and
- Applicable regulations governing the delivery of assisted living services.

Aides must pass a competency exam. Each agency shall have an in-service education policy that provides an annual average of at least one hour bimonthly for each assisted living aide.

The in-service training shall include but not be limited to current information regarding specific service procedures and techniques, and information related to the population being served.

*Residential care homes.* New staff must receive an initial orientation prior to being allowed to work independently including, but not limited to, safety and emergency procedures for staff and residents, the policies and procedures of the RCH, and resident rights.

Continuing education for program staff shall be required for 1% of the total annual hours worked (to a maximum of 12 hours) per year. Such education shall include, but is not limited to, resident rights, behavioral management, personal care, nutrition and food safety, and health and safety in general.

## **Background Check**

Not described.

## **Monitoring**

ALSA's are required to establish a quality assurance committee that consists of a physician, a RN, and a social worker. The committee meets every four months and reviews the ALSA policies on program evaluations, assessment and referral criteria, service records, evaluation of client satisfaction, standards of care, and professional issues relating to the delivery of services. Program evaluations are also to be conducted by the quality assurance committee. The evaluation examines the extent to which the MRC's policies and resources are adequate to meet the needs of residents. The committee is also responsible for reviewing a sample of resident records to determine whether agency policies were followed, whether services are provided only to residents whose LOC needs can be met by the ALSA, and whether care is coordinated and

appropriate referrals are made when needed. The committee submits an annual report to the ALSA summarizing findings and recommendations. The report and actions taken to implement recommendations are made available to the state Department of Public Health.

Agencies are inspected biennially. Penalties include revocation, suspension, or censure; letter of reprimand; probation; a restriction on acquisition of other entities; a consent order compelling compliance; and civil monetary penalties.

## **Fees**

Fees are not required for ALSAs. Legislation to require a fee of \$400 for a two year license is pending. RCHs pay a fee of \$450 for a two year license.

# DELAWARE

**Citation** Assisted living facilities: Title 16 Health and Safety, Division 3225 §1.0 et seq.  
Rest residential homes: Delaware code, Part II §59.0 et seq.

## General Approach and Recent Developments

The state added an assisted living category in 1997. No additional rest residential homes will be licensed and most have converted to ALFs. A Medicaid waiver was implemented in 1999.

The regulations were revised in July 2004. The definition of a reportable incident was revised to include all occurrences and events involving abuse, neglect or financial exploitation. The changes also require emergency electrical generators in ALFs and the prohibition against facilities serving an individual with a central line from an ALF was removed by creating an exception for subcutaneous venous ports.

Changes in October 2002 added a “purpose” section that describes the goal of the regulations to “promote and ensure the health, safety and well-being of all residents of ALFs ... to ensure that service providers will be accountable to their residents and the Department and to differentiate assisted living from nursing facilities.” It replaces the purpose statement that directs that the “services are provided based on the social philosophy of care and must include oversight, food, shelter and the provision or coordination of a range of services that promote quality of life of the individual. The social philosophy of care promotes the consumer’s independence, privacy, dignity and is provided in a home-like environment.”

## Adult Foster Care

The DHSS Division of Long-Term Care Residents Protection licenses family care rest homes which provide resident beds and personal care services for two or three residents who can no longer live independently and/or who need a family living situation. The home should provide friendly understanding to persons living there as well as appropriate care in order that the resident's self-esteem, self-image and role as a contributing member of the community may be reinforced. At the time of admission the client should be able to do all of the ADLs; that is, washing, bathing, feeding self, dressing, ambulating and providing for personal activities such as hygiene, comfort, toilet needs and so forth. No client with an indwelling catheter should be admitted unless all catheter care can be entirely done by the client. Rules are available at: <http://www.state.de.us/research/AdminCode/title16/3000/3315.shtml>.

Web Address	Content
<a href="http://www.dhss.delaware.gov/dhss/dlterp/services.html">http://www.dhss.delaware.gov/dhss/dlterp/services.html</a>	Provider, lists
<a href="http://www.state.de.us/research/AdminCode/title16/3000/3225.shtml#TopOfPage">http://www.state.de.us/research/AdminCode/title16/3000/3225.shtml#TopOfPage</a>	Regulations

Supply						
Category	2007		2004		2002	
	Facilities	Units	Facilities	Units	Facilities	Units
Assisted living facilities	29	1,804	29	1,738	27	1,300
Rest residential homes	3	NR	3	NR	6	160

## Definition

*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 IADLs.

*Rest residential home* is an institution that provides resident beds and personal care services for persons who are normally able to manage ADLs. The home should provide friendly understanding to persons living there as well as appropriate care in order that the resident's self-esteem, self-image, and role as a contributing member of the community may be reinforced.

## Unit Requirements

*Assisted living.* The rules require 100 square feet for single bedrooms in new facilities and converted facilities of more than 10 units, and 80 square feet per resident for rooms with two residents. No more than two residents may share a room. Bathrooms are provided in the unit or, if shared, one for every four residents. Consumers must have access to a readily available central kitchen if one is not provided in the unit. Bathing facilities must be provided in the unit or in a readily accessible area.

*Rest residential homes* provide 100 square feet for single occupancy and 80 square feet per resident for multiple occupancy rooms. No more than four people may share a room. One bathtub or shower and one toilet and wash basin are required for every four residents.

## Admission/Retention Policy

*Assisted living.* The rules do not allow agencies to admit people who require more than intermittent or short-term nursing care; require skilled monitoring, testing, and aggressive adjustment of medications and treatments; require monitoring of a chronic medical condition that is not essentially stabilized; are bedridden more than 14 days; have Stage III or IV pressure sores; require a ventilator; require treatment for a disease or condition which requires more than contact isolation; have an unstable tracheotomy or a stable tracheotomy of less than six months' duration; have an unstable peg tube; require IV or central line; wander to the extent that facilities cannot provide adequate supervision or security arrangements; pose a threat to themselves or others; or are socially inappropriate. Waivers may be granted to allow facilities to temporarily care for people with excluded conditions for up to 90 days so long as services are provided by appropriate health professionals. Revised regulations allow individuals needing an IV or central

line to be served if the facility meets specified documentation and service requirements. Resident specific waivers may be granted to continue serving residents with the above conditions if a physical states that they condition will improve within 90 days.

*Rest residential homes.* No specific requirements are stated other than in the definition of a resident.

## **Nursing Home Admission Policy**

Eligibility for the waiver is based on professional judgment concerning ADLs, and medication and safety supervision. Individuals must have impairments in two ADLs to receive waiver services in the home, and services in ALFs are targeted to people with three ADL impairments.

## **Services**

*Assisted living.* A medical evaluation and an assessment by an RN must be completed 30 days prior to admission using the Department's uniform assessment instrument and must be reviewed within 30 days after admission. Individual service agreements address all the physical, medical and psycho-social services to be provided: personal care, services by a licensed nurse, food, nutrition and hydration, environmental services (i.e., laundry, housekeeping, trash removal, and safety), psycho-social/emotional, banking, transportation, furnishings, assistive technology and durable medical equipment, rehabilitation services, and interpretive services.

Managed or negotiated risk agreements are used to describe mutually agreeable action that balances resident choice and independence with the health and safety of the resident and others. A managed/negotiated risk agreement is negotiated when the risks are tolerable to all parties participating in the development of the managed/negotiated risk agreement and a mutually agreeable action is negotiated to provide the greatest amount of resident autonomy with the least amount of risk. The resident must be capable of making choices and decisions and understanding consequences. The agreement clearly describes the problem, issue or service that is the subject of the managed/negotiated risk agreement; describes the choices available to the resident as well as the risks and benefits associated with each choice, the ALF's recommendations or desired outcome, and the resident's desired preference; indicates the agreed-upon option; describes the agreed upon responsibilities of all parties and is a part of the service agreement.

Facilities must use a standard assessment form developed by the licensing agency to assess functional, cognitive, physical, medical and psycho-social needs and status.

*Rest residential homes* provide shelter, housekeeping, board, and personal surveillance or direction in ADLs.

## **Dietary**

Food services are covered in the tenant service agreement.

## **Agreements**

Prior to executing a contract, residents must receive a statement of all charges. The contract includes non-financial and financial components. Financial topics include the rates for services and other ancillary charges, billing and payment policies, criteria for additional charges as needs change, and the process for changing the rates (60 day notice unless due to changes in acuity). The non-financial issues include a listing of basic and optional services; optional services that may be provided by third parties; a statement of resident's rights and an explanation of the grievance procedure; 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, staff's right to enter a resident's room, resident rights and obligations, temporary absence policy, interim service arrangement during an emergency, discharge policies and procedures, obligations of the facility, and a listing of the resident's personal belongings. The financial areas include the party responsible for handling finances, obtaining equipment and supplies, arranging services not covered by the contract, disposing of belongings, and the rate structure and payment provisions.

## **Provisions for Serving People with Dementia**

Facilities offering special care must disclose the philosophy of care; the population served; admission and discharge process and criteria; the assessment, care planning and implementation process; staffing plan and training policies; physical environment and design features; resident activities; family role; psycho-social services; nutrition and hydration services; policies on wandering, safe storage of medications and costs.

## **Medication Administration**

Aides who have passed an examination are allowed to assist with self-administration of medications. Rules governing assistance with medications are covered by regulations issued by the Board of Nursing. An RN must review medications within 30 days of admission for people who self-administer to assess the resident's cognitive and physical ability and need for assistance. Reviews are also conducted for residents who self-administer to ensure proper labeling and storage, that medications have been received, and to determine their effects and the presence of adverse side effects.

## Public Financing

The state provides waiver services to elders and adults with disabilities in ALFs with income below 250% of the federal SSI level. The SSI payment and state supplement is \$704 a month. The room and board payment for SSI beneficiaries is \$598 and residents retain a PNA of \$106 a month. Residents with higher incomes may be charged a higher room and board amount. Three levels of payment for services are available. The daily rates are: Level I, \$34.48 per day; Level II, \$42.37 per day; and Level III, \$51.41 per day. Facilities receive a 10% additional payment for residents with dementia or other cognitive impairments. The payment levels are based on spending for HCBS waiver clients living in their own homes and participants in the AFC program. Family members are allowed to supplement room and board payments.

The Medicaid waiver program coverage began late in 1999.

Medicaid Participation					
2007		2004		2002	
Facilities	Participation	Facilities	Participation	Facilities	Participation
15	217	29	14	11	NR

Medicaid Payment Rates (2007)			
	Level I	Level II	Level III
Room and board	\$598	\$509	\$598
Services	\$1,034	\$1,271	\$1,544
Total	\$1,632	\$1,869	\$2,142

## Staffing

ALFs must employ a sufficient number of trained staff to meet the needs of residents. They must also have a director of nursing who is a RN who is full-time in facilities over 25 beds, 20 hours a week in facilities with 5-24 beds, and eight hours a week in facilities under five beds.

## Training

*Assisted living administrators.* Requirements for administrators vary with the size of the facility. Facilities over 25 units must have a full-time nursing home administrator; 5-24 beds, a half-time nursing home administrator. Facilities with four or fewer beds must have an administrator with a baccalaureate degree or associates degree with two years experience, an RN with four years experience, or an LPN with four years experience or five years experience in a related health or social service field.

*Staff.* Resident assistant orientation covers fire and life safety and emergency disaster plans; infection control; basic food service; first aid and the Heimlich maneuver; job responsibilities; health and psycho-social needs of the residents served; 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. Orientation is required for temporary staff.

*Rest residential homes.* Nurse aide/nurse assistant staff must complete a training course approved by the state Board of Nursing and the Board of Health. Aides/assistants must be certified prior to employment. Section 609 describes the curriculum and the competencies that must be measured in the following areas: nurse aide role and function; environmental needs; psycho-social needs; and physical needs. Section 59.610 describes the qualifications of instructors and the training instructors must receive.

## **Background Check**

Facilities must obtain a report of each employee's entire criminal history record from the state Bureau of Identification and a report from DHSS regarding its review of a report of the person's entire federal criminal history. The state also has a mandatory drug testing law. Civil money penalties of \$1,000-\$5,000 per occurrence for violations of the criminal background check and drug testing law may be imposed by the licensing agency.

## **Monitoring**

*Assisted living.* Facilities must develop and implement an on-going quality assurance program that includes internal monitoring of performance and resident satisfaction. Satisfaction surveys of all residents must be conducted twice a year. Pending regulations will require reporting of falls without injury and falls with injuries that do not require transfer to an acute care facility or do not require reassessment of the resident; errors or omissions in treatment or medication; injuries of unknown source; and lost items, in accordance with facility policy.

## **Fees**

Fees are set by statute. The fee for an initial application and background examination is \$500. Annual fees are \$400 for facilities under 100 beds and \$550 for facilities over 100 beds.

# DISTRICT OF COLUMBIA

**Citation**      Community Residence Facilities: DC Law 5-48; DC Code §32-1301 et seq.;  
                          Chapter 34, §3400 et seq.  
                          Assisted Living Residences: DC Law 13-127 §60847 of DC Register, p. 2647

## General Approach and Recent Developments

The Assisted Living Residence Regulatory Act was passed in June 2000. Licensing is expected to begin in 2007. The assisted living law includes a philosophy of care that emphasizes personal dignity, autonomy, independence, privacy, and freedom of choice. The services and physical environment should enhance a person’s ability to age in place in a home-like setting by increasing or decreasing services as needed.

The HCBS Medicaid waiver was amended in June 2003 to include a new category of service for assisted living. The service will be implemented after licensure regulations for assisted living are developed.

## Adult Foster Care

No provisions reported.

Web Address	Content
<a href="http://app.doh.dc.gov/services/administration_offices/hra/crcfd/comm_res_fac.shtm">http://app.doh.dc.gov/services/administration_offices/hra/crcfd/comm_res_fac.shtm</a>	Provider, list

Category	Supply					
	2007*		2004*		2002	
	Facilities	Units	Facilities	Units	Facilities	Units
Community residence facility	22	509	200	1,866	NR	NR
* The figures reported for 2007 include facilities licensed to serve older adults. Figures reported for 2004 also include facilities that serve individuals with developmental disabilities.						

## Definition

An *assisted living residence* means an entity, whether public or private, for profit or not for profit, 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 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.

A *community residence facility* is one that provides safe, hygienic sheltered living arrangements for one or more individuals aged 18 years or older (except in the case of group homes for mentally retarded persons, no minimum age limitation shall apply), not related by blood or marriage to the residence director, who are ambulatory and able to perform the ADLs with minimal assistance. The definition includes facilities, including halfway houses and group homes for mentally retarded persons, which 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 mental retardation. The definition does not include facilities providing sheltered living arrangements to persons who are in the custody of the Department of Corrections of the District of Columbia.

## **Unit Requirements**

*Assisted living residences.* Newly constructed or renovated rooms must have 80 square feet per resident. No more than two persons may share a bedroom. Full bathrooms must be available for every six residents. ALRs serving more than 16 residents may offer living units that include kitchenette, living rooms, and bathrooms. Units that do not include bathrooms must limit sharing of bathrooms to four residents.

*Community residence facilities.* No more than four persons may share a bedroom. Minimum square footage and bathing and toilet facilities requirements are specified in the District of Columbia Housing Code (14 DCMR).

## **Admission/Retention Policy**

*Assisted living residences.* ALRs may not accept those who are dangerous to themselves or others, exhibit behavior that negatively impacts the lives of others, are at risk for health or safety complications which cannot be addressed by the home, and requires more than 35 hours a week of skilled nursing and home health aide services, provided on less than a daily basis, and residents who 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.

Residents have the right to remain in the facility despite a recommendation to transfer, if they obtain additional services that are acceptable to the ALR.

*Community residence facilities.* Prospective residents, the residence director and the resident's physician must agree that the prospective resident does not need professional care and can be assisted safely and adequately within a community residence facility. 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 mayor, persons who are not generally oriented or who are substantially ambulatory but need minimal ADL assistance may be admitted if sufficient staff resources are available.

## **Nursing Home Admission Policy**

Not described.

### **Services**

*Assisted living residences.* Services include 24-hour supervision and oversight, three nutritious meals and snacks modified to meet individual dietary needs, at a minimum some assistance with ADLs and IADLs to meet scheduled and unscheduled needs, and laundry/housekeeping services. ALRs facilitate access to appropriate health and social services and provide or coordinate transportation to community-based services.

An assessment must be completed within 30 days of admission. An individual service plan is required that is signed by the resident and identifies services provided, when they are provided, and by whom. The plan is based on a medical, rehabilitation, and psycho-social assessment; functional assessment; and reasonable accommodation of resident and surrogate preferences. A shared responsibility agreement is also required. Whenever disagreements arise as to lifestyle, personal behavior, safety, and service plans the ALR staff, resident or surrogate, and other relevant service providers shall attempt to develop a shared responsibility agreement.

The ALR must explain to the resident, or surrogate, why the decision or action may pose risks and suggest alternatives to the resident; and discuss with the resident, or surrogate, how the ALR might mitigate potential risks. If the resident decides to take action that may involve increased risk of personal harm and conflict with the ALR's usual responsibilities, the ALR describes to the resident the action or range of actions subject to negotiation; and negotiate a shared responsibility agreement, with the resident as a full partner, acceptable to the resident and the ALR that meets all reasonable requirements implicated. The shared responsibility agreement shall be signed by the resident or surrogate and the ALR.

*Community residence facilities.* Meals, housekeeping, laundry, and dietary services are provided. Short-term nursing care, 72 hours, may be provided or arranged by the facility.

### **Dietary**

Not specified.

### **Agreements**

*Assisted living residences.* Written contracts cover the ALRs' 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, arrangements for notification in the event of the resident's death,

obligations for handling finances, renting of equipment, coordinating and contracting for services not provided by the ALR, purchase of medications and durable medical equipment, rate structure and payment provisions, 45-day notice for changes in rates, procedures to be followed in the event the resident can no longer pay for services, and terms governing refunds.

## **Provisions for Serving People with Dementia**

Not described.

## **Medication Administration**

*Assisted living residences.* Trained aides may administer medications. A medication aide training program approved by the Board of Nursing will be developed. ALRs must arrange for an on-site review by a RN every 45 days that covers supervision of administration by trained medication aides, resident responses to medications, and resident ability to self-administer medications.

*Community residence facilities.* Facilities must provide each resident a means of storing medications. Assisting with self-administration is listed as an ADL.

## **Public Financing**

*Assisted living residences.* Medicaid HCBS waiver coverage will be implemented in 2007. The Assisted living services include PCA services, homemaker, chore aide, attendant care, medication administration, therapeutic social and recreational services, transportation and intermittent skilled nursing. Participating facilities will receive \$60 a day for services. The SSI payment standard will be \$1,869 and residents will retain \$100 for personal needs.

*Community residence facilities.* The SSI payment standard is \$623 a month and the PNA is \$70.

## **Staffing**

Administrators must have a high school diploma or GED and at least one year's experience as a direct care provider/administrator and have satisfactory knowledge of the philosophy of assisted living, the health and psycho-social needs of residents, assessment process, development and use of ISPs, medication administration, provision of ADL/IADL assistance, residents' rights, fire and life safety codes, infection control, food safety and sanitation, first aid and CPR, emergency disaster plans, human resource management, and financial management.

The ALR must have a staffing plan to assure the safety and proper care of residents based on the needs of residents, the size and layout of the facility, and the capabilities and training of staff.

## **Training**

Forty hours of initial training is required on delivering care for bedbound residents, use of first aid kits, procedures for detecting and reporting abuse, managing difficult behaviors, advanced body mechanics, communicating with adults with communication deficits, recognizing the signs and symptoms of dementia, caring for people with cognitive impairments, techniques for assisting in overcoming trauma, awareness of changes in conditions, basic competence in housekeeping, laundry, food handling and meal preparation and any specialized training for special needs not covered by the basic training.

Staff must complete 12 hours of in-service training annually on emergency procedures and disaster drills, and rights of residents. Staff must also complete 12 hours of annual training on managing residents with dementia conducted by a nationally recognized organization with experience in Alzheimer's care.

## **Background Check**

*Assisted living residences.* Background checks as required by federal and district laws are required for both categories.

*Community residence facilities.* The licensing agency may conduct background checks on the licensee which include contacts with the police to determine criminal convictions.

## **Monitoring**

*Assisted living residences.* The proposed system, as outlined in the RFP, will measure the ability of the ALR to fulfill customers' expectations and to provide for the health and safety of the residents. Surveyors will gather information from a variety of sources including: interviews with the residents, family, staff and other customers; and, from a review of the medical records. It will also include a customary inspection of life safety support, fire safety systems, emergency and disaster planning, physical plant, environmental services, food services, sanitation, medical administration and other systems.

## **Fees**

*Assisted living residences.* \$100 plus an additional \$6 per bed.

*Community residence facilities.* \$50 for 1-5 beds; \$75 for 6-10 beds; \$100 for 11-10 beds; \$150 for 21-40 beds; \$200 for 41-60 beds; \$250 for 61-80 beds; \$300 for 81-100 beds; \$350 for 101-150 beds and \$400 for 151 or more beds.

# FLORIDA

**Citation** Assisted living facilities: Florida Statutes Chapter 400 Part 3; Florida Administrative Code Chapter 58A-5 et seq.

## General Approach and Recent Developments

Licensed facilities are being encouraged to register on the Agency’s Emergency Status System which contains information that can be used before, during and after a disaster. The state provides for several types of ALF licensing: standard, ECC, LNS, and limited mental health services. Training requirements were updated in 2005 and elopement standards were added in 2006. In July 2003, responsibility for training administrators and service staff was transferred from the Department of Elder Affairs to private organizations.

## Adult Foster Care

Adult family care homes are licensed separately. The licensee must live in the home and may be licensed to care for no more than five individuals. Rules are available at: <http://www.floridaaffordableassistedliving.org/documents/392258A.pdf>.

Web Address	Content
<a href="https://www.flrules.org/gateway/ChapterHome.asp?Chapter=58A-5">https://www.flrules.org/gateway/ChapterHome.asp?Chapter=58A-5</a>	Rules
<a href="http://elderaffairs.state.fl.us/english/LMD/alf.html">http://elderaffairs.state.fl.us/english/LMD/alf.html</a>	Consumer
<a href="http://www.floridaaffordableassistedliving.org/">http://www.floridaaffordableassistedliving.org/</a>	Provider, consumer
<a href="http://ahca.myflorida.com/MCHQ/Long_Term_Care/Assisted_living/alf.shtml">http://ahca.myflorida.com/MCHQ/Long_Term_Care/Assisted_living/alf.shtml</a>	Provider, rules, forms

Category	Supply					
	2007		2004		2002	
	Facilities	Units	Facilities	Units	Facilities	Units
Assisted living facilities	2,400	75,450	2,250	74,762	2,328	78,348

## Definition

*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, whether operated for profit or not, which undertakes through its ownership or management to provide housing, meals, and one or more personal services for a period exceeding 24 hours to one or more adults who are not relatives of the owner or administrator.

*Standard.* A facility licensed to provide housing, meals, and one or more personal care services for a period exceeding 24 hours. Personal 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 a person licensed under Chapter 464, F.S., to

administer medication and perform other tasks as specified in §400.4255, F.S., such as take vital signs, manage individual weekly pill organizers for residents who self-administer medication, give prepackaged enemas ordered by the physician, observe residents, and document in the resident's record.

*Limited nursing services.* A facility licensed to provide any of the services under a standard license and those services specified in §58A-5.031(1)(a)-(m). Those services include: conducting passive range of motion exercises; applying ice caps or collars; applying heat; cutting toenails of diabetic residents or residents with a documented circulatory problem if the written approval of the resident's health care provider has been obtained; performing ear and eye irrigations; conducting a urine dipstick test; replacing established self-maintained in-dwelling catheter or performing intermittent urinary catheterizations; performing digital stool removal therapies; 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; caring for casts, braces, and splints; conducting nursing assessments if conducted by, or under the direct supervision of, a RN; and for hospice patients, providing any nursing service permitted within the scope of the nurse's license, including 24-hour supervision.

*Extended congregate care.* 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 LOC in assisted living which requires an additional license. Facilities with an ECC license must develop policies which allow residents to age in place and which maximize independence, dignity, choice, and decision making; specify the personal and supportive services that will be provided; specify the nursing services to be provided; and describe the procedures to ensure that unscheduled service needs are met.

*Limited mental health license.* An ALF that is licensed to serve three or more mental health residents. A mental health resident is an individual who receives Social Security Disability Insurance (SSDI) or SSI due to a mental disorder as defined by the Social Security Administration and receives optional state supplementation (OSS). The facility, mental health resident, and case manager must complete a community living support plan that includes the needs of the resident that must be met in order to enable the resident to live in an ALF and the community. The mental health provider and the facility must execute a cooperative agreement with each mental health resident which provides procedures and directions for accessing emergency and after-hours care.

## **Unit Requirements**

Facilities licensed to provide ECC must provide private rooms or apartments, or semi-private room or apartment shared with a roommate of choice, with a lockable entry door. Facilities that offer rooms rather than apartments must have bathrooms shared by no more than

four residents. Private rooms must be 80 square feet and shared rooms 60 square feet per resident.

Facilities that do not have the ECC license and were licensed after October 1999 may offer shared rooms (maximum of two per room), a bathroom for every six residents, and bathing facilities for every eight residents. Facilities licensed prior to October 1999 may allow four people to share a room.

## **Admission/Retention Policy**

*Admission.* The regulations for “admissions” to all ALFs are specific (see matrix below).

*Continued residency.* Additional criteria affect continued residency. In standard ALFs, people who are bedridden more than seven 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 the resident contracts with a home health agency or RN.

In ECC facilities, residents may not be retained if they are bedridden for more than 14 days. Terminally ill residents may continue to reside in any ALF if a licensed hospice agency coordinates services, an interdisciplinary care plan is developed, all parties agree to the continued residency, and all documentation requirements are maintained in the resident’s file.

To receive services under the Assisted Living for the Elderly (ALE) Medicaid waiver, which covers assisted living services, case management services, and incontinence supplies, tenants must be 60 years of age or older and meet the following requirements:

1. Medicaid eligible.
2. Determined disabled according to Social Security standards if under 65 years of age.
3. Deemed appropriate for ALF placement by the facility administrator.
4. Moving out of a nursing facility or other institutional program, be an ALF resident needing additional services in order to remain in the ALF, or be living at home and determined at risk of nursing facility placement and desiring to move into an ALF.
5. Have a case manager employed by a waiver enrolled case management agency.
6. Meet one or more functional criteria listed below:
  - Require assistance with four or more ADLs or three ADLs plus supervision or administration of medications;
  - Require total help with one or more ADLs;
  - Have a diagnosis of Alzheimer’s disease or another type of dementia and require assistance with two or more ADLs;

- Have a diagnosed degenerative or chronic medical condition requiring nursing services that cannot be provided in a standard ALF but are available in an ALF licensed for LNS or ECC; and
- Be a Medicaid-eligible recipient who meets ALF criteria, awaiting discharge from a nursing home but cannot return to a private residence because of a need for supervision, personal care, periodic nursing services, or a combination of the three.

Only facilities with an ECC or LNS and semi-private rooms and bathrooms are allowed to participate in the ALE waiver program.

## **Nursing Home Admission Policy**

Eligibility for the waiver is higher than the nursing home criteria. Waiver eligibility is limited to the following conditions as determined by using the Comprehensive Client Assessment:

- Requires assistance with four or more ADLs or three ADLs plus assistance with administration of medication.
- Requires total help with one or more ADLs.
- Has a diagnosis of Alzheimer’s disease or another type of dementia and requires assistance with two or more ADLs.
- Has a diagnosed degenerative or chronic medical condition requiring nursing services that cannot be provided in a standard licensed ALF but are available for an ALF that is licensed to provide LNS or ECC services.
- Is a Medicaid-eligible resident awaiting discharge from a nursing home who cannot return to a private residence because of the need for supervision, personal care services, periodic nursing services, or a combination of the three.
- Is receiving case management and is in need of assisted living services as determined by the community case manager and meets eligibility criteria as determined by the state’s Comprehensive Assessment and Review for Long-Term Care Services (CARES) program.

## **Services**

Four licensure types are available: standard, LNS, limited mental health, and ECC. Standard facilities provide personal care services, and may provide administration of medications if offered by the facility. Facilities with an ECC license may provide a higher level of service and must make available the following additional 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. If the individual needs assistance with self-administration the facility must inform the resident of the qualifications of staff who will be providing this assistance, and if unlicensed staff will be providing such assistance, obtain the resident's or the resident's surrogate, guardian, or attorney-in-fact's informed consent to provide such assistance; supervision of residents with dementia and cognitive impairments; health education and counseling and the implementation of health-promoting programs and preventive regimes; provision or arrangement for rehabilitation services; and provision of escort services to health-related appointments.

Other supportive services that may be provided include social service needs, counseling, emotional support, networking, assistance securing social and leisure services, shopping, escort, companionship, family support, information and referral, transportation, and assistance developing and implementing self-directed activities. In addition, facilities provide on-going medical and social evaluation, dietary management, and medication administration.

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.

ECC facilities are allowed to use managed risk agreements which is 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.

## **Dietary**

The state's tenth edition of the recommended dietary allowances is the standard used to evaluate meals. The rules specify the servings of protein, vegetables, fruits, bread and starches, milk, fats, and water that must be served. All special diets must be reviewed annually by a registered dietician, licensed dietician/nutritionist, or a dietetic technician supervised by a registered dietician or nutritionist. Therapeutic diets must be prepared as ordered by a health

professional. The person responsible for food service must obtain two hours of continuing education in nutrition and food service. Staff who prepare or serve food must receive a minimum of one hour in-service training in safe food handling practices within 30 days of employment.

## **Agreements**

The resident contract must contain: a list of specific services, supplies and accommodations to be provided; the daily, weekly or monthly rate; additional services available and charges; 30 day notice of rate increases; rights, duties and obligations of the resident; refund policy; bed hold policy; statement of the organization's religious affiliation if any; and the process for making transfer arrangements.

Facilities with an ECC license must describe the additional personal, supportive, and nursing services provided; the costs; and any limitations on where residents must reside.

Resident contracts must include a list of specific services, supplies and accommodations provided, including LNS and ECC services; the basic daily, weekly, or monthly rate; a list of any additional services available and their charges; a provision giving at least a 30-day notice of rate changes; rights, duties, and obligations of residents; purpose of advance payments or deposits and refund policy; bed hold policy; a statement of any religious affiliation; and a notice of transfer if the facility is not able to serve the resident.

## **Provisions for Serving People with Dementia**

Facilities may admit and retain residents with dementia. Training requirements have been increased for facilities advertising themselves as providing special care for persons with Alzheimer's disease or related dementia. Facilities must provide supervision for all residents.

In addition to assisted living core training, staff must receive four hours of initial training covering understanding Alzheimer's disease; characteristics of the disease; communicating with resident; family issues; resident environment; and ethical issues. Direct caregivers must obtain an additional four hours of training within nine months of employment covering: behavior management; assistance with ADLs; activities for residents; stress management for the caregiver; and medical information. Direct caregivers must receive annually four hours of training on topics specified by the Department of Elder Affairs.

State law (Chapter 429.177) requires that facilities that provide special care for persons who have Alzheimer's disease or other related disorders 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. Facilities with 17 or more resident must have an awake staff member on duty at night. Facilities with less than 17 residents may have staff on duty or mechanisms to monitor and ensure safety. Activities designed for people with dementia must be offered.

## **Medication Administration**

Unlicensed staff who meet training requirements may assist with self-administration of medications. Assistance includes taking previously dispensed, properly labeled containers from where they are stored and bringing it 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; returning the medication container to proper storage; and keeping a record of when a resident receives assistance with self-administration. Licensed nursing staff may administer medications.

## **Public Financing**

Services in residential settings are reimbursed for low income residents through SSI, SSDI, OSS, an OSS to the federal SSI payment, Medicaid ACS, which is a Medicaid state plan service, and two Medicaid programs: an ALE waiver and the Nursing Home Diversion program.

The OSS payment standard is \$647.40 a month including a PNA of \$54.

Coverage of ACS under the state plan was implemented in September 2001 in all ALFs and in AFHs in January 2002. ACS includes health support; assistance with ADLs; assistance with IADLs and assistance with self-administration of medication. This Medicaid program is optional state plan service for individuals in ALFs, AFCHs, and RTFs. The payment rate is \$9.28 for each day the recipient was receiving services in the facility.

ALE waiver services are available in ALFs licensed for ECC and/or LNS. Providers receive \$32.20 a day (\$966 per 30-day month) for services. Payments are calculated to maintain a total provider reimbursement rate of \$1,556 per 30-day month. The payment for case managements is \$100 a month and incontinence supplies are reimbursed \$125 a month.

To be eligible for the waiver program, ALE recipients must be 60 years of age or older, require a nursing home LOC, receive SSI or have income under 300% of the federal SSI benefit, or have income under 88% of the federal poverty level.

Only facilities with an ECC or LNS license may participate in the waiver program. The State allows and caps the amount of supplemental income that may be received. ALE waiver beneficiaries must be offered a private room or apartment or a unit that is shared with the approval of the beneficiary. Additionally, to be eligible for participation, a facility may not have had a Class I or Class II violation during the past five years, nor have had uncorrected Class III violations during the past two years.

Services reimbursed include: attendant call system; attendant care; behavior management; personal care services; chore and homemaker services; medication administration; intermittent

nursing care services; occupational therapy; physical therapy; speech therapy; therapeutic social and recreational services; specialized medical equipment; and incontinence supplies.

Facilities may receive payment for both waiver services and ACS. Recipients eligible for both ACS and ALE waiver assistance must have a service plan in which services that are considered ACS are shown and identified separately from those provided under the waiver.

Medicaid Participation						
	2007		2004		2002	
	Facilities	Participation	Facilities	Participation	Facilities	Participation
Assisted living for the elderly	478	3,623	581	4,167	299	2,681
Assistive care services	NR	7,766	1,527	14,188	1,565	9,990

## Staffing

Every ALF must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of adequate care to all residents.

LNS facilities must employ or contract with a nurse(s) who must be available to provide nursing services as needed by residents. The LNS facility shall maintain documentation of the qualifications of nurses providing LNS in the facility's personnel files.

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

Rules require that facilities must employ sufficient staff in accordance with required ratios (staff hours/week) and based on the physical and mental condition of residents, size and layout of the facility, capabilities of trained staff, and compliance with all minimum standards (up to five residents, 168 staff hours per week; 6-15 residents, 212 hours; 16-25 residents, 253 hours). Staff must be employed that are able to assure the safety and proper care of individual residents and implement the evacuation and emergency management plan. At least one staff must be awake in facilities with 17 or more residents.

## Training

*Administrators* must be at least 21 years old, have received a high school diploma or GED, or have been an administrator for one of the last three years of a licensed Florida ALF that met minimum standards. Effective July 1997, administrators must complete a competency exam following completion of ALF core training. Administrators must undergo Federal Bureau of Investigation (FBI) and Florida Department of Law Enforcement (FDLE) background screening.

Administrators and direct care staff must successfully complete a 26-hour ALF core training program and a competency test. The 26-hour core educational requirement must cover at least the following topics:

- State law and rules on ALFs;
- Resident rights and identifying and reporting abuse, neglect, and exploitation;
- Special needs of elderly persons, persons with mental illness, and persons with developmental disabilities and how to meet those needs;
- Nutrition and food service, including acceptable sanitation practices for preparing, storing, and serving food;
- Medication management, recordkeeping, and proper techniques for assisting residents with self-administered medication;
- Fire safety requirements, including fire evacuation; and other emergency procedures; and
- Care for persons with Alzheimer’s disease and related disorders.

*Nutrition and food service.* The administrator or person responsible for the facility’s food service and day-to-day supervision of food services staff shall participate in continuing education a minimum of two hours annually.

Administrators must also receive 12 hours of continuing education every two years. The administrator of an ECC facility and the ECC supervisor must complete six 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 six hours of continuing training every two years.

*Staff.* In addition to the core training, new staff must complete one hour of training in each of the following areas: infection control, including universal precautions and sanitation procedures. A minimum of one hour must cover reporting major incidents and emergency procedures. A minimum of one hour must also cover resident rights and recognizing/reporting abuse, neglect, or exploitation. Three hours is required on resident behavior and needs and providing assistance with ADLs. Staff who prepare or serve food must receive a minimum of one hour in-service training in safe food handling practices. HIV/AIDS training is required biennially. Staff that assist with self-administration of medications must receive four hours of training prior to assuming these responsibilities.

Two hours of in-service training that addresses ECC, concepts, statutory and rule requirements and delivery of personal care and supportive services is required for *ECC direct care staff*.

Facilities which advertise that it provides special care for persons with Alzheimer’s disease or other related disorders or who maintain secured areas are required to ensure that staff who have regular contact with or provide direct care to residents with Alzheimer’s disease and related disorders receive four hours of initial training within three months of employment in understanding the disease, characteristics of Alzheimer’s disease, communication with residents

with Alzheimer's disease, family issues, resident environment, and ethical issues. An additional four hours is required for direct care staff within nine months covering behavior management, assistance with ADLs, activities, stress management for caregivers, and medical information. Direct care staff must participate in four hours of continuing education each year.

Core training and Alzheimer's disease training may be obtained from persons approved by the Department of Elder Affairs, or designee. The Department maintains a website listing approved trainers. Competency evaluations are conducted by the University of South Florida.

## **Background Check**

Florida law requires ALF owners (if individuals), administrators, and financial officers to be screened by the FBI and FDLE. ALF owners or administrators must screen all employees who provide personal services to residents through FDLE. An FBI and FDLE screening must also be conducted on an officer or board member of a firm, corporation, partnership, or association, or any person owning 5% or more of the facility if the agency has probable cause to believe that such person has been convicted of any offense in Section 435.04, F.S., Employment Screening.

## **Monitoring**

A 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.

Rules adopted in 2001 allow facilities to voluntarily adopt an internal risk management and quality assurance program. Facilities are required to file preliminary and full adverse incident reports within one and 15 days respectively. The reports are confidential as provided by law and cannot be used in civil or administrative actions, except in disciplinary proceedings by the Florida Agency for Health Care Administration or appropriate regulatory board. Facilities must also report monthly liability claims filed. The quality assurance program is intended to assess care practices, incident reports, deficiencies, and resident grievances and develop plans of action in response to findings.

## **Fees**

The base biennial fee for a standard ALF license is \$335 per license plus \$56 per private bed. Total fees for a standard license do not exceed \$12,325. Facilities providing ECC services pay a fee of \$467, plus \$10 per bed. Facilities with a limited nursing license pay \$276, plus \$10 per bed.

<b>Admission Requirements</b>	
<b>Basic Assisted Living, Limited Nursing Service, Limited Mental Health</b>	<b>Extended Congregate Care</b>
<p>18 years of age;</p> <p>Be able to perform ADLs with supervision or assistance (but not total assistance);</p> <p>Be free of signs and symptoms of communicable diseases;</p> <p>Able to transfer with assistance, if necessary;</p> <p>Able to take own medications with assistance from staff if needed;</p> <p>Not be a danger to self or others;</p> <p>Not require licensed professional mental health services on a 24-hour-a-day basis;</p> <p>Be able to meet special dietary needs;</p> <p>Not be bedridden;</p> <p>Not require: oral or nasopharyngeal suctioning, assistance with tube feeding, monitoring of blood gases, intermittent positive pressure breathing therapy, skilled rehabilitation services, or treatment of unstable surgical incisions;</p> <p>Not require 24-hour nursing supervision; and</p> <p>Not have any Stage III or IV pressure ulcers (residents with Stage II ulcers may be served if the facility has a LNS license or resident contracts for care with a home health agency or nurse).</p>	<p>18 years of age;</p> <p>Free of signs and symptoms of communicable disease;</p> <p>Able to transfer, with assistance, if necessary;</p> <p>Not be a danger to self or others;</p> <p>Not be bedridden;</p> <p>Not require: oral or nasopharyngeal suctioning, nasogastric tube feeding, monitoring of blood gases, intermittent positive breathing pressure, skilled rehabilitative services, or treatment of unstable surgical incisions;</p> <p>Not require 24-hour nursing supervision; and</p> <p>Not have Stage III or IV pressure sores.</p>

# GEORGIA

**Citation**      Personal Care Homes: Georgia Code Annotated §31-2-4 et seq.; §31-7-2.1 et seq.; Georgia Regulations §290-5-35.01 et seq.  
 Community Living Arrangements: Georgia Code Annotated §31-7-1 et seq.; §37-1-22, et seq., Chapter 290-9-37

## General Approach and Recent Developments

ORS formed a workgroup to develop a system for profiling or rating facilities using survey findings. A five tiered rating will be tested that includes a rating for the most recent survey and a cumulative rating, most likely composed of the two most recent surveys, to show changes over time. The system will help compare facilities with very few but serious citations to those that may have multiple less serious citations. The rating system is expected to be available on the agency’s website in early 2008. Rules for a new category, community living arrangements, were issued in 2002 and serve people with mental health needs, developmental disabilities and addictive diseases. The Department of Community Health administers a CON requirement for facilities with 25 or more residents.

## Adult Foster Care

AFCHs are covered by the PCH rules. There are not separate regulations for these providers.

Web Address	Content
<a href="http://ors.dhr.georgia.gov">http://ors.dhr.georgia.gov</a>	Regulations, laws, provider tools, list search, training, forms and applications
<a href="http://www.ors.dhr.state.ga.us">http://www.ors.dhr.state.ga.us</a>	Inspection reports

Category	Supply					
	2007		2004		2002	
	Facilities	Units	Facilities	Units	Facilities	Units
Personal care homes	1,860	26,500	1,687	25,434	1,648	25,563

## Definition

*Personal care home* means any dwelling, whether operated for profit or not, which undertakes through its ownership or management to provide or arrange for the provision of housing, food services, and one or more personal services for two or more adults who are not related to the owner or administrator by blood or marriage.

*Community living arrangement* means any residence, whether operated for profit or not, that undertakes through its ownership or management to provide or arrange for the provision of

daily personal services, supports, care, or treatment exclusively for two or more adults who are not related to the owner or administrator by blood or marriage and whose residential services are financially supported, in whole or in part, by funds designated through the Department of Human Resources, Division of Mental Health, Developmental Disabilities, and Addictive Diseases.

## **Unit Requirements**

*Personal care homes.* Bedrooms must have at least 80 square feet of usable floor space per resident. There may be no more than four residents per bedroom. Spouses may be permitted, but not required to share a bedroom. Both the occupant and the administrator or on-site manager must be provided with keys for rooms with lockable doors.

*Community living arrangement.* Two people may share a room if there is sufficient space. One bathroom must be available for every four residents.

## **Admission/Retention Policy**

*Personal care homes* serve people 18 and older who meet the personal care definition of ambulatory, “a resident who has the ability to move from place to place by walking, either unaided or aided by prosthesis, brace, cane, crutches, walker or hand rails, or by propelling a wheelchair; who can respond to an emergency condition ... and escape with minimal human assistance ....” PCHs cannot admit or retain persons who need physical or chemical restraints, isolation, or confinement for behavioral control. Residents may not be bed-bound or require continuous medical or nursing care and treatment.

If short-term medical, nursing, health or supportive services are necessary, the resident (or representative) is responsible for purchasing them from licensed providers that are managed independently of the home. The home may assist in the arrangement for such services, but not the provision of those services. Applicants requiring continuous medical or nursing services shall not be admitted or retained. Facilities may receive waivers of the admission/retention requirements.

*Community living arrangement.* Facilities may not admit or retain anyone they are not equipped to serve.

## **Nursing Home Admission Policy**

Revisions to the criteria are being considered. Currently, to qualify for an intermediate LOC, the individual has a stable medical condition requiring intermittent skilled nursing services under the direction of a physician and a mental or functional impairment that would prevent self-executing of the required nursing care (see table).

Intermediate Level-of-Care		
Medical Condition	Mental Status	Functional Status
One of the following: Nutrition management;  Maintenance and preventive skin care;  Catheter care;  Therapy services;  Restorative nursing services;  Monitoring of vital signs; or  Management and administration of medications	One of the following: Documented short or long-term memory deficits;  Moderate or severely impaired cognitive skills;  Problem behavior; or  Undetermined cognitive patterns which cannot be assessed by a mental status exam (e.g., aphasia).	One of the following: Requires limited/extensive assistance with transfer and locomotion;  Assistance with feeding (continuing stand-by supervision, encouragement or cuing required and set-up help);  Direct assistance of another person to maintain continence;  Documented communication deficits;  Direct stand-by supervision or cuing with one person's assistance to complete dressing and personal hygiene (this deficit must be combined with one of the above).

## Services

*Personal care homes.* Room, meals, and personal services which include, but are not limited to, individual assistance with, or supervision of, self-administered medication, assistance with ambulation and transfer, and essential ADLs. Homes are responsible 24-hours-a-day for the well-being of residents.

*Community living arrangement.* Services include meals, and services that are commensurate with the needs of residents, and social, recreational and educational activities. Each resident must have a service plan or a course of action written by an appropriate health professional that includes areas of the resident's life that require services, supports, or care; goals, outcomes, and expectations; objectives; and interventions to be carried out.

## Dietary

At least three meals a day shall be provided that meet the general requirements for nutrition published by the department as found in the recommended daily diet allowances of the Food and Nutrition Board. One nutritious snack must be offered mid-afternoon and evening. At least one person qualified by training or experience shall be responsible for food preparation. Homes shall arrange for special diets as prescribed.

## Agreements

*Personal care homes.* Resident agreements must be made available prior to and upon move-in that cover all fees and daily, weekly, or monthly charges; services available for an additional fee; 60-day notice of changes; authorization to release medical records; provisions for on-going assessment of resident needs; provisions for transportation services; refund policy; and a copy of house rules.

*Community living arrangement.* The agreement includes all services to be delivered; fees and charges and a description of how they are assessed; refund policy; a statement of the facility's responsibility for personal belongings; a copy of the expectations of the resident; and the procedures for handling discharges and transfers.

## Provisions for Serving People with Dementia

Any program advertised as serving residents with Alzheimer's disease must complete a disclosure form that describes the philosophy, services, the cost of services, admission and discharge criteria, staff ratios, training, the physical environment, frequency and type of activities, and family support programs.

## Medication Administration

*Personal care homes.* Staff may assist with self-administration by reminding, reading labels, checking dosage, and pouring medications. Generally, medications may only be administered by a licensed RN from an outside agency. Injectable medications may be administered by an appropriately licensed person. Physicians may designate a staff person to inject insulin under an established medical protocol.

*Community living arrangement.* A licensed nurse, physician assistant or other certified staff may administer medications. Other staff may administer certain medications if they have been trained by a licensed nurse or physician assistant, and the person's training and ability are verified.

## Public Financing

A Medicaid HCBS waiver reimburses two models of PCHs -- group homes serving seven to 24 people and the family model agencies serving 2-6 people in the Community Care Services program. Group homes are reimbursed at \$35.04 per day for Medicaid services. SSI beneficiaries receive \$623 a month, from which \$528 is paid for room and board and the beneficiary retains a PNA of \$95 a month. Room and board payments may be supplemented by family members or other parties. Residents who do not receive SSI may be charged a higher amount for room and board.

Medicaid Participation					
2007		2004		2002	
Facilities	Participation	Facilities	Participation	Facilities	Participation
375	2,300	465	2,851	444	2,759

## **Staffing**

*Personal care homes.* 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 one staff person per 15 residents during waking hours and one staff person per 25 residents during non-waking hours.

*Community living arrangement.* Facilities provide qualified and trained staff that is sufficient to meet the needs of residents.

## **Training**

*Personal care homes.* All employees must receive work-related training acceptable to the Department within the first 60 days of employment. This training must include: current certification in emergency first aid, except where the staff person is a currently licensed health care professional; current certification in CPR; emergency evacuation procedures; medical and social needs and characteristics of the resident population; residents' rights; and a copy of the Long-Term Care Resident Abuse Reporting Act.

Direct care staff are required to complete 16 hours of continuing education a year in courses approved by the Department covering but not limited to: working with the elderly; working with residents with Alzheimer's disease; working with the mentally retarded, mentally ill, and developmentally disabled; social and recreational activities; legal issues; physical maintenance and fire safety; housekeeping; or topics as needed or determined by the Department.

*Community living arrangement.* Staff must be trained in medical, physical, behavioral and social needs; ethics and cultural competence; techniques of de-escalation and to prevent behavioral crises; fire safety and emergency evacuation techniques; policies and procedures for use of restraints, quiet time and other protection devices; and medications of residents.

## **Background Check**

*Personal care homes.* The Administrator and on-site manager must obtain a satisfactory fingerprint records check determination obtained from the local law enforcement agency.

The director or on-site manager and staff who provide personal services to a resident on behalf of the PCH or to perform any duties at the PCH which involve personal contact with any paying resident are required to have a criminal background check. The fee for a finger print check is \$3 and \$24 for a criminal records check.

*Community living arrangement.* Fingerprint and criminal background checks are required.

## **Monitoring**

ORS conducts initial, annual, and follow-up inspections and complaint investigations. Inspections are generally conducted on an unannounced basis. ORS has the authority to take the following actions against a licensee: impose fines, revoke a license, limit or restrict a license, prohibit persons in management or control, suspend any license for a definite period or for an indefinite period, or administer a public reprimand. ORS has the authority to take the following actions against applicants for a permit: refuse to grant a license, prohibit persons in management or control, or limit or restrict a license.

## **Fees**

None.

# HAWAII

**Citation**      Assisted living facilities: Hawaii Administrative Rules §11-90-1 et seq.  
 Adult residential care homes: Hawaii Administrative Rules §11-100-1 et seq.  
 Extended care adult residential care homes: Hawaii Administrative Rules §11-101-1 et seq.

## General Approach and Recent Developments

The licensing agency continues to work on revisions to the assisted living regulations dealing with structural requirements, staffing, nutrition, and service plans. The agency responsible for enforcing building codes has intervened with facilities that meet the R-1 (residential apartment) code. As a result, these facilities must only serve residents who are ambulatory and can evacuate in an emergency. Providers contend enforcement limits their ability to implement other aspects of the regulations that support aging-in-place.

The licensing agency is developing rules that will govern licensing fees that would be deposited into a special fund that could be used for training and other activities related to licensing. Revised rules for adult RCH and extended care adult RCHs were approved in 2006.

## Adult Foster Care

AFCHs are covered by adult RCH regulations. Type I homes serve five or fewer residents. Rules for Medicaid coverage are available at:  
[http://www.hawaii.gov/dhs/main/har/har\\_current/17-1418.pdf](http://www.hawaii.gov/dhs/main/har/har_current/17-1418.pdf).

Web Address	Content
<a href="http://www.hawaii.gov/health/permits/hospital/index.html">http://www.hawaii.gov/health/permits/hospital/index.html</a>	Rules
<a href="http://www.hawaii.gov/health/elder-care/health-assurance/licensing/index.html">http://www.hawaii.gov/health/elder-care/health-assurance/licensing/index.html</a>	List

Category	Supply					
	2007		2004		2002	
	Facilities	Units	Facilities	Units	Facilities	Units
Adult residential care homes	480	2,540	543	2,882	545	2,882
Assisted living	10	1,744	7	1,008	3	354

## Definition

*Assisted living facility* means a facility as defined in §321-15.1, HRS. This facility shall consist of a building complex offering dwelling units to individuals and services to allow residents to maintain an independent assisted living lifestyle. The environment of assisted living shall include one in which meals are provided, staff are available on a 24-hour basis, and services are based on the individual needs of each resident. Each resident, family member, and

significant other shall work together with the facility staff to assess what is needed to support the resident in his or her greatest capacity for living independently. The facility shall be designed to maximize the independence and self-esteem of limited-mobility persons who feel that they are no longer able to live on their own.

Assisted living means encouraging and supporting individuals to live independently and receive services and assistance to maintain independence. All individuals have a right to live independently with respect for their privacy and dignity and to live in a setting free from restraints.

*Adult residential care home* means any facility providing 24-hour living accommodations, for a fee, to adults unrelated to the family, who require at least minimal assistance in ADLs, but who do not need the services of an intermediate care facility (ICF). There are two types of homes -- Type I homes serve five or fewer residents and Type II serve six or more residents. Adult RCHs may obtain an extended care license to serve a limited number of residents who meet the nursing home LOC.

## **Unit Requirements**

*Assisted living.* The rules require apartment units with a bathroom, refrigerator, and cooking capacity, including a sink and a minimum of 220 square feet, not including the bathroom (sink, shower, and toilet). The cooking capacity may be removed or disconnected depending on the needs of the resident. Other requirements include wiring for phone and television, a private accessible mail box, and a call system monitored 24-hours-a-day by staff.

*Adult residential care homes.* The rules for Type II facilities allow four residents to share a room. Single rooms must have 90 square feet and multiple-occupancy rooms 70 square feet per occupant. One toilet is required for every eight residents, one shower for every 14 residents, and one lavatory for every ten residents.

## **Admission/Retention Policy**

*Assisted living facility.* Each facility must develop admission policies and procedures that support the principles of dignity and choice. Facilities must also develop discharge policies and procedures that allow a 14-day notice for behavior or needs that exceed the facility's ability to meet, or based on the resident's established pattern of non-compliance. The rules do not specify who may be admitted and retained. Rather, each facility may use its professional judgment and the capacity and expertise of the staff in determining who may be served.

*Adult residential care homes.* Homes without an extended care license may not serve residents needing nursing home care. Type I extended care homes may serve no more than two residents qualifying for nursing home care and Type II homes may serve no more than 10% of its residents needing this LOC.

## **Nursing Home Admission Policy**

To qualify for an ICF level, beneficiaries must need intermittent skilled nursing, daily skilled nursing assessment and 24-hour supervision provided by RNs or LPNs. They may also require non-skilled nursing services such as administration of medications, eye drops and ointments, general maintenance care of colostomies or ileostomies, and other services and significant assistance with ADLs.

## **Services**

*Assisted living facilities* shall provide awake, 24-hour, on-site staff; three dietician approved meals a day; laundry services; opportunities for individual and group socialization; services to assist with ADLs; nursing assessment, health monitoring and routine nursing tasks; housekeeping; 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, pharmacist, therapy, podiatry), barber/beauty care, hospice, home health, and other services.

Managed risk agreements may be used by facilities. A separate form is used for the agreement and the provisions are included in the service plan.

## **Dietary**

Facilities provide three meals a day, snacks, and modified diets that have been evaluated and approved by a dietitian on a semiannual basis and are appropriate to the residents' needs and choices.

## **Agreements**

*Assisted living facilities.* Residents' agreements are required to be available prior to and upon move-in and describe the services provided, rates charged, and the conditions under which additional services or fees may be charged.

## **Provisions for Serving People with Dementia**

Not specified.

## **Medication Administration**

*Assisted living facilities.* The rules allow assistance with self-administration and administration of medication as allowed under the Nurse Practice Act. Residents may keep medications in their unit. Medications in units shared by two residents may be kept in a locked container in the unit. Medications administered by the facility must be reviewed at least every 90 days by a RN or physician.

## **Public Financing**

Assisted living was added as a Medicaid waiver service in 2000 for elders and people with disabilities. ALFs and extended adult residential care homes (E-ARCH) may participate. One ALF contracts with Medicaid and serves five residents. Eighty E-ARCH homes serve approximately 1,400 Medicaid beneficiaries. The state offers a flat rate of \$66.77 a day for services in ALFs. The monthly SSI payment is \$623 for assisted living residents who qualify for SSI.

Payments for E-ARCH residents vary based on the individual's Medicaid eligibility group and LOC. Level II clients have higher skilled nursing needs and/or behaviors that require more service and supervision than Level I clients. The payment standard (federal SSI payment and state supplement) for SSI beneficiaries is \$1,245 a month, and the Medicaid payment is \$24.98 a day for Level I and \$41.06 for Level II. Beneficiaries who qualify for Medicaid under the Medically Needy category retain \$418 a month for room and board. The Medicaid payment is \$50.69 a day for Level I and \$66.77 a day for Level II. The state expects to increase the Medically Needy income standard to \$496 a month.

## **Staffing**

*Assisted living facilities* must have licensed nursing staff available seven days a week to meet care management and monitoring needs of residents.

*Adult residential care homes.* Licensees must submit a plan showing how they will obtain a RN and case manager. Sufficient staff must be on duty 24-hours a day to meet resident needs.

## **Training**

*Assisted living facilities.* The *administrator/director* must have two years experience in the health and social services field and show evidence of having completed an ALF administrator's course acceptable to the Department.

All *staff* shall be trained in CPR and first aid. The facility shall have written policies and procedures that incorporate the assisted living principles of individuality, independence, dignity, privacy, choice, and home-like environment. In-service education consists of an orientation for

all new employees to acquaint them with the philosophy, organization, practice and goals of assisted living; and on-going in-service training on a regularly scheduled basis (minimum of six hours annually).

*Adult residential care homes.* A RN must train and monitor primary caregivers.

## **Background Check**

*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.

## **Monitoring**

*Assisted living facilities.* Facilities are inspected biannually. The agency may suspend, revoke, or refuse to issue a license for violations of regulations. Other enforcement steps include increased monitoring frequency, restrictions, requiring additional training, and monetary fines. The licensing agency holds quarterly meetings with providers to discuss general survey findings and other regulatory issues.

## **Fees**

None. Regulations that will establish fees are being developed.

# IDAHO

**Citation** Residential or Assisted Living Facilities: Idaho Administrative Rules IDAPA 16, Title 03, Chapter 22

## General Approach and Recent Developments

Regulations were revised in March 2006. The title and scope of the regulations describes the philosophy which is “to provide choice, dignity and independence to residents while maintaining a safe, humane, and home-like living arrangement for individuals needing assistance with daily activities and personal care. These rules set standards for providing services that maintain a safe and healthy environment.” The state covers services in licensed facilities under the Medicaid state plan and the HCBS waiver. Revisions to the criminal background check requirements are being developed. All facilities must install sprinkler systems by 2010 if they serve individuals who cannot evacuate safely. Life safety code requirements for small facilities were strengthened in 2006.

## Adult Foster Care

Certified family homes are regulated separately and provide care to one or two adults, who are unable to reside on their own and require help with ADLs, protection and security, and need encouragement toward independence. The Department of Health and Welfare sets standards for certified family homes. Rules are available at:

<http://adm.idaho.gov/adminrules/rules/idapa16/0319.pdf>.

Web Address	Content
<a href="http://adm.idaho.gov/adminrules/rules/idapa16/0322.pdf">http://adm.idaho.gov/adminrules/rules/idapa16/0322.pdf</a>	Rules
<a href="http://www.healthandwelfare.idaho.gov/site/3630/default.aspx">http://www.healthandwelfare.idaho.gov/site/3630/default.aspx</a>	Provider, survey check lists, application, training materials
<a href="https://chu.dhw.idaho.gov/">https://chu.dhw.idaho.gov/</a>	Criminal history stie

Category	Supply					
	2007		2004		2002	
	Facilities	Units	Facilities	Units	Facilities	Units
Residential care or assisted living	278	6,819	266	6,193	253	5,815

## Definition

*Residential or assisted living facility* means a facility or 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. In this chapter, RCFs or ALFs are referred to as “facilities.” Distinct segments of a facility may be

licensed separately, provided each segment functions independently and meets all applicable rules.

## **Unit Requirements**

Facilities licensed after July 1, 1992, must not have more than two residents in each bedroom and provide 100 square feet of floor space per single-bed room and 80 square feet per resident in multi-bed rooms. There must be at least one toilet for every six persons, residents, or employees, and at least one tub or shower for every eight persons, residents, or employees. New construction must meet the requirements of the ADA Accessibility Guidelines and the Life Safety Code. Existing facilities must remove as many barriers as possible without creating an undue burden on the facility.

## **Admission/Retention Policy**

The revised statute and regulations dropped licensing by the LOC provided. Residents may not be admitted or retained if they require on-going skilled nursing or care that is not within the legally licensed authority of the facility. Residents who require on-going highly technical skilled nursing services may not be served. Residents may not be served who require gastronomy tube, arterial-venal shunts or supra-pubic catheters inserted within the previous 21 days; receive continuous total parenteral nutrition or IV therapy; require physical restraints, including bed rails, comatose, except for a resident who has been assessed by a physician or authorized provider who has determined that death is likely to occur within 14-30 days; rely on a mechanically supported breathing system, except for residents who use continuous positive airway pressure; has a tracheotomy who is unable to care for the tracheotomy independently; are fed by a syringe; have open, draining wounds for which the drainage cannot be contained; have a Stage III or IV pressure ulcer; or with any type of pressure ulcer or open wound that is not improving bi-weekly; have methicillin-resistant staphylococcus aureus in an active stage (infective stage).

The facility must assure a licensed nurse is available to meet the needs of any resident who has needs requiring a nurse. Residents cannot be admitted or retained who have physical, emotional, or social needs that are not compatible with the other residents in the facility or that are violent or a danger to himself or others. Residents requiring assistance in ambulation must reside on the first story unless the facility complies with specified sections of the rules.

Facilities may request a waiver to serve people if they show good cause for granting the waiver, describe the extenuating circumstances and any compensating factors such as additional floor space or staffing that have a bearing on the waiver.

Facilities are required to ask if the resident has an advance directive, and they may assist residents in developing advance directives.

## Nursing Home Admission Policy

The assessment areas are divided into critical, high, and medium indicators. To qualify for nursing home admission, applicants must have one or more critical indicators; two or more high indicators; one high and two medium indicators; or four or more medium indicators. The indicators are presented below.

Criteria for Determining Nursing Home Need	
Indicators	Level of Need
Critical -- 12 points for each indicator	Total assistance preparing meals  Total assistance in toileting  Total or extensive assistance with medications which require decision making prior to taking or assessment of efficacy after taking
High -- 6 points for each indicator	Extensive assistance preparing or eating meals  Total or extensive assistance with routine medications  Total, extensive, or moderate assistance with transferring  Total or extensive assistance with mobility  Total or extensive assistance with personal hygiene  Total assistance with supervision for a section of the uniform assessment instrument
Medium -- 3 points for each indicator	Moderate assistance with personal hygiene, preparing or eating meals, mobility, medications, toileting  Total, extensive, or moderate assistance with dressing  Total, extensive, or moderate assistance with bathing  Frequent or continual supervision in one or more of the following: orientation, memory, judgment, wandering, disruptive/socially inappropriate behavior, assaultive/destructive behavior, self preservation, or danger to self or others

## Services

Services are included in a negotiated service agreement and may include room; board; assistance with ADLs; supervision; assistance and monitoring of medications; laundering of linens owned by the facility; coordination of outside services; arrangement for routine, urgent, and emergency medical and dental services; emergency interventions; housekeeping services; maintenance; utilities; access to basic television in common areas; maintenance of self-help skills; recreational activities; and transportation to trips to social functions.

A uniform assessment and a negotiated service agreement must be used with residents. The agreement covers the results from the uniform assessment; the level of support in ADLs; health services; the level of assistance for medications; the frequency of needed services; the scope of needed assistance; habilitation needs and the program being used if applicable; training needs; identification of specific behavioral symptoms; situations that trigger the behavior symptoms and the specific interventions for each behavioral symptom; physician or authorized provider's signed and dated orders; admission records; community support systems; the resident's desires; transfer plans; discharge plans; and the identification of individual services being provided by other providers and who is providing the service.

## **Dietary**

The menu must be adjusted for age, sex, and activity as approved by a registered dietitian. Physicians' or authorized provider orders must be received for therapeutic or modified diets. The facility must have a menu planned or approved, signed and dated by a registered dietitian prior to being served to the resident. The planned menu must meet nutritional standards. Menus will provide a sufficient variety of foods in adequate amounts at each meal. Food selections must include foods that are served in the community, in season, as well as residents' preferences, food habits, and physical abilities. The menus must be prepared in advance and available to residents on request. Snacks must be available and offered to residents between meals and at bedtime. The facility must have a therapeutic diet menu planned or approved, signed and dated by a registered dietitian prior to being served to a resident.

## **Agreements**

The admission agreements must be signed prior to or on the date of admission. The agreement must include: services provided; staffing patterns and qualifications; whether the facility carries professional liability insurance; the facility's and resident's roles and responsibilities for assistance with medication administration; fee descriptions; whether the facility is responsible for personal funds; handling of a partial month's refund; conditions for emergency transfers; permission to transfer pertinent information; resident's responsibilities; and other items. The agreement may be integrated with the negotiated service agreement provided all requirements for both are met.

An agreement may not be terminated except under the following conditions: a 30 day written notice; the resident's physical or mental condition deteriorates to a level where the facility can no longer provide care; non-payment; for the protection of the resident or other residents from harm; and other conditions.

## **Provisions for Serving People with Dementia**

A facility admitting and retaining residents with diagnosis of dementia, mental illness, developmental disability, or traumatic brain injury must train staff to meet the specialized needs of these residents. The means and methods of training are at the facility's discretion. The training should address the following areas: an 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; ADLs; and stress reduction for facility personnel and resident.

Other training is required for facilities that serve individuals with mental illness, developmental disabilities or traumatic brain injuries.

## Medication Administration

Only licensed nurses may administer medications for residents. Aides who have passed required training may assist residents with medications. The requirements for administration and assistance with self-administration of medications by unlicensed assistive personnel are specified by the Board of Nursing. Facilities must have a policy describing the process the nurse will use to delegate assistance with medication and how it will be documented.

## Public Financing

Personal care in assisted living was added as a state plan service in 2000. Services under a Medicaid HCBS waiver using the waiver application definition and including medication administration and assistance with personal finances was implemented in 1999. Elders, people with disabilities, and people with mental retardation, traumatic brain injuries, or developmental disabilities are eligible. Coverage was phased in across the state. The HCBS aged and disabled waiver program serves 2,231 residents living in residential or ALFs. Individuals are eligible for the waiver using the 300% SSI eligibility criteria.

State plan services are available to individuals who require no more than 16 hours of personal care services per week. Individuals must meet state income limits for financial eligibility. Providers are paid based on four levels of need which are determined by the number of hours of assistance needed. Payment rates range from \$125.30 to \$225.54 a month. The resident is responsible for paying for room and board. The state's suggested limit is \$542 per month; however the facility may charge the resident more. Family supplementation is allowed. Any money remaining after paying for room and board is retained as a PNA.

HCBS waiver payments are capped at the average per capita nursing home cost and individual payments are based on a care plan. The facility can set its rate for room and board however the state's suggested rate is \$542 per month for rent, utilities, and food. The individual SSI payment rate for individuals residing in residential facilities is \$623. Any monies remaining after payment of room and board is retained as the PNA.

State supplementation to the SSI program has been phased out. In 2002, the Legislature directed the transition of individuals who were receiving the supplemental grant to the Medicaid state plan. Supplementation for the room and board payment is allowed in all categories. A uniform assessment instrument is used to determine the unmet ADL needs for all applicants. The unmet needs are converted to a payment that is available to the beneficiary regardless of where he or she lives: in assisted living or their own home or apartment. The process was developed to eliminate differences in payment and service delivery depending on where a person lived.

Medicaid Participation					
2007		2004		2002	
Facilities	Participation	Facilities	Participation	Facilities	Participation
279	2,231	265	1,870	35	720

## **Staffing**

Facilities must have written staffing policies and procedures based on the numbers of residents, resident needs, and configuration of the facility. A LPN must visit the facility at least once every 90 days or when there is a change in the resident's condition.

Small facilities 15 beds or less must have at least one or more qualified and trained staff, immediately available, in the facility during resident sleeping hours. If any resident has been assessed as having night needs or is incapable of calling for assistance staff must be up and awake. For facilities licensed for 16 beds or more, qualified and trained staff must be up and awake and immediately available, in the facility during resident sleeping hours.

Facilities must employ and schedule sufficient personnel to provide care, during all hours, required in each resident's Negotiated Service Agreement, to assure residents' health, safety, comfort, and supervision, and to assure the interior and exterior of the facility is maintained in a safe and clean manner; and provide for at least one direct care staff with certification in first aid and CPR in the facility at all times.

## **Training**

*Administrators* must have a valid residential care administrator's license. Personnel must be given an orientation to the facility and participate in a continuing training program developed by the facility.

*Staff.* New staff must receive a minimum of 16 hours of job-related orientation training before they are allowed to provide unsupervised personal assistance to residents. Orientation training must include: the philosophy of residential care or assisted living and how it guides care giving; resident rights; cultural awareness; providing assistance with ADLs and IADLs; how to respond to emergencies; documentation associated with resident care needs and the provision of care to meet those needs; identifying and reporting changes in residents' health and mental condition or both; documenting and reporting adverse outcomes (such as resident falls, elopement, lost items); advance directives and do not resuscitate (DNR) orders; relevant policies and procedures; and the role of the Negotiated Service Agreement. All staff employed by the facility, including housekeeping personnel, or contract personnel, or both, who may come into contact with potentially infectious material, must be trained in infection control procedures for universal precautions. Each employee must receive a minimum of eight hours of job-related continuing training per year.

Before staff can begin assisting residents with medications, the staff must have successfully completed a Board of Nursing approved medication assistance course. This training is not included as part of the minimum of 16 hours of orientation training or minimum of eight hours of continuing training requirement per year.

## **Background Check**

Effective October 1, 2007, all applicants for licensure must submit a criminal history clearance as described in IDHW rules Title 05, Chapter 05. The rules include finger printing, FBI, National Criminal History Background Check System, state registries and Medicaid sanctions lists. Individuals pay \$48 for the cost of the check.

## **Monitoring**

With the exception of the initial surveys for licensure, all inspections and investigations shall be made unannounced and without prior notice. 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 three year survey cycle or once every 12 months, or more frequently at the discretion of the Licensing and Survey Agency for those facilities receiving core issue deficiencies during any survey. Surveys will be conducted until the facility attains two consecutive surveys, excluding follow-up surveys, without a core issue deficiency. Surveys are done at least every 36 months for those facilities with no core issue deficiencies for two or more consecutive surveys. Complaint investigation surveys are done based on the potential severity of the complaint. Inspections entail reviews of the quality of care and service delivery, resident records, and other items relating to the running of the facility. If deficiencies are found, then plans of correction are made and follow-up surveys are conducted to determine if corrections have been made. Complaints against the facility are investigated by the licensing agency. A complainant's name or identifying characteristics may not be made public unless "the complainant consents in writing to the disclosure; the investigation results in a judicial proceeding and disclosure is ordered by the court; or the disclosure is essential to the investigation. The complainant shall be given the opportunity to withdraw the complaint before disclosure."

Enforcement options include ban on admissions, ban on residents with certain diagnosis, civil monetary penalties, appointment of temporary management, suspension or revocation of the license, transfer of residents, issuing a provisional license and other remedies. Facilities operating without a license may be subject to six months in jail and fines up to \$5,000.

In 2004, the Department changed the survey focus from a pure regulatory compliance survey process to a survey process that combined compliance oversight with technical assistance. The Department regularly partners with the industry to present focused training based on trends identified through the survey process. The survey process rewards well performing facilities in that they are placed on a three year survey cycle. Facilities that do not have a track record of high performance are surveyed annually until they can establish a high performing track record and earn their way on to a three year survey cycle. When significant issues are found during survey, a plan of correction is required from the facility and once the facility has remedied the problems, a follow-up survey is conducted.

## **Fees**

\$500 for a building evaluation.

# ILLINOIS

**Citation** Assisted Living and Shared Housing Act: Title 210 ILCS 9  
Assisted living and shared housing establishments: 77 ILL Admin. Code Part 295  
Sheltered care facility: 77 ILL Admin. Code Part 330 et seq.  
Supportive living facilities: Title 89, Chapter I, Subchapter d, Part 146

## General Approach and Recent Developments

Legislation permitting issuance of a two year license and increasing the licensing fee is pending before the legislature. Rules governing assisted living establishments and shared housing establishments were amended in 2004. Legislation passed in 2005 that expands shared housing establishments from 12 to 16 residents; allows licensed health professionals to administer sliding scale insulin and requires all licensing applications to be complete within six months of the initial filing. SLF rules were amended in 2005 and 2006.

The law does not allow Medicaid to cover services in assisted living establishments; however, a “supportive living facility” program has been implemented in “certified” locations that offers similar services. The program serves elderly and disabled Medicaid beneficiaries who need assistance with ADLs. It targets lighter need nursing facility residents who are unable to remain in their homes. A SLF may be converted nursing home units or free-standing buildings that integrate housing, health, personal care, and supportive services in home-like residential settings. A maximum of 2,750 Medicaid residents can be served under a 1915(c) waiver that applies only to the demonstration.

Rules to implement P.A. 93-141, which added a provision for a floating license, are being developed. The floating license amendment allows an Assisted Living and Shared Housing Establishment in which 80% of the residents are at least 55 years of age or older, that is operated as housing for the elderly, and meets the construction and operating standards contained in Section 20 of the Act, to request a floating license for any number of individual living units within the establishment, up to, but not including, total capacity. The establishment must have adequate staff to meet the scheduled and unscheduled needs of the residents living in the licensed living units, and all staff must meet the requirements of the assisted living regulations. All mandatory and optional services must be available to residents of the licensed units. Designation as a licensed living unit may be temporary to accommodate a resident’s changing needs without requiring the resident to move.

Changes to the sheltered care facility rules were made in 2006 and 2007 that modify requirements for criminal background and sex offender registry checks for residents.

## Adult Foster Care

No provisions were reported.

Web Address	Content
<a href="http://www.ilga.gov/commission/jcar/admincode/077/07700295sections.html">http://www.ilga.gov/commission/jcar/admincode/077/07700295sections.html</a>	Assisted living rules
<a href="http://www.ilga.gov/commission/jcar/admincode/077/077003300A01100R.html">http://www.ilga.gov/commission/jcar/admincode/077/077003300A01100R.html</a>	Shelter care rules
<a href="http://www.idph.state.il.us/healthca/assisted_living_list.htm">http://www.idph.state.il.us/healthca/assisted_living_list.htm</a>	Assisted living list
<a href="http://www.idph.state.il.us/healthca/sheltered_care_list.htm">http://www.idph.state.il.us/healthca/sheltered_care_list.htm</a>	Shelter care unit
<a href="http://www.idph.state.il.us/pdf/assistedlivingapp.pdf">http://www.idph.state.il.us/pdf/assistedlivingapp.pdf</a>	Application
<a href="http://www.sfillinois.com/">http://www.sfillinois.com/</a>	Supportive living facility home page

Category	Supply					
	2007		2004		2002	
	Facilities	Units	Facilities	Units	Facilities	Units
Assisted living	184	8,988	120	5,830	24	1,667
Shared housing	25	202	13	92	NA	NA
Shelter care facilities	137	7,610	149	8,484	156	8,740

## Definition

*Assisted living establishment* means a home, building or residence, or any other place where sleeping accommodations are provided for at least three unrelated adults, at least 80% of whom are 55 years of age or older and where the following are provided:

- Services consistent with a social model that is based on the premise that a resident's unit in assisted living and shared housing is his or her own home.
- Community-based residential care for persons who need assistance with ADLs, including personal, supportive, and intermittent health-related services available 24 hours per day, if needed, to meet the scheduled and unscheduled needs of a resident.
- Mandatory services, whether provided directly by the establishment or by another entity arranged for by the establishment with the consent of the resident.
- A physical environment that is a home-like setting that includes the following and such other elements as established by the Department in conjunction with the assisted living and shared housing advisory board: individual living units each of which shall accommodate small kitchen appliances and contain private bathing, washing, and toilet facilities, or private washing and toilet facilities with a common bathing room readily accessible to each resident. Units shall be maintained for single occupancy unless shared by consent.

*Shared housing establishment* means a publicly or privately operated free-standing residence for 16 or fewer persons, at least 80% of whom are 55 years of age or older and who are unrelated to the owners and one manager of the residence, where the following are provided:

- Services consistent with a social model that is based on the premise that the resident's unit is his or her own home.
- Community-based residential care for persons who need assistance with ADLs, including housing and personal, supportive, and intermittent health-related services available 24 hours per day, if needed, to meet the scheduled and unscheduled needs of a resident.
- Mandatory services, whether provided directly by the establishment or by another entity arranged for by the establishment with the consent of the resident.

*Sheltered care facility* means a facility licensed under the nursing home care act that provides maintenance and personal care but does not provide routine nursing care.

*Supportive living facility* means a residential setting that provides or coordinates personal care services, 24-hour supervision and assistance (scheduled and unscheduled), activities, and health-related services with a service program and physical environment designed to minimize the need for residents to move within or from the setting to accommodate changing needs and preferences; has an organized mission, service programs, and a physical environment designed to maximize residents' dignity, autonomy, privacy, and independence; and encourages family and community involvement.

## **Unit Requirements**

*Assisted living establishments* require single occupancy units unless shared by choice. Units must accommodate small appliances, including a sink, toilet, and assistive devices if needed. Bathing facilities may be in the unit or in a common room.

*Shared housing establishments* may have shared bathrooms (1:4) and tub/shower facilities (1:6).

*Sheltered care facilities* allow no more than four persons to share a room. Single rooms must be 70 square feet and multiple occupancy rooms 60 square feet per person. One lavatory is required for every ten residents and one shower/bath is required for every 15 residents. A lavatory and shower/bath is required on each floor.

*Supportive living facility.* Free-standing sites must provide apartments with 300 square feet of living space, including closets and bathroom. Apartments for individuals wishing to share the unit must have 450 square feet of living space, including closets and bathroom. Units must have a full bathroom, lockable doors, emergency call system, heating and cooling controls, wiring for private telephone, access to cable television or satellite dish, a sink, microwave oven or stove, and refrigerator and a separate bedroom for each unrelated occupant for SLFs approved for participation on or after October 18, 2004. Nursing homes converting a portion of a facility must offer apartments with 160 square feet for single occupancy and 320 square feet if two people want to share a unit.

## **Admission/Retention Policy**

*Assisted living establishments.* Facilities may not accept 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 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, which is defined as substantially disabled for not less than one year in the areas of self-maintenance, social functioning, activities of community living and work skills. This does not include Alzheimer's disease and other forms of dementia. They may also not accept 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 owner or operator of the establishment, its parent entity, or any other entity with ownership common to either the owner or operator or parent entity, including but not limited to an affiliate of the owner or operator:

- IV therapy or feedings;
- Gastronomy feedings;
- Insertion, sterile irrigation, and replacement of a catheter, except for routine maintenance of urinary catheters;
- Sterile wound care;
- Sliding scale insulin;
- Routine insulin injections; and
- Stage III or IV decubitus ulcers.

In addition, residents may not be accepted who need five or more skilled nursing visits a week for three or more weeks unless the course of treatment is rehabilitative and the need is temporary.

If any of the above conditions are met, a resident's occupancy agreement shall be terminated, except for individuals who are terminally ill who receive or would qualify for hospice and such care coordinated by a licensed hospice provider.

*Sheltered care facility.* No resident needing nursing care may be admitted or retained. Persons who have a communicable disease or are mentally ill, need treatment for mental illness, are likely to harm others, or are destructive of property or themselves may not be admitted or retained.

*Supportive living facilities* may serve elderly (age 65 or older) or disabled residents age 22 or over who have been screened and determined to meet the nursing facility LOC criteria. Residents must also 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 cannot be met by the SLF. The SLF must develop a service plan and execute a written contract with each resident that includes services the resident will receive and other terms of the agreement.

## **Nursing Home Admission Policy**

Waiver eligibility is based on a Determination of Need (DON) score. The score is derived from the MMSE, six ADLs, nine IADLs (including ability to perform routine health and special health tasks and ability to recognize and respond to danger when left alone). Each ADL, IADL and special factors are rated by level of impairment (0-3) and unmet need for care (0-3). Scores for each area are summed and applicants with a DON score of 29 or more are eligible. The MMSE component is weighted toward people with moderate or severe dementia. The process is designed to target services to people with high levels of impairment who may have informal supports and people with lower levels of impairment without informal supports.

## **Services**

*Assisted living establishments.* No more than 180 days prior to admission, a comprehensive assessment that includes an evaluation of a prospective resident's physical, cognitive, and psycho-social condition shall be completed by a physician. This assessment must be updated annually by a physician, or upon significant change in condition. Establishments may use their own evaluation/assessment tools, but this does not take the place of the physician assessment. Mandatory services include three meals a day, housekeeping, laundry, security, emergency response system, and assistance with ADLs. Optional services include medication reminders, supervision of self-administered medications and medication administration, and non-medical services defined by rule.

Assisted living, which promotes resident choice, autonomy, and decision making, should be based on a contract model designed to result in a negotiated agreement between the resident or the resident's representative and the provider, clearly identifying the services to be provided. This model assumes that residents are able to direct services provided for them and will designate a representative to direct these services if they themselves are unable to do so. This model supports the principle that there is an acceptable balance between consumer protection and resident willingness to accept risk and that most consumers are competent to make their own judgments about the services they are obtaining. Regulation of assisted living establishments and shared housing establishments must be sufficiently flexible to allow residents to age in place within the parameters of the statute. Services provided must ensure that the residents have the rights and responsibilities to direct the scope of services they receive and to make individual choices based on their needs and preferences. These establishments shall 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 negotiated risk in residential surroundings.

"Negotiated risk" is the 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 assures that the resident and the resident's representative, if any, are informed of the risks of these decisions and of the potential consequences of assuming these risks. The rules allow assisted living and shared housing establishments to use a risk agreement that describes the problem, issue or service that is

covered, the choices available to the resident and their risks or consequences, the resulting agreement, mutual responsibilities, and a review time frame. The agreement is limited to the individual's care and personal environment and does not waive any requirements of the regulations.

*Sheltered care facility* may provide personal care, group and individual activities, assistance with self administration of medications or administration by a physician or licensed nurse. Flue shots and language assistance services were added in 2005.

*Supportive living facilities* must provide a combination of housing, personal, and health-related services that promote autonomy, dignity, and quality of life and respond to the individual needs of residents. Room and board includes three meals per day. Services include nursing services, personal care, medication oversight and assistance in self-administration, housekeeping services, laundry service, 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 completion of a resident assessment and service plan, a quarterly health status evaluation, administration of medication when residents are temporarily unable to self-administer, medication set-up, health counseling, episodic and intermittent health promotion or disease prevention counseling, and teaching self-care in meeting routine and special health care needs that can be met by other staff under supervision of a RN. Facilities are expected to involve family members in service planning. Residents must receive an initial assessment within 24 hours of admission and a comprehensive assessment within 14 days. Assessments are updated at least annually.

## **Dietary**

Assisted living and shared housing facilities offering special diets must contract with or employ a dietician. Meals must be nutritionally balanced and accommodate resident preferences.

Shelter care facilities must provide three meals or two meals and a breakfast bar. Meals must meet the requirements for a general diet for an adult recommended by the Food and Nutrition Board, National Research Council. Therapeutic diets ordered by a physician must be provided.

SLFs must contract with a licensed dietitian who is on-site at least twice a quarter for at least eight hours (cumulative) to provide consultation and training.

## **Agreements**

*Assisted living and shared housing.* Contracts with residents include the duration of the contract; base rate and a description of services; additional services available and their fee; description of the process for terminating or modifying the contract; the complaint resolution process; resident obligations; billing and payment procedures; the admission, risk management, and termination procedures; resident rights; the department's annual on-site review process;

terms of occupancy; charges during absences; refund policy; notice for changes in fees; and policy concerning notification of relatives of changes in the resident's condition. Contracts must also include statements that Medicaid is not available for payment of services and that there is a risk management procedure.

*Supportive living facilities.* Agreements cover services provided under Medicaid; arrangements for payment; grievance procedure; termination provisions; rules for staff, management, and resident conduct; and resident rights. The agreement includes services available for an additional fee and arrangements to share a unit.

## **Provisions for Serving People with Dementia**

*Assisted living and shared housing facilities* that offer special care programs for people with dementia must file a disclosure statement if they serve people with dementia. The statement includes the form of care or treatment; philosophy; admission and retention policies; assessment care planning and implementation guidelines; staffing ratios; physical environment; activities; role of family members; and the cost of care.

Facilities are not allowed to 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. The rules specify that residents must be assessed prior to admission with any one or a combination of assessment tools, based upon the resident's condition and stage in the disease process. The rules list a number of tools that may be used, such as the Functional Activities Questionnaire, Clock Drawing Test, and Functional Assessment Staging, among others.

Operators offering special care must develop and implement policies and procedures that ensure the continued safety of all residents in the establishment; provide coordination of communications with each resident, resident's representative, relatives and other persons identified in the resident's service plan; provide, in the service plan, appropriate cognitive stimulation and activities to maximize functioning, which include a structure and rhythm that are comfortable and predictable; offer an appropriate balance of rest and activity, and private and social time; allow residents to express their accustomed social roles, whatever they may be; offer residents access to familiar activities that they enjoyed doing and that tap memories and retained abilities; and provide the flexibility to accommodate variations in the resident's mood, energy level, and inclination; provide an appropriate number of staff for its resident population.

Sufficient numbers of staff, with qualifications, adequate skills, education, and experience to meet the 24-hour scheduled and unscheduled needs of the residents must be available to serve the resident population. Special care facilities must provide 1.4 hours of services per resident per day (assistance with ADLs, activities-based programming, and services delivered to the resident to meet the unique needs of residents with dementia); require the manager and direct care staff to complete sufficient comprehensive and on-going dementia and cognitive deficit training; and develop emergency procedures and staffing patterns to respond to the needs of residents.

*Shelter care facilities.* The law does not allow facilities to serve anyone with dementia if they do not have the staff with the skills to meet the individual's needs. The rules will provide for use of a validated dementia specific standard to assess residents. The assessment must be completed and approved by the resident's physician prior to move-in and annually. Residents cannot be accepted if they pose a danger that cannot be eliminated through treatment. Facilities offering SCUs must disclose information about their program, ensure that residents have a designated representative, and develop and implement policies and procedures for people who wander, need supervision and assistance when evacuating. In addition, they must provide cognitive stimulation, appropriate staffing patterns, and emergency procedures. Facilities must provide each resident 1.4 hours of service per day (ADLs, activities, and other services to meet unique needs).

*Managers* of special care facilities must have a college degree with course work in dementia and one year of experience and must complete six hours of training a year. *Staff* receive four hours of orientation in dementia care, 16 hours of on-the-job training, and 12 hours in-service training a year. The rules list the topics that are covered under each requirement.

## **Medication Administration**

*Assisted living and shared housing establishments* may assist with self-administered medications, supervise, or administer medications. Policies related to administration must be approved by a physician, pharmacist, or RN. Only a licensed health care professional employed by the establishment may administer medications including injections, oral medications, topical treatments, eye and ear drops, nitroglycerin patches Or sliding scale insulin injections.

*Sheltered care facilities.* All medications taken by residents shall be self-administered, unless administered by licensed personnel. No person shall be admitted to a facility who is not capable of taking his or her own medications. Facility staff may remind residents when to take medications and watch to ensure that they follow the directions on the container. All medications must be stored in a locked area at all times. Although there is some conflict between the sections of the regulation governing medication administration, in practice, licensed staff are allowed to administer medications "to some residents for control purposes" when it is not safe for the resident to self-administer.

## **Public Financing**

*Assisted living and shared housing.* The law does not permit the use of Medicaid funds in licensed facilities.

*Supportive living facilities.* The state has implemented a program to serve elders and adults with disabilities who are Medicaid waiver beneficiaries in SLFs (see <http://www.slfillinois.com>). SLFs are certified. For Medicaid residents, participating facilities must be willing to accept the SSI rate, \$623 a month in 2007 (less a \$90 PNA) as payment for room and board. The service payment is based on 60% of the average nursing facility rate paid in the region. SLFs may be

certified as eligible Food Stamp vendors and receive these benefits for eligible residents. Room and board charges are limited \$533 for single occupancy and \$377 per person for shared occupancy. Income supplementation is allowed. Funding for services is included in the Medicaid nursing home budget and is not part of a separate appropriation.

A moratorium on new applications was removed. The program has 81 operating SLFs with 4,681 participants in 2007. The program targets “lighter” care nursing home eligible residents with a DON score (see below) between 29 and 47 on a 100-point scale. Residents with scores above 47 may be served if the facility has the capacity to do so.

Medicaid Participation					
2007		2004		2002	
Facilities	Participation	Facilities	Participation	Facilities	Participation
81	4,681	41	1,602	13	293

Medicaid Payment Rates by Geographic Area (2007)				
Region	Daily	R&B	Medicaid	Total
Chicago	\$66.92	\$533	\$1,883	\$2,540
South suburb	\$62.57	\$533	\$1,797	\$2,410
Northwest	\$58.48	\$533	\$1,639	\$2,287
Central	\$56.13	\$533	\$1,552	\$2,216
West central	\$52.34	\$533	\$1,552	\$2,103
St. Louis	\$55.87	\$533	\$1,445	\$2,209
South	\$50.76	\$533	\$1,384	\$2,056

## Staffing

*Assisted living and shared housing.* Establishments must have sufficient numbers of trained staff to meet the 24-hour scheduled and unscheduled needs of residents. Assisted living establishments must have at least one awake staff on duty who has CPR training.

*Sheltered care facility.* Facilities must have staffing patterns that are sufficient to meet the needs of residents. At least one awake staff member is required.

*Supportive living facilities* must provide licensed and certified staff that are sufficient to meet the needs of residents in conjunction with contractual agreements. Personal care services and assistance with self-administration of medications must be provided by CNAs. SLFs must contract with a dietician.

## Training

*Assisted living and shared housing.* Administrators must be 21 and have a high school diploma or equivalency, one year management experience or two years of experience in health care, housing, or hospitality.

Managers of SCUs must be 21 years of age and have: a college degree with documented course work in dementia care, plus one year of experience working with persons with dementia; or at least two years of management experience with persons with dementia. The manager or supervisor must complete six hours of additional annual continuing education regarding dementia care.

*Staff* must complete an orientation that addresses 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. Additional orientation covers needs of residents; service plans; internal policies; job responsibilities and limitations; and ADLs. Eight hours of annual training is required for staff and managers on topics listed above.

In SCUs, all staff members must receive an additional four hours of dementia-specific orientation prior to assuming job responsibilities without direct supervision within the Alzheimer's/dementia program. Training must cover, at a minimum: basic information about the causes, progression, and management of Alzheimer's disease and other related dementia disorders; techniques for creating an environment that minimizes challenging behavior; identifying and alleviating safety risks to residents with Alzheimer's disease; techniques for successful communication with individuals with dementia; and residents' rights.

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: encouraging independence in and providing assistance with the ADLs emergency and evacuation procedures specific to the dementia population; techniques for creating an environment that minimizes challenging behaviors; resident rights and choice for persons with dementia, working with families, caregiver stress; and techniques for successful communication.

Direct care staff must annually complete 12 hours of in-service education regarding Alzheimer's disease and other related dementia disorders. Topics may include: assessing resident capabilities and developing and implementing service plans; promoting resident dignity, independence, individuality, privacy and choice; planning and facilitating activities appropriate for the dementia resident; communicating with families and other persons interested in the resident; resident rights and principles of self-determination; care of elderly persons with physical, cognitive, behavioral and social disabilities; medical and social needs of the resident; common psycho-tropics and side effects; local community resources; and other related issues.

*Sheltered care facility.* The *administrator* shall arrange for facility supervisory personnel to annually attend appropriate education programs on supervision, nutrition, and other pertinent subjects. *Staff* training shall include an in-service program embracing orientation to the facility and its policies, skill training, and on-going education carried out to enable all personnel to perform their duties effectively. Written records of program content and personnel attending shall be kept.

*Supportive living facilities.* *Administrators* must have at least five years' experience in providing health care services in assisted living settings, in-patient hospital, long-term care

setting, ADC, or in a related field. The manager also must have at least two years of progressive management experience.

*Staff* shall 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 and encouraging independence, training that includes techniques for working with persons with disabilities and the elderly populations; and in the case of an SLF serving persons with disabilities, disability specific sensitivity training conducted by an outside entity familiar with working with persons with disabilities as part of staff orientation and at least annually thereafter. Nurses' assistants must be certified or enrolled in and pursuing certification. A trained staff person must be responsible for planning and directing social and recreation activities. Nurses must be licensed. Twenty-four-hour response staff must be certified in emergency resuscitation.

## **Background Check**

State legislation passed during the spring of 1995 prohibits sheltered care facilities from knowingly hiring, employing, or retaining any individual in a position with duties involving direct care for residents who have been convicted of committing or attempting to commit designated criminal offenses, unless a waiver has been granted by the Illinois Department of Public Health. The legislation was expanded to include SLFs in 1999.

Rules implementing the "Health Care Worker Background Check Code" were effective in 2004. Health care employers will be required to establish a policy concerning employment of individuals whose criminal history record checks indicate convictions for offenses that are not disqualifying. The employer is also required to develop a policy concerning employment of individuals who have been granted waivers. The rules require the establishment to check employee status with the Nurse Aide Registry. Establishments may be fined \$100 for each failure to conduct a required criminal background check.

Rules passed in November 2003 changed the process for granting waivers of the health care worker criminal history background check requirements. The new rule specifies that waiver applicants must have met all court obligations (probation, adhering to a fine or restitution schedule) and satisfactorily completed a drug and/or alcohol recovery program, if applicable. Mitigating circumstances are expanded to reference drug/alcohol rehabilitation programs, anger management or domestic violence prevention programs, completion of court-ordered obligations, and nurse registry and criminal history status in other states.

Managers who provide direct care must complete a background check. The rules list specific offenses that preclude hiring of staff.

## Monitoring

Assisted living and shared housing establishments are inspected annually. This is an annual unannounced visit. The annual visit focuses on compliance with rules, solving resident issues and concerns and the establishment's QI process. Each establishment must have a QI program that covers oversight and monitoring; resident satisfaction; and a QI process that has benchmarks, is data driven, and focuses on resident satisfaction. A system is needed to detect and resolve problems. The existence, results, and process of the QI system cannot be used as evidence in any civil or criminal proceeding.

Remedies for violations include consultation, a statement of correction, administrative warning, mandatory training, imposed order of correction, fines and revocation of the license. Civil penalties may be applied up to \$10,000 for violations and up to \$5,000-\$10,000 per instance for keeping residents who exceed the care needs in the law.

The monitoring process is collaborative in nature, with an emphasis on meeting the needs of the residents. During this process, the state provides information on best practices and shares concerns about the quality of care with suggestions for how to fix the problems or the names of individuals the establishment may contact for assistance. Oversight is not enforcement-driven, but is based more on a social model promoting quality of care. The functions of surveying and providing education are the responsibility of the same staff. Assisted living staff consists of one RN program manager, one surveyor and an administrative assistant. Long-term care staff are only used for occasional complaint investigations.

*Supportive living facilities.* Participating facilities will be Medicaid certified and monitored, at least annually, by the Department of Healthcare and Family Services. Monitoring includes contract requirements, resident autonomy, resident rights, adequacy of service provision, quality assurance process, safety of the environment, program policies and procedures, information provided to low income residents, review of resident assessment and service plans, resident satisfaction surveys, check-in system, and food service.

Facilities must have a grievance process and a quality assurance process. Complaints may be heard informally. If not resolved or if the resident prefers, grievances may be submitted through the facility's formal process. Residents may use the Medicaid appeals process for denial or delay of service.

Internal quality assurance procedures must encompass resident satisfaction, oversight and monitoring; peer review; utilization review; procedures for preventing, detecting and reporting resident neglect and abuse; and on-going QI. The committee must establish review schedules, objectives for improving service quality, including quality indicators and measures, and a mechanism for tracking improvements based on care outcomes. A system with outcome indicators must be developed that measures: quality of services; residents' rating of services; cleanliness and furnishings in common areas; service availability and adequacy of service provision and coordination; provision of a safe environment; socialization activities; and resident autonomy.

## **Fees**

Fees for sheltered care facilities are \$995 per year. The fee for assisted living establishments is \$300 per facility, plus \$5 per unit. The fee for shared housing is \$150.

# INDIANA

**Citation**      Assisted living: 460 IAC 1-11-1 et seq.  
                      Residential care facilities: 410 IAC 16.2 Rule 5

## General Approach and Recent Developments

RCFs are licensed under the licensure category for health facilities. This licensure category also includes rules for comprehensive care facilities, commonly known as nursing homes. Senate Enrolled Act 333 (2007) requires that administrators be licensed and the development of education, experience and training requirements by the Board of Health facility administrators. Regulations were readopted in 2007. Rules for housing with services establishments were filed in 2005.

## Adult Foster Care

AFC is a covered Medicaid HCBS waiver. Certification standards define AFC as “the family home in which consumer care is provided to three or fewer elderly individuals or adults with physical and/or cognitive disabilities who are not members of the provider’s or primary caregiver’s family. The care is provided in a home-like environment for compensation. For the purpose of these certification standards, the AFCH does not include any house, institution, hotel or other similar living situation that supplies room and/or board only, if no consumer thereof requires any element of care.”

Web Address	Content
<a href="http://www.state.in.us/legislative/iac/title410.html">http://www.state.in.us/legislative/iac/title410.html</a>	Rules (Article 16.2)
<a href="http://www.in.gov/isdh/regsvcs/lte/resdir/">http://www.in.gov/isdh/regsvcs/lte/resdir/</a>	List
<a href="http://www.in.gov/legislative/iac/T04600/A00010.PDF?">http://www.in.gov/legislative/iac/T04600/A00010.PDF?</a>	Housing with services rules
<a href="http://www.in.gov/icpr/Webfile/formsdiv/48896.pdf">http://www.in.gov/icpr/Webfile/formsdiv/48896.pdf</a>	Alzheimer’s disclosure form
<a href="http://www.in.gov/icpr/webfile/formsdiv/49028.pdf">http://www.in.gov/icpr/webfile/formsdiv/49028.pdf</a>	Housing with services disclosure

Category	Supply					
	2007		2004		2002	
	Facilities	Units	Facilities	Units	Facilities	Units
Residential care facilities	190	14,655	147	11,767	140	11,555
Housing with services establishments	271	18,658	300	NR	NR	NR

## Definition

*Residential care facilities.* A health facility that provides residential nursing care or administers medications prescribed by a physician must be licensed as a RCF. A facility that provides services such as room, meals, laundry, activities, housekeeping, and limited assistance in ADLs, without providing administration of medications or residential nursing care is not required to be licensed. The provision by a licensed home health agency of medication

administration or residential nursing care in a facility which provides room, meals, a laundry, activities, housekeeping, and limited assistance in ADLs does not require the facility to be licensed, regardless of whether the facility and the home health agency have common ownership, provided, however, that the resident is given the opportunity to contract with other home health agencies at any time during the resident's stay at the facility.

*A housing with service establishment* is defined as an establishment providing sleeping accommodations to at least five residents and offering or providing 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 mean home health services, attendant and personal care services, professional nursing services, and central storage and distribution of medications. Supportive services mean help with personal laundry, handling or assisting with personal funds, arranging for medical services, health-related services, or social services.

## **Unit Requirements**

*Residential care facilities.* Rules require 100 square feet for single rooms and 80 square feet per bed for multiple occupancy rooms. For facilities licensed after 1984, no more than four people may share a room. One toilet and sink is required for every eight residents in facilities licensed after 1984.

## **Admission/Retention Policy**

*Residential care facilities* may not admit or retain individuals who require 24-hour comprehensive nursing care. Facilities that retain appropriate professional staff may provide comprehensive nursing care to residents needing care for a self-limiting condition. Residents must be discharged if the resident is a danger to self or others, requires 24-hours-a-day comprehensive nursing care or comprehensive nursing oversight; requires less than 24 hour per day comprehensive nursing care, comprehensive nursing oversight, or rehabilitative therapies and has not entered into a contract with an appropriately licensed provider of the resident's choice to provide those therapies, is not medically stable or meets two of the following three criteria unless the resident is medically-stable and the facility can meet the resident's needs: (1) requires total assistance with eating; (2) requires total assistance with toileting; and (3) requires total assistance with transferring.

*Housing with services establishments.* The establishment must, in the disclosure form, indicate when a resident must be transferred because the establishment and the resident are unable to develop a means for assuring that the resident is able to respond to an emergency in a manner that is consistent with local fire and safety requirements and when the establishment is unable to assure that the resident's physical, mental, and psycho-social needs can be met. Except as stated in the contract, residency in the housing with services establishment may not be terminated due to a change in a resident's health or care needs. Except where the resident's health or safety or the health or safety of others are endangered, an operator shall provide at least

thirty (30) days notice to the resident or the resident's designated representative before terminating the resident's residency.

## **Nursing Home Admission Policy**

Individuals are eligible if they have an unstable medical condition or three or more of 14 substantial medical conditions or ADL impairments. The list includes: supervision and direct assistance on a daily basis to ensure that prescribed medication is taken correctly; 24-hour supervision and/or direct assistance due to confusion; disorientation not related to a mental illness; inability to eat, transfer from bed or chair, change clothes, bathe, manage bladder and/or bowel functions or ambulate or use a wheelchair without direct assistance. The criteria allow a person with three ADLs, or two ADLs and the need for medication assistance to receive waiver services.

## **Services**

*Residential care facilities.* Services offered to a resident must be appropriate to the scope, frequency, need and preference of the resident. Services must be reviewed and revised as appropriate and discussed with the resident as his or her needs change. If administration of medications and/or the provision of residential 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 residential nursing services must be ordered by a physician and supervised by a licensed nurse on the premises or on call.

The facility must provide activities programs appropriate to the ability and interests of the residents. Scheduled transportation must be provided or coordinated to community-based activities.

Each facility must determine whether it will administer medications or provide residential nursing services. This must be clearly stated in the admission agreement.

Residential nursing care may include, but is not limited to: identifying human responses to actual or potential health conditions, deriving a nursing diagnosis, 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, or administering, supervising, delegating, and evaluating nursing activities.

A minor regimen may include, but is not limited to: assistance with self-maintained ex-dwelling or indwelling catheter care for a chronic condition; prophylactic and palliative skin care; routine dressing that does not require packaging or irrigation; general maintenance care of ostomy; restorative nursing assistance; toileting care; routine blood glucose testing; enema and digital stool removal therapies; general maintenance care in connection with braces, splints, and plaster casts; observation of self-maintained prosthetic devices; administration of subcutaneous and intramuscular injections; metered dose inhalers, nebulizer/aerosol treatments self-

administered by a resident, and routine administration of medical gases after a therapy regimen has been established.

*Housing with services establishments.* Except as stated in the contract and identified in the disclosure document, an operator may not restrict the ability of a resident to use a home health agency, home health provider, or case management service of the resident's choice or require a resident to use home health services.

## **Dietary**

*Residential care facilities.* Facilities must make available three meals a day, seven 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 temporary need for meals to be delivered to the resident's room. All modified diets must be prescribed by a physician.

*Housing with services establishments.* Not specified.

## **Agreements**

*Residential care facilities.* Some of the provisions typically included in resident agreements are contained in the section on resident rights. They include the right to receive (at the time of admission) a written notice of the basic daily or monthly rate; all facility services (including those offered on a need basis); information on related charges; and admission, readmission, and discharge policies. A 30-day notice of changes in rates or services is required.

An evaluation of the individual needs of each resident must be initiated before admission and must be updated at least semiannually or upon a significant change in condition. Subsequent evaluations must be used to compare against the baseline evaluation to assure that the care a resident requires is within the range of personal care and supervision provided by the facility. At a minimum the evaluation must include information on the resident's physical and mental status, independence in ADLs, weight, and ability to self-administer medications.

*Housing with services establishments.* Contracts include the name, street and mailing address of the establishment, the owner and managing entity, if any; a statement describing the disclosure document and licensure status; term of the contract; services to be provided in the base rate; additional services available and their cost; process for changing the contract; complaint resolution process; the resident's designated representative, if any; the establishment's referral procedures if the contract is terminated; the criteria used by the establishment to determine who may continue to reside in the establishment; a description of the process for assuring that the resident's needs are assessed on admission and periodically thereafter in conjunction with the resident and the resident's representative and for assuring that the resident's physical, mental, and psycho-social needs are met within the terms of the contract criteria for residence; the billing and payment procedures and requirements; that an establishment's contract

must state that: except as stated in the contract, residency in the establishment may not be terminated due to a change in the resident's health or care needs; the ability of a resident to engage in activities away from the establishment regardless of time, duration, and distance of the activities may not be restricted; except to protect the rights and activities of other residents, the establishment may not restrict the ability of a resident to have visitors and to receive family members and guests; and except as stated in the contract and identified in the disclosure document, the operator may not: restrict the ability of a resident to use a home health agency, home health provider, hospice, home health attendant, or case management service of the resident's choice; or require a resident to use home health services; that except where a resident's health or safety or the health and safety of others are endangered, an operator shall provide at least 30 days notice to the resident or the resident's designated representative before terminating the resident's residency.

## **Provisions for Serving People with Dementia**

*Residential care facilities.* Facilities that offer special care must complete a disclosure statement that includes: the facility's mission or philosophy statement concerning the needs of residents with Alzheimer's disease, a related disorder, or dementia; the process and criteria the health facility uses to determine placement, transfer, or discharge from Alzheimer's and dementia special care; the process for the assessment, establishment, and implementation of a plan of Alzheimer's and dementia special care, including how and when changes are made to a plan of care; the following information concerning the staff of the Alzheimer's and dementia SCU. The disclosure statement must also include: the staff-to-patient ratio for each shift; the positions and classifications of staff; the initial training or special education requirements of the staff; and the qualities and amount of continuing education and in-service training required for staff; a description of the Alzheimer's and dementia SCU and the unit's design features; the frequency and types of activities for the residents of the facility who have Alzheimer's disease, a related disorder, or dementia; the extent that the health facility's Alzheimer's and dementia SCU and program offers family support programs and solicits input from family members; guidelines for using physical and chemical restraints in providing Alzheimer's and dementia special care; an itemization of the health facility's charges and fees for Alzheimer's and dementia special care and related services; and any other features, services, or characteristics that the health facility believes distinguishes the health facility from Alzheimer's and dementia.

Facilities that are required to submit an Alzheimer's and dementia SCU disclosure form must designate a director. The director must have a degree from an educational institution in a health care, mental health, or social service profession or be a licensed health facility administrator. The director shall have a minimum of one year work experience with dementia or Alzheimer's residents, or both, within the past five years. Persons serving as a director for an existing Alzheimer's and dementia SCU at the time of adoption of this rule are exempt from the degree and experience requirements. The director shall have a minimum of 12 hours of dementia-specific training within three months of initial employment as the director of the Alzheimer's and dementia SCU and six hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia.

Staff caring for residents in dementia-specific units must have a minimum of six hours of dementia-specific training within six months and three hours annually thereafter.

*Housing with services establishments.* Not specified.

## **Medication Administration**

*Residential care facilities.* Medications may be administered under physician's order by licensed nursing personnel or qualified medication aides. Other treatments may be given by 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 documentation of undesirable effects is required, followed by notification of the resident's physician.

Residents who self-medicate may keep and use prescription and non-prescription medications in their unit as long as they are kept secure.

## **Public Financing**

*Assisted living.* Services are covered under an HCBS waiver. Assisted living is a comprehensive, residential service provided through the Aged and Disabled Medicaid Waiver and the Assisted Living Medicaid Waiver. Individuals who receive this service reside in an independent setting, provided by a licensed residential care provider. It is a bundle of services, which may include, but is not limited to, the following: personal care, homemaker, attendant care, medication oversight, social and recreational programming. The individual lives independently, or with a roommate if he/she so chooses. Personalized care must be furnished to clients who reside in their own living units. The apartment-like setting includes an area for a kitchenette, living area, bedroom area, and bathroom. Meals and/or nutritious snacks are also available and must meet the dietary reference intake (DRI) for adults. There is 24-hour on-site response staff, and an on-call nurse available. Regulations governing participation in the waiver are available at <http://www.in.gov/legislative/iac/T04600/A00080.PDF>.

In 2004, 14 facilities were approved for the waiver program and 71 beneficiaries were served. The number of participating facilities grew to 43 in the summer of 2007 after rates were increased. The number of participants was not reported. Licensed facilities must meet additional requirements for private bedrooms and baths, and a number of additional service requirements. Existing unlicensed ALFs that have submitted a disclosure form and are considered housing with services establishments and meet the waiver program requirements have not expressed an interest in becoming waiver providers because they would need to become licensed, and would need to serve a much higher acuity population than desired.

Medicaid contracting requirements provide for private apartments, shared only by choice, square footage, meal preparation, temperature controls, and door locks that differ from the

licensing rules. A three-tiered payment system has been developed based on points from the assessment process. Rates have increased since 2004 (see table below). The rates do not include room and board. The SSI payment maximum is currently \$623 (less a \$52 PNA). The state has not issued a policy on family supplementation. The waiver uses the definition and covered services included in the HCBS waiver preprinted format: case management, RN oversight, personal care, homemaker, chore, attendant care, companion, medication oversight, and therapeutic and recreational programming.

The Residential Care Assistance Program is a state-funded program that covers limited services for residents who are aged, blind, mentally ill or disabled, low income, and/or cannot live alone but do not qualify for nursing home care. Payments are based on a flat rate. County home (housing with services establishments) rates are \$27 per day for room, board, laundry, housekeeping, and limited oversight. Private RCF rates are \$39.35 per day. Nineteen county homes and 42 RCFs served 418 county home residents and 1,121 people in private RCFs respectively as of March 2004.

Medicaid Participation					
2007		2004		2002	
Facilities	Participation	Facilities	Participation	Facilities	Participation
43	NR	14	71	8	22

Medicaid Payment Rates (July 1, 2007)	
Level	Daily Rate
Level 1: (<36 points)	\$62.74
Level 2: (36–60 points)	\$71.85
Level 3: (61–75 points)	\$80.93

## Staffing

*Residential care facilities.* Each facility must have one administrator who is responsible for the overall administration of the facility. Staff shall be sufficient in number, qualifications and training to meet the 24-hour scheduled and unscheduled needs of the residents and services provided. A minimum of one awake staff person, with CPR and first aid certificates, must be on duty at all times. If 50 or more residents require nursing services and/or administration of medication, at least one nursing staff person must be on staff at all times. For facilities with 100 or more residents requiring nursing services and/or administration of medication, at least one awake staff person must be on duty at all times, with an additional staff person required for every additional 50 residents. Employees providing more than limited assistance with the ADLs must be either a CNA 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 one year, an activities director training course approved by the State. Facilities may employ dining assistants who may only 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/IV feedings.

*Housing with services establishments.* Not specified.

## **Training**

*Residential care facilities.* Administrators must be licensed.

*Staff (residential care facilities).* Prior to working independently, each employee shall be given an orientation of the facility by the supervisor. Orientation of all employees shall include:

- Instructions on the needs of the specialized populations served in the facility;
- A review of the facility’s policy manual and applicable procedures including organizational chart, personnel policies, appearance and grooming, and resident rights;
- Instructions in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures;
- A detailed review of the appropriate job description, including a demonstration of equipment and procedures required of the specific position to which the employee will be assigned;
- Review of ethical considerations and confidentiality in resident care and records;
- For direct care staff, personal introduction to and instruction in the particular needs of each resident to whom the employee will be providing care; and
- Documentation of orientation in the employee’s personnel record.

On-going training must include resident’s rights, prevention and control of infection, fire prevention, safety, and accident prevention, the needs of specialized populations served, medication administration, and nursing care. For nursing personnel, training must include at least eight hours of in-service per calendar year and four hours of training for non-nursing personnel.

Any unlicensed employee providing more than limited assistance with ADLs must be either a CNA or home health aide. Dining assistants must complete a 16 hour training program that has been approved by the department.

## **Background Check**

Not described.

## **Monitoring**

*Residential care facilities.* Annual surveys are conducted by the Department of Health.

*Housing with services establishments.* The state may impose financial penalties for violations of the disclosure requirement. A housing with services establishment may request a review of the penalty. If the state determines that an establishment has had substantial and repeated violations, the state may prohibit an establishment from using the term “assisted living” to describe the establishment’s services and operations to the public. If the state determines that the establishment has made intentional violations of the disclosure requirement or has made fraudulent and material misrepresentatives to a resident, the state may request the attorney general to investigate and take appropriate action against the operator or administrator.

## **Fees**

Licensure fees are collected annually: \$200 for the first 50 beds and each additional bed is \$10.

# IOWA

**Citation** Assisted living programs: Iowa Code 231C and 321 IAC Chapter 25, 26, and 27; IAC 661--5.626 Assisted Living Housing (Life Safety)  
 Residential care facilities: IAC Chapter 57 and Chapter 60  
 Related codes that affect but do not specifically reference assisted living: 655 IAC Chapter 6-Nurse Practice; 645 IAC Chapter 63-Salons; Iowa Code Chapter 155A-Pharmacy; 481 IAC Chapters 30 & 32-Food Service Establishments

## General Approach and Recent Developments

Responsibility for promulgating regulations was transferred to the Department of Inspections and Appeals from the Department of Elder Affairs in 2007 (SF 601) following the transfer of oversight in 2004. Revisions to the regulations were effective April 14, 2004. During the past few years, the LOC provided has received increased attention.

Legislation passed in 2005 (HF 617) directed the Department of Human Services to prepare a Medicaid HCBS waiver application to cover assisted living. ALPs currently provide attendant care services to waiver participants.

## Adult Foster Care

Elder group homes are licensed as a single-family residence that is operated by a person who is providing room, board, and personal care and may provide health-related services to three through five elders who are not related to the person providing the service, and which is staffed by an on-site manager 24 hours per day, seven days per week. Rules are available at: [http://www.legis.state.ia.us/ACO/IAChtml/321.htm#agency\\_321](http://www.legis.state.ia.us/ACO/IAChtml/321.htm#agency_321).

Web Address	Content
<a href="http://www.state.ia.us/elderaffairs/services/aliving.html">http://www.state.ia.us/elderaffairs/services/aliving.html</a>	Consumer
<a href="https://dia-hfd.iowa.gov/DIA_HFD/Process.doc">https://dia-hfd.iowa.gov/DIA_HFD/Process.doc</a>	List, application, provider*
<a href="http://www.legis.state.ia.us/Rules/Current/iac/321iac/32126/32126.pdf">http://www.legis.state.ia.us/Rules/Current/iac/321iac/32126/32126.pdf</a>	Monitoring rules
<a href="http://www.legis.state.ia.us/ACO/IAChtml/321.htm">http://www.legis.state.ia.us/ACO/IAChtml/321.htm</a>	Rules

\* List = entities book; application -- documents (scroll down)

Category	Supply					
	2007		2004		2002	
	Facilities	Units	Facilities	Units	Facilities	Units
Assisted living programs	209	10,332	184	8,246	154	6,199
Assisted living programs for people with dementia	39	2,740	NR	NR	NR	NR

## **Definition**

“Assisted living means provision of housing with services which may include, but are not limited to, health-related care, personal care and assistance with IADLs to six or more tenants in a physical structure which provides a home-like environment. Assisted living also includes encouragement of family involvement, tenant self-direction, and tenant participation in decisions that emphasize choice, dignity, privacy, individuality, shared risk, and independence. Assisted living includes the provision of housing and assistance with IADLs only if personal care or health-related care is also included” (96 Acts, Chapter 1192). SF 2193 modified the definition by including housing and IADLs only if personal care and health-related services are included.

A dementia-specific ALP means an ALP that either serves five or more tenants with dementia or cognitive disorder at Stage IV or above on the Global Deterioration Scale or holds itself out as providing special care for persons with cognitive disorder or dementia, such as Alzheimer’s disease, in a dedicated setting.

## **Unit Requirements**

ALPs may have private dwelling units with lockable doors and individual cooking facilities. In facilities built before July 2001, units must have at least one room with not less than 120 square feet of floor area. Other habitable rooms must have at least 70 square feet. Each single occupancy dwelling unit in buildings built after July 2001 must have at least 240 square feet of floor area, excluding bathrooms. Units used for double occupancy must have at least 340 square feet, excluding bathrooms. The space requirements are lower for dementia units.

## **Admission/Retention Policy**

Programs may not admit or retain tenants who 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; are under age 18; require more than part-time or intermittent health-related care (21 days); on a routine basis have unmanageable incontinence; or meet the program’s transfer criteria. Part-time or intermittent nursing care includes licensed nursing care for unstable conditions, daily medication injections (except stable diabetes), daily assessment or treatment of conditions such as an open wound or pressure ulcer, total care for unmanageable incontinence, or routine two-person assistance with standing, transfer, or evacuation. Managed risk statements must be used. The facility’s policy is stated in the application for certification.

Exceptions to the limit on part-time or intermittent health care may be requested for residents who need hospice care or temporarily need more than part-time or intermittent health care for more than 21 days. Approvals may be given 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 tenants is not jeopardized.

## **Nursing Home Admission Policy**

Intermediate LOC can be approved if the individual requires daily supervision with dressing and personal hygiene in conjunction with one of the following: cognitive functions; mobility; skin; pulmonary status; continence; physical functioning -- eating, medications, communication/hearing/vision patterns; or prior living circumstances -- psycho-social.

Intermediate LOC can also be approved if the individual requires physical assistance by one or more persons to perform dressing and personal hygiene.

## **Services**

The certification application includes the process for assessing tenants' health status, functional and cognitive ability and a copy of each assessment tool. Individualized service plans (ISPs) are required. Programs must provide some personal care or health-related services and at least one meal a day. 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. Skilled services and therapies combined with personal care and nurse delegated activities may not total more than eight hours a day. Service plans must be developed for each tenant, and plans for tenants needing personal care or health-related services must be developed with a multidisciplinary team (including a health professional and human services professional) and the tenant.

The rules allow a managed risk statement which includes the tenant's or responsible person's signed acknowledgment of the shared responsibility for identifying and meeting needs and the process for managing risk and upholding tenant autonomy when tenant decision making may result in poor outcomes for the tenant or others.

## **Dietary**

Facilities must have the capacity to provide hot or other appropriate meals at least once a day or to coordinate with other community providers to make arrangements for the availability of meals. Therapeutic diets may be provided.

## **Agreements**

Each tenant signs an occupancy agreement and managed risk statement prior to admission. The agreement includes a shared responsibility/managed risk policy, all fees, charges, and rates describing tenancy and basic services covered, any additional and optional services and their cost. It also includes a statement regarding the impact of the fee structure on third-party payments and whether they will be accepted by the program; procedure for non-payment of fees; identification of the person responsible for making payment; guarantee of a 30-day written notice

of any changes in the agreement unless the tenant's health status or behavior creates a substantial threat to health and safety; occupancy and transfer criteria; grievance policies; emergency response policy; the staffing policy including whether or not staff are available 24-hours a day, whether delegation will be used and how staffing will be adapted to meet changing needs. Additional provisions are added for programs serving people with dementia; refund policy; statement regarding billing, telephone number to make a complaint; a copy of the tenant's rights provisions; and a statement that tenant landlord law applies to ALPs.

## **Provisions for Serving People with Dementia**

Units built in a neighborhood design offer 150 square feet of floor excluding bathroom for single occupancy and 250 square feet for double occupancy. The difference in square footage must be added to the common areas. Facilities must have an operating door alarm system. Visual or audible alarms may be disconnected if it is disruptive to a tenant. The tenant agreement must include a description of the services and programming. Dementia-specific ALPs must have one or more staff persons who monitor tenants as indicated in each tenant's service plan. The staff shall be awake and on duty 24-hours-a-day in the proximate area, and check on tenants as indicated in the tenants' service plans.

Programs must have a system, program, or staff procedure that responds to emergency needs in lieu of a personal emergency response system. Training for all employees includes six hours on specified topics that include: explanation of the disease; philosophy and program; skills for communicating with residents and family; family issues; importance of planned and spontaneous activities; providing ADL assistance; service planning and social history; working with challenging tenants; simplifying cuing and redirecting; and staff support and stress reduction.

## **Medication Administration**

Written medication plans are required. Nurse delegation rules allow administration and supervision of routine, oral medications by trained unlicensed personnel. RNs may delegate injections to licensed nursing staff. Delegation rules are issued by the Board of Nursing. RNs must monitor administration, ensure orders are current and are administered consistent with the orders. They must also document the resident's health status and progress every 90 days.

## **Public Financing**

Assisted living is covered through a Medicaid HCBS waiver, state service funds, and a state-funded rent supplement program.

*Medicaid.* Certified or accredited ALPs may be providers of Medicaid HCBS waiver including: assistive devices, chore, consumer directed attendant care, emergency response, home

delivered meals, home health aide, homemaker, nursing, nutritional counseling, respite, senior companions, and transportation.

Services are reimbursed on a fee-for-services basis according to the care plan. There is a maximum cap of \$1,083 per month on care plans.

Medicaid Participation					
2007		2004		2002	
Facilities	Participation	Facilities	Participation	Facilities	Participation
155	497	73	126	54	129

The SSI payment standard is \$623 and the PNA was increased from \$30 to \$50. The resident's room and board payment is separate from the Medicaid service amount. The state uses the 300% special income level eligibility option. Residents may retain up to \$1,869 a month of their income to cover room and board and other costs. Family supplementation of resident income for room and board costs is allowed up to the \$1,869 limit.

*State Supplementary Assistance.* This state-funded program provides up to \$26.50 a day for in-home health-related services that are not covered under other programs or for HCBS assisted living residents who need more care than is available under the service cap. Services may include nursing and personal care tasks when certified by a physician that the services can be provided in a person's home, including assisted living.

*State rental assistance program.* This program works like HUD's Section 8 program and pays rental expenses for low income beneficiaries who do are on a waiting list for a federal, state or local rent subsidy. Beneficiaries pay 30% of their income for rent. The program can pay the difference between the tenant's payment and the fair market rent set by HUD. Participants must be eligible for waiver services. The average duration of the subsidy is 12 months and the average payment is \$152 per month. In FY 2007, 1,635 Medicaid beneficiaries received subsidy payments.

## Staffing

Sufficient staffing must be available at all times to meet the needs of residents. Programs administering medications or providing health-related services must provide for a RN to monitor medications, ensure physician orders are current, and assess and monitor health status (90 days). Each program must provide access to a 24-hour emergency response system.

## Training

*Administrators.* The owner or sponsor of the ALP is responsible for ensuring that both management and direct service employees receive training appropriate to the task.

*Staff.* The ALP shall have a staffing and training plan on file and maintain documentation of training received by staff. All personnel of the ALP shall be able to implement the ALP's accident, fire safety, and emergency procedures.

## **Background Check**

Prior to employment in an ALP, a candidate must first undergo a criminal history and dependent adult abuse records check if the individual will provide direct services to consumers. The Department of Human Services will perform an evaluation of any criminal history or founded dependent adult abuse to determine whether a prospective employee may be employed and, if so, in what capacity. [Iowa Code chapter 135C.33]

## **Monitoring**

Monitoring staff hold community meetings with tenants during their site reviews. The meetings often identify concerns about quality and practice for the monitors. A protocol based on the certification requirements is used to guide the review. Tenants, program staff, and family members are interviewed. During the review, rules may be clarified and explained. Monitoring staff often participate in training meetings organized by three associations representing ALPs.

## **Fees**

The regulations require a \$900 fee for reviewing blue prints. The two year initial certification fee is \$750. The recertification fee for a non-accredited program is \$1,000 and \$125 for an accredited program.

# KANSAS

**Citation**      Assisted living/Residential Health Care Facilities: KAR §28-39-144 et.seq.

## General Approach and Recent Developments

Regulations are being reviewed in 2007. Minor revisions are expected to be made in 2008. Licensing rules were last amended in October 1999 and the recent focus has been on monitoring, training and improving outcomes. The licensing law creates an overall framework for adult care homes which includes nursing facilities, nursing facility for mental health, ICF-MR, ALF, residential health care facility, home plus, boarding care home, and ADC facility. The regulations differentiate among the categories of adult care homes.

## Adult Foster Care

AFC providers are licensed as a type of Home Plus facilities and may serve not more than eight individuals. The statute and regulations are available at:

[http://www.agingkansas.org/ProviderInfo/regs/RegSets/Home\\_Plus\\_Regs\\_Total.pdf](http://www.agingkansas.org/ProviderInfo/regs/RegSets/Home_Plus_Regs_Total.pdf).

Web Address	Content
<a href="http://www.agingkansas.org/ProviderInfo/regs/reg_index.html">http://www.agingkansas.org/ProviderInfo/regs/reg_index.html</a>	Rules
<a href="http://www.agingkansas.org/ProviderInfo/BestPractice/BP_Index.htm">http://www.agingkansas.org/ProviderInfo/BestPractice/BP_Index.htm</a>	Best practices

Category	Supply					
	2007		2004		2002	
	Facilities	Units	Facilities	Units	Facilities	Units
Assisted living facilities	120	7,351	191	7,971	129	5,658
Residential health care facilities	49	2,919			98	2,918
Home Plus	70	456	NR	NR	44	94

## Definition

*Assisted living facility* means any place or facility caring for six or more individuals not related within the third degree of relationship to the administrator, operator, or owner by blood or marriage and who, by choice or due to functional impairments, may need personal care and may need supervised nursing care to compensate for ADLs limitations and in which the place or facility includes apartments for residents and provides or coordinates a range of services including personal care or supervised nursing care available 24-hours-a-day, seven days a week for the support of resident independence. The provision of skilled nursing procedures to a resident in an ALF is not prohibited by this act. Generally, the skilled services provided in an ALF shall be provided on an intermittent or limited term basis, or, if limited in scope, on a regular basis.

The rules provide that the administrator or operator of facilities ensure that written policies and procedures are developed and implemented which incorporate the principles of individuality, autonomy, dignity, choice, privacy, and a home-like environment.

## **Unit Requirements**

Each facility must offer apartments which include areas for sleeping, living, storage, kitchen (with sink, refrigerator, stove or microwave, and space for storage of utensils and supplies), and bathroom. They must also offer at least 200 square feet of living space, excluding bathroom, closets, lockers, wardrobes, other built-in fixed items, alcoves, and vestibules. Facilities licensed prior to January 1, 1995, as an intermediate personal care facility, are not required to offer kitchens and private baths.

Residential health care facilities are required to have individual living units with at least 100 square feet of living space and a private toilet room with a bathing facility.

## **Admission/Retention Policy**

Each facility develops admission, transfer, and discharge policies which protect the rights of residents. Facilities may not admit or retain people with the following conditions unless the negotiated service agreement includes hospice or family support services which are available 24-hours-a-day or similar resources:

- Incontinence where the resident cannot or will not participate in management of the problem;
- Immobility requiring total assistance in exiting the building;
- Any on-going condition requiring two-person transfer;
- Any on-going skilled nursing intervention needed 24-hours-a-day for an extended period of time; or
- Any behavioral symptom that exceeds manageability.

## **Nursing Home Admission Policy**

A standard Client Assessment Referral Evaluation (CARE) is used to assess impairments in ADLs and IADLs and risk. ADLs and IADLs are weighted. ADLs: dressing and mobility (3); bathing and eating (4); toileting and transfer (5). IADLs: meal preparation and medical management (5); money management (4); and shopping, transportation, telephone use, laundry, and housekeeping (3). The weightings are multiplied by a factor based on the need for no assistance (0); physical assistance or supervision (1), and unable to perform (3). Risk factors include: bladder incontinence (5), risk of abuse, neglect, or exploitation by others (5), falls (3), lack of support (4), and impaired cognition (4).

To be eligible, applicants must have a minimum of two ADLs with minimum combined weight of six; impairments in a minimum of three IADLs with a minimum combined weight of nine; and a total minimum score of 26, or a minimum score of 26 with at least 12 points in IADL impairments and the remaining 14 in any combination of IADL, ADL, and risk factor points.

## **Services**

Services may include meals; health care services based on an assessment by a licensed nurse; housekeeping; medical, dental, and social transportation; and other services necessary to support the health and safety of the resident. Health care services include personal care, supervised nursing care, and wellness and health monitoring. The service agreement contains the skilled nursing services to be provided and the licensed person or agency providing services.

## **Dietary**

A dietetic services supervisor or licensed dietician must provide scheduled on-site supervision in facilities with 11 or more residents. 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 USDA and HHS.

## **Agreements**

Facilities must develop a negotiated service agreement with each resident in collaboration with the resident, the resident's legal representative, family (if agreed to by the resident), or case manager. The agreement describes the services to be provided, the provider of service, and the parties responsible for payment when services are provided by an outside agency. The agreement supports the dignity, privacy, choice, individuality, and autonomy of the resident. The agreement is reviewed at least annually or when requested by any of the participating parties. The agreements also address services that are refused by the resident; the potential negative consequences; and the resident's acceptance of the risks involved.

## **Provisions for Serving People with Dementia**

People with special needs may be served if the facility has admission and discharge criteria that identify the diagnosis, behavior, or specific clinical needs of the residents to be served. A written physician's order is required for admission. Prior to admission, the resident or their legal representative must be informed of the services and programs available. Staff must complete training on the needs of the residents to be served. Exits must be controlled in the least restrictive possible manner.

## **Medication Administration**

A drug regimen review conducted by a pharmacist is required for residents who receive assistance with medication administration or whose medications are administered by facility staff. Medication aides may administer oral and topical medications and assist with medication administration. Medication reminding may be performed by a licensed nurse, medication aide, or nurse aide. Medication reminding includes asking if the medication has been taken, handing the medication to the resident, and opening the container. Medication reminding does not include taking the medication out of the container.

## **Public Financing**

Medicaid waiver services have been available since 1997 to elderly recipients who meet the nursing home LOC criteria and have income below 300% of the federal SSI payment. The room and board amount is negotiated between the facility and the resident. SSI beneficiaries retain a \$30 PNA.

The state uses a “care plan” method for paying for services. The care plan is developed by a case manager in the AAA. Services are billed fee-for-service. The maximum rate for health care attendant services is \$3.31 per unit (15 minutes) for Level I tasks and \$3.66 per unit for Level II tasks. Plans requiring a mix of both levels are reimbursed at the Level II rate.

Family members may supplement resident income for room and board costs and services that are not part of the plan of care.

The Medicaid waiver includes ALFs as a provider of respite and health care attendant services. The services covered by the waiver include respite care, sleep cycle support, health care attendant (Level I and Level II), ADC, and wellness monitoring. Sleep cycle support means “non-nursing physical assistance and supervision during the consumer’s normal sleeping hours in the consumer’s place of residence, excluding nursing facilities” and includes “physical assistance or supervision with toileting, transferring and mobility, prompting and reminding of medication.”

Health care attendant “provides physical assistance with ADLs and IADLs for individuals who are unable to perform one or more activities independently.” IADLs, excluding medication management or medication administration, may be performed without nurse supervision. These services are limited to 12 hours a day.

Level I activities include assistance with ADLs and IADLs (i.e., bathing, grooming, toileting, transferring, feeding, mobility, accompanying to obtain necessary medical services, shopping, house cleaning, meal preparation, laundry, and life management).

Level II activities are health maintenance activities and include monitoring vital signs, supervision and/or training of nursing procedures, ostomy care, catheter care, enteral nutrition,

medication administration/assistance, wound care, range of motion, and reporting changes in function or condition. These services must be authorized by a physician or a nurse.

Medicaid Participation					
2007		2004		2002	
Facilities	Participation	Facilities	Participation	Facilities	Participation
NR	NR	155*	769*	155	769
* Estimate. The Kansas Frail Elderly waiver does not track facilities. They track service providers who provide attendant care, ALF, RCF, Home Plus facilities, and board and care homes.					

## Staffing

Sufficient numbers of qualified personnel must be available to ensure that residents receive services in accordance with negotiated service agreements.

## Training

*Administrator.* The licensee shall appoint an administrator or operator who holds a Kansas license as an adult care home administrator or has successfully completed an operator training program as designated by the secretary. The hours of training for operators was increased from 24 to 32 to spend more time on regulatory requirements and nursing issues.

*Staff.* Facilities shall provide orientation to new employees and regular in-service training for all employees to ensure that services provided assist residents to attain and maintain their individuality, autonomy, dignity, independence, and ability to make choices in a home-like environment.

In-service education must include: principles of assisted living; fire prevention and safety; disaster procedures; accident prevention; resident rights; infection control; and prevention of abuse, neglect, or exploitation of residents.

In-service education on treatment of behavioral symptoms shall be provided to all employees of facilities that admit residents with dementia.

## Background Check

Not described.

## Monitoring

Surveyors inspect every facility annually. Consistent enforcement of the regulations has been credited with improved compliance and fewer complaints. Deficiencies are written more concisely with a focus on the consumer and outcomes. Under a new survey process, facility staff accompany the surveyor during the review. Problem areas are identified and discussed with the

staff. Educational efforts have been increased. The licensing agency conducts regular one-day training courses for nurses, owners and operators on the role of nursing in assisted living, how to conduct an assessment and develop a service plan, managing medications and the Nurse Practice Act. During the training, scenarios are presented and participants prepare a care plan based on the information presented.

## **Fees**

\$50, plus \$15 for each resident.

# KENTUCKY

**Citation**      Assisted living community certification: 910 KAR 1:240; relates to KRS 194A.700-729; 42 USC 3029  
 Statutory authority: KRS 194A.050(1), 194A.707(1)  
 Personal care homes: 902 KAR 20:036

## General Approach and Recent Developments

Changes to the certification requirements have been proposed and will be completed by the end of 2007. An ALC must be certified by the state in order to operate and market itself as an ALC. ALCs are considered private business entities. There is no public funding. A Bill (HB 174) was passed in 2001 that requires coverage of services in ALFs by long-term care insurance policies. Regulations were promulgated in 2001.

## Adult Foster Care

Family Care Homes are licensed by the Cabinet for Health and Family Services, Office of Inspector General. Family care homes provide 24-hour supervision and personal care services in residential accommodations for a resident who because of impaired capacity for self-care, elects to have or requires a protective environment but does not have an illness, injury, or disability for which constant medical care or skilled nursing services are required. Residents must be ambulatory or mobile nonambulatory and able to manage most of the ADLs. Rules are available at: <http://www.lrc.state.ky.us/kar/902/020/041.htm>.

Web Address	Content
<a href="http://chfs.ky.gov/agencies/os/dail/ALC.htm">http://chfs.ky.gov/agencies/os/dail/ALC.htm</a>	Rules, list, guide, application
<a href="http://chfs.ky.gov/NR/rdonlyres/1F3858AE-18A8-4E11-BB10-7A29A7F022A6/0/PCHDirectory.doc">http://chfs.ky.gov/NR/rdonlyres/1F3858AE-18A8-4E11-BB10-7A29A7F022A6/0/PCHDirectory.doc</a>	List personal homes
<a href="http://chfs.ky.gov/oig/tckarkrs.htm">http://chfs.ky.gov/oig/tckarkrs.htm</a>	Rules personal care homes

Category	Supply					
	2007		2004		2002	
	Facilities	Units	Facilities	Units	Facilities	Units
Personal care homes	192	6,802	204	7,389	204	7,792
Assisted living communities	97	NA	83	NA	73	NA

## Definition

*Assisted Living Community* means a series of living units on the same site, operated as one business entity, and certified under KRS 194A.707 to provide services for five or more adult persons not related within the third degree of consanguinity to the owner or manager.

*Personal Care Homes* are establishments with permanent facilities including resident beds. Services provided include continuous supervision, basic health and health-related services, personal care services, residential care services, and social and recreational activities.

## **Unit Requirements**

*Assisted Living Community.* Each living unit in an ALC shall have at least 200 square feet for single occupancy, or for double occupancy if the room is shared with a spouse or another individual by mutual agreement; 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; and have an individual thermostat control if the ALC has more than 20 units. Units may be shared only by choice. Any ALC 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, or for each living unit having 200 square feet for single occupancy, or for double occupancy if the room is shared with a spouse or another individual by mutual agreement. Such communities must have a minimum of one bathtub or shower for every five residents.

*Personal Care Homes.* No requirements are specified for room size. The maximum number of beds per room is four. At least 66% of the beds in the facility must be located in rooms designed for one or two beds. Facilities using central bathing areas must have bathrooms and showers/baths for each sex on each floor. One toilet is required for every eight residents, a lavatory for every 16 residents, and a shower/bath tub for every 12 residents.

## **Admission/Retention Policy**

*Assisted Living Community.* A client shall be ambulatory or mobile non-ambulatory, unless due to a temporary health condition for which health services are being provided in accordance with KRS 194A.705(2) and (3) not be a danger to self or others.

*Personal Care Home.* PCHs may admit persons who are 16 years or older and who are ambulatory or mobile non-ambulatory and whose care needs do not exceed the capability of the home. Persons who are non-ambulatory or non-mobile may not be admitted to a PCH. Residents must be able to manage most of the ADLs. Residents must have a complete medical evaluation upon admission or within 14 days prior to admission. Residents whose care is not within the scope of services of a PCH must be transferred to an appropriate facility.

## **Nursing Home Admission Policy**

Not reported.

## **Services**

*Assisted Living Community.* The ALC shall provide each client with the following services according to the lease agreement: assistance with ADLs and IADLs; three meals and snacks made available each day; scheduled daily social activities that address the general preferences of clients; and assistance with self-administration of medication. Clients of an ALC may arrange for additional services under direct contract or arrangement with an outside agent, professional, provider, or other individual designated by the client if permitted by the policies of the ALC. Upon entering into a lease agreement, an ALC must inform the client in writing about policies relating to the contracting or arranging for additional services. ALCs may not provide health care services.

*Personal Care Home.* All homes must provide basic health and health-related services including: continuous supervision and monitoring; supervision of self-administration of medications, storage, and control when necessary; and arrangements for obtaining therapeutic services ordered by the resident's physician which are not available in the facility; activities; housekeeping and maintenance services; laundry; three meals a day; and personal care.

## **Dietary**

*Assisted Living Community.* No provisions specified.

*Personal Care Home.* Three meals and snacks are required. 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 the nutrition needs of residents as contained in the current recommended dietary allowances of the Food and Nutrition Board. All staff must be trained in accordance with their duties. Training for food staff must cover therapeutic diets.

## **Agreements**

*Assisted Living Community.* A lease agreement is required that includes: client data for the purposes of providing services which includes a functional needs assessment pertaining to a client's ability to perform ADLs and IADLs; emergency contact name; name of responsible party or legal guardian; attending physician's name; information regarding personal preferences and social factors; advance directives; optional information helpful to identify services that meet the client's needs; general services and fee structure; information regarding specific services provided, unit, and associated fees; a minimum 30-day notice for a change in fee structure; a minimum 30-day notice for move-out notices for non-payment; refund and cancellation policies; payment responsibilities and arrangements; the owner's covenant to comply with appropriate laws and regulations; conditions for termination; terms of occupancy; reasonable rules of conduct for staff, management, and tenant; grievance policies; and a copy of the tenant's rights. It may also include additional services that will be provided or arranged. Agreements must

provide for single occupancy apartment unless shared by mutual agreement. An ALC must assist a client in making alternative living arrangements in the event of a move-out notice.

*Personal Care Home.* Upon admission the resident and a responsible family member must be informed in writing of the home's policies, fees, reimbursement, visitation rights during serious illness, visiting hours, types of diets offered, and services rendered.

## **Provisions for Serving People with Dementia**

*Assisted Living Community.* Resident lease agreements contain a description of special programming, staffing, or training for serving clients with special needs. Facilities serving people with special needs are required to provide consumers with information about the special programming, staffing, or training that is offered.

*Personal Care Home.* Not specified.

## **Medication Administration**

*Assisted Living Community.* The statute allows assistance with self-administration of medication which means: reminding the client to take medications; reading the medication's label; confirming that medication is being taken by the client 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 client; and making available the means of communicating with the client's physician and pharmacy for prescriptions by telephone, facsimile, or other electronic device.

*Personal Care Home.* Medications shall not be administered or provided to any resident except on the order of a licensed physician or other ordering personnel acting within the limits of their statutory scope of practice. Administration of all medications must be kept in the resident's record. All medications must be kept in a locked place.

## **Public Financing**

No Medicaid funds are available for either category.

## **Staffing**

*Assisted Living Community.* Staffing in ALCs shall be sufficient in number and qualification to meet the 24-hour scheduled and unscheduled needs of its clients and services provided. One awake staff member must be on site at all times. A designated manager who is at least 21 years of age with a high school or GED diploma must be employed.

*Personal Care Home.* Staffing patterns are based on the needs of residents. One attendant must be awake and on duty on each floor in the facility at all times. The home must identify a staff person responsible for the activities program.

## **Training**

*Assisted Living Community.* ALC staff and management shall receive orientation and in-service education on the following topics as applicable to the employee's assigned duties: client rights; community policies; adult first aid; CPR; adult abuse and neglect; Alzheimer's disease and other types of dementia; emergency procedures; aging process; assistance with ADLs and IADLs; particular needs or conditions if the ALC markets itself as providing special programming, staffing, or training on behalf of clients with particular needs or conditions; and assistance with self-administration of medication.

*Personal Care Home.* All PCH employees shall receive in-service training to correspond with the duties of their respective jobs. Documentation of in-service training shall be maintained in the employee's record and shall include: who gave the training, date and period of time training was given, and a summary of what the training consisted of. In-service training shall include but not be limited to the following:

- Policies of the facility in regard to the performance of their duties;
- Services provided by the facility;
- Record-keeping procedures;
- Procedures for reporting adult and child abuse, neglect, or exploitation;
- Patient rights;
- Methods of assisting patients 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.

## **Background Check**

*Assisted Living Community* applicants must assure that no officer, director, trustee, limited partner, or shareholder has ever been convicted of a felony, Class A misdemeanor or abuse of a person.

## **Monitoring**

*Assisted Living Community.* Unless there is a formal complaint lodged against a facility, the state does not conduct oversight and monitoring of the quality of care in ALCs. The state conducts a certification review upon application, and an annual recertification review. These reviews ensure compliance with the certification requirements. Any ALC that provides services or markets itself as assisted living without filing a current application or receiving certification may be fined up to \$500 per day.

## **Fees**

*Assisted Living Community.* \$20 per unit, \$300 minimum, and \$1,600 maximum. A fee of \$250 is charged for architectural review, lease agreement, and notification of conditional compliance to a lender.

*Personal Care Home.* \$4 per bed with a minimum of \$80.

# LOUISIANA

**Citation** Adult residential care facility: Louisiana Revised Statutes Annotated §2151 et seq.; LA administrative code title 48, §8801 et seq.

## General Approach and Recent Developments

The regulations for adult residential care facilities, which include ALFs, were initially approved in 1999, and created core requirements for adult residential care facilities plus three modules for ALFs, PCHs, and shelter care facilities. The modules contain separate requirements for administrators, staff training, and living units. The rules state that the purpose of the regulations is to promote the availability of appropriate services for elderly and disabled persons in a residential environment; to enhance the dignity, independence, privacy, choice, and decision making ability of the residents; and to promote the concept of aging-in-place.

## Adult Foster Care

PCHs are adult RCHs/facilities that provide room and board and personal services, for compensation, to two but not more than eight residents in a congregate living and dining setting and is in a home that is designed as any other private dwelling in the neighborhood. PCHs comply with the core standards and those in the PCH module.

Web Address	Content
<a href="http://www.dss.state.la.us/Documents/OS/Adult_Residential.pdf">http://www.dss.state.la.us/Documents/OS/Adult_Residential.pdf</a>	Rules
<a href="http://www.dss.state.la.us/departments/os/licensing/default.asp">http://www.dss.state.la.us/departments/os/licensing/default.asp</a>	List

Category	Supply					
	2007		2004		2002	
	Facilities	Units	Facilities	Units	Facilities	Units
Assisted living facilities	75	4,700	67	4,157	66	3,906
Personal care homes	30	189	44	286	29	176
Shelter care homes	18	468	17	543	26	841

## Definition

*Adult residential care home* means a publicly or privately operated residence that provides personal assistance, lodging, and meals (for compensation) to two or more adults who are unrelated to the residence licensee, owner, or director.

*Assisted living home/facility* means an adult RCF that provides room, board, and personal services, for compensation, to two or more residents that reside in individual living units which contain, at a minimum, one room with a kitchenette and a private bathroom.

*Personal care home* means an adult RCF that provides room, board, and personal services, for compensation, to two but not more than eight residents in a congregate living setting and is in a home that is designed as any other private dwelling in the neighborhood.

*Shelter care home* means an adult RCF that provides room, board, and personal services, for compensation, to nine or more residents in a congregate living and dining setting.

## **Unit Requirements**

*Assisted living facilities* must offer apartment-style units with lockable doors to ensure privacy, dignity, and independence. Efficiency/studio units must provide 250 square feet excluding bathrooms and closets and may be shared by no more than two people by choice. Units with separate bedrooms shall have a living area of at least 190 square feet, excluding bathroom and closets. Each separate bedroom must have 120 square feet.

*Personal care homes* offer a home-like atmosphere with 100 square feet in single occupancy rooms and 70 square feet per resident for double occupancy rooms.

*Shelter care facilities* must have 100 square feet in single occupancy rooms and 160 square feet for double occupancy rooms. No more than two residents may share a room, and they must agree in writing to share a room. Facilities must have adequate toilet, bathing, and hand washing facilities in conformance with the state sanitary code.

## **Admission/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 may be accepted or retained if the resident can provide or arrange for care through appropriate private duty personnel, does not need continuous nursing care for more than 90 days, and the provider can meet the resident's needs. Facilities may not enter into contracts with outside providers to deliver health-related services. These services must be arranged by the resident, family members, or the resident's representative. Residents must be discharged if a physician certifies that more than 90 days of continuous care is needed or the resident is a danger to himself or others.

## **Nursing Home Admission Policy**

The state has criteria for skilled nursing care and two levels of intermediate care. The minimum criteria for admission to a nursing home include: requiring supervision or assistance with personal care needs, assistance in eating, administration of medications, injections less than daily, skin care, protection from hazards, mild confusion or withdrawal, medications for stable conditions or those requiring monitoring once a day, and stable blood pressure requiring daily

monitoring. The determination is made by a physician based on his or her professional judgment of the above factors.

## **Services**

Basic services provided include assistance with ADLs and IADLs, three meals a day, personal and other laundry, opportunities for individual and group socialization, housekeeping, services for residents who have behavior problems, recreation services, 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.

## **Dietary**

Menus must be reviewed and approved by a nutritionist or dietician to assure nutritional appropriateness. Facilities must make reasonable accommodations to meet dietary requirements and religious and ethnic preferences; to make snacks, fruit, and beverages available when requested; and to provide meals in a resident's room (on a temporary basis). Medically prescribed special diets must be provided and planned or approved by a registered licensed dietician.

## **Agreements**

Agreements must include: clear and specific occupancy criteria and procedures (admission, transfer, and discharge); basic services available; optional services available; payment provisions (covered and non-covered services; service packages; and à la carte, regular, and extra fees; payer; due date; funding source); modification provisions including at least a 30-day notice of rate changes; refund policy; authority of the licensing agency to examine records; general facility policies/house rules; responsibilities of the facility, resident, and family for overseeing medical care, purchasing supplies/equipment, and handling emergencies and finances; and the availability of a service plan. Facilities must allow review by an attorney.

## **Provisions for Serving People with Dementia**

None specified.

## **Medication Administration**

Facilities may provide assistance with self-administration of medications, however, residents may be assisted with pouring or otherwise taking medications only if they are cognitive

of what the medication is, what it is for, and the need for the medication. Residents may contract with an outside source for medication administration. Staff assisting with medications must have training on the policies and procedures for assistance.

## **Public Financing**

A four-year pilot program approved by the legislature in 1997 to test the feasibility of covering assisted living under Medicaid has been deferred by budget problems but is still under consideration. Legislation passed in 2000 extended authority for the project until 2005. The project intended to serve 60 people in two sites. The project will include two ALFs and serve elderly Medicaid beneficiaries who can no longer live at home because they need additional care with ADLs but do not require continuous nursing care and have no alternative under the traditional model except institutional care. The pilot “shall maximize the independence of the elderly while providing the assistance that the special needs of this population require.” The Bill defines assisted living as “a residential congregate housing environment combined with the capacity by in-house staff or others to provide supportive personal services, 24-hour supervision and assistance, whether or not such assistance is scheduled, social and health-related services to maximize residents’ dignity, autonomy, privacy, and independence and to encourage facility and community involvement.” Residents must be offered a chance to live in private quarters with a lockable door, bedroom, kitchenette, and bathroom.

## **Staffing**

Providers must demonstrate that sufficient staff are scheduled and available to meet the 24-hour scheduled and unscheduled needs of residents and show adequate coverage for each day and night. ALFs and shelter care facilities must have at least one awake staff on duty at night.

## **Training**

*Administrators* must be 21 years of age. Assisted living administrators must have a bachelor’s degree plus two years of experience in the field of health, social, management administration, or in lieu of a degree, six years of experience and education or a master’s degree in geriatrics, health care administration, or a human service related field.

*Shelter care home administrators* must have two years of college and two years experience or four years experience in lieu of college or a bachelor’s degree. PCH administrators must have two years of college training plus one year experience or three years of experience in lieu of college or a bachelor’s degree.

*Staff.* An orientation program shall include but not be limited to thorough coverage of the following areas: 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. Direct

care staff orientation must cover training in resident care services (personal care), infection control, and any specialized training to meet resident needs. All direct care staff must receive certification in first aid. An annual training plan must be developed that includes the topics covered by the orientation.

## **Background Check**

Licenses may be denied based on 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. Providers must include the results of a criminal history check in each employee's personnel file.

## **Monitoring**

The Department of Health shall make at least annual inspections. Complaints are to be reviewed and investigated by the appropriate state agency.

## **Fees**

The annual licensing fee for ALFs is \$175 for 2-4 beds; \$200 for 5-8 beds; and \$250 for nine or more beds. The fee for PCHs is \$200.

# MAINE

**Citation**      Assisted Living Programs: 10-149 Chapter 113

## General Approach and Recent Developments

The state licenses five types of facilities providing assisted living services -- ALPs and four levels of RCFs. The levels vary primarily by size. RCFs may offer the same services ALPs do, but provide bedrooms rather than apartment units. The scope sections of the rules establish a philosophy of regulation to support services that are individualized to meet resident needs and encourage each resident's right to independence, choice and decision making, while providing a safe environment.

Minor revisions to the regulations were made in 2006. Legislation is pending that would provide injunctive relief to intervene with unlicensed facilities and to set maximum fines that may be imposed for licensing violations.

## Adult Foster Care

The licensing rules include requirements based on the size of the facility, ownership and staffing.

Web Address	Content
<a href="http://www.maine.gov/dhhs/beas/alls/assisted.htm">http://www.maine.gov/dhhs/beas/alls/assisted.htm</a>	Rules, list

Category	Supply						
	2007		2004		Category	2000	
	Facilities	Units	Facilities	Units		Facilities	Units
Level I residential care facility	67	121	95	161	Level I residential care facility	473	1,711
Level II and III residential care facility	396	1,675	415	1,785	Level II residential care facility	192	5,220
Level IV residential care facility	184	5,283	201	5,647			
Assisted living program	34	1,624	30	1,429	Congregate housing	24	1,133

## Definition

*Assisted living services* means the provision by an ALP, either directly by the provider or indirectly through contracts with persons, entities or agencies, of assisted living services which include personal supervision; protection from environmental hazards; assistance with ADLs and IADLs; diversional, motivational or recreational activities; dietary services; care management services; administration of medications; and nursing services.

Assisted living services may be provided in two types of settings -- ALPs and RCFs. RCFs are further divided into four subgroups.

*Assisted living program* means a program of assisted living services provided to consumers 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. The types of ALPs governed by these regulations include:

- Type I -- an ALP that provides assisted housing services and medication administration directly or indirectly through contracts with persons, entities or agencies.
- Type II -- an ALP that provides assisted housing services, medication administration and nursing services directly or indirectly through contracts with persons, entities or agencies to provide services of a registered professional nurse; and/or registered professional nurse coordination and oversight of consumer services provided by unlicensed health care assistive personnel.

*Residential care facility* means a house or other place that, for consideration, is maintained wholly or partly for the purpose of providing residents with assisted living services.

[NOTE: Both ALPs and RCFs provide assisted living services. The definition of the living unit differs.]

RCFs provide housing and services to residents in private or semi-private bedrooms in buildings with common living areas and dining areas. There are four types of RCFs:

- 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 which employs three or more persons who are not owners and are not related to the owner.
- Level IV -- licensed capacity of more than six residents.

*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 dementia. 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.

## **Unit Requirements**

ALPs are multi-unit residential buildings that provide apartments and must meet state and local building codes.

Level I-IV RCFs must offer 100 square feet for single rooms and 80 square feet for double rooms. Level IV facilities provide one toilet and sink for every six residents. Facilities licensed

on or after May 30, 2002, must have one bathing facility for ten users (one for 15 residents for facilities licensed prior to May 30, 2002). No more than two residents may share a room.

## **Admission/Retention Policy**

The rules encourage aging-in-place and have very flexible policies to achieve that goal. In its application, all facilities must describe who may be admitted and the types of services, including the scope of nursing services, to be provided. Facilities may discharge tenants who pose a direct threat to the health and safety of others, damage property, or whose continued occupancy would require modification of the essential nature of the program. The rules also require facilities to permit reasonable modifications at the expense of the tenant or other willing payer to allow persons with disabilities to reside in licensed facilities. Providers may require the disabled individual to return the premises to its prior condition.

## **Nursing Home Admission Policy**

Individuals must meet medical, medical/functional or cognitive/behavior requirements. Individuals must have a need for daily skilled nursing *or* extensive assistance in three of the following ADLs: bed mobility, transfer, locomotion, eating and toileting; *or* a combination of three needs in the following areas: skilled nursing, cognition, behavior, and at least limited assist in one of the following ADLs: bed mobility, transfer, locomotion, eating and toileting.

The list of nursing services includes any specified physician-ordered services provided on a frequent rather than daily basis; professional nursing assessment, observation and management for impaired memory, and impaired recall ability, and impaired cognitive ability; professional nursing assessment, observation, and management for problems including wandering, physical abuse, verbal abuse or socially inappropriate behavior; administration of treatments, procedures, or dressing changes that involve prescription medications and require nursing care and monitoring; and professional nursing for physician-ordered radiation therapy, chemotherapy, or dialysis. Skilled services also include physician-ordered occupational, physical, or speech/language therapy or some combination of the three, which must require the professional skills of a licensed or registered therapist.

The cognition and/or behavior requirements apply for individuals who do not require professional nursing intervention at least three days per week but are eligible if they have a qualifying score on the Cognitive Screen and/or Behavioral Screen, in combination with a need for at least “limited assistance” with an ADL, for a total of three service needs. The qualifying scores are cognitive score = 13 points and two ADL’s; or cognitive score = 13 points, and behavioral score = 14 and one ADL; or behavioral score = 14 points and two ADL’s.

## Services

All facility levels are required to describe the scope of services provided, including scope of nursing services consistent with applicable state and federal law as part of their licensing application.

ALPs must offer service coordination, housekeeping services, assistance with ADLs and IADLs, at least one nutritious meal a day, chore services and other services identified in a service plan.

Level I, II, and III residents have the right to receive assistance from the provider to implement any reasonable plan of service developed with community or state agencies.

Level IV residents are able receive individualized services that help them age in place, function optimally in the facility and in the community, engage in constructive activity, and manage their health conditions and accommodate individual choices and preferences. The regulations require 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.

Residents must be assessed within 30 calendar days of admission and reassessed annually or when there is a significant change in condition. A service plan must be developed and implemented within 30 calendar days of admission based upon the assessment. The plan addresses areas in which the resident needs encouragement, assistance or an intervention strategy. The plan describes strategies and approaches to meet the resident's needs, names of who will arrange and/or deliver services, when and how often services will be provided and goals to improve or maintain the resident's level of functioning. Residents are encouraged to be as independent as possible in their functioning, including ADLs and normal household tasks if they choose, unless contraindicated by the resident's duly authorized licensed practitioner.

## Dietary

*Assisted living program.* A registered dietician must approve menus and menu cycles annually. Menus must be planned in accordance with resident needs and preferences. Therapeutic diets must be ordered by any duly licensed practitioner in all levels. A least one nutritious meal a day must be delivered by the ALP.

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 (NAS). 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.

## **Agreements**

The state requires adoption of a standard contract for all assisted living services. All resident contracts contain standard 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/program's basic rate. Each contract may not contain a provision for the discharge of a resident that is inconsistent with state law or rule; a provision that may require or imply a lesser standard of care or responsibility than is required by law or rule; provide for at least 30 calendar day's notice prior to any changes in rates, responsibilities, services to be provided or any other items included in the contract; may not require a deposit or other prepayment, except one month's rent in an ALP, which may be used as a security deposit provided there is a statement of the explicit return policy of the facility with regard to the security deposit; and may not contain a provision that provides for the payment of attorney fees or any other cost of collecting payments from the resident. Additional information is appended to the contract -- grievance procedure, tenancy obligations, resident rights, and a copy of the admissions policy.

In addition, an information packet must also be provided that contains advance directives information; information regarding the type of facility and the licensing status; the Maine Long-Term Care Ombudsman Program brochure; toll-free telephone numbers for the Office of Advocacy of the Department of Behavioral and Developmental Services (BDS) if the facility has residents who receive services from BDS; Adult Protective Services; Assisted Living Licensing Services and Division of Licensing and Certification; the process and criteria for placement in, or transfer or discharge from, the program; and the program's staff qualifications.

## **Provisions for Serving People with Dementia**

The provisions for serving people with dementia apply to all levels. Facilities must provide written information about their philosophy; the process used for resident assessment and 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 provided by the program; a description of family involvement and the availability of family support programs; a description of security measures provided by the facility; a description of in-service training provided for staff; and policies with criteria and procedures for admission and discharge of residents to and from the facility/unit.

The design must include secured outdoor space and walkways; high contrast between floors, walls, and doorways; non-reflective surfaces; and even lighting to minimize glare. Residents may not be locked inside or outside of their rooms. Residents are encouraged and assisted to decorate their unit with personal items and furnishings. Facilities try to individually identify each resident's room to help with recognition. Facilities also have policies and procedures to deal with wandering. Electronic locking devices may be used on exterior doors if they release in an emergency.

These facilities must provide individual and/or group activities covering gross motor skills, self care, social interaction, crafts, sensory enhancement, as well as outdoor and spiritual activities.

For pre-service training, all facilities with Alzheimer's/dementia care units must provide a minimum of eight hours of classroom orientation and eight hours of clinical orientation to all new employees assigned to the unit. The trainer(s) shall be qualified with experience and knowledge in the care of individuals with Alzheimer's disease and other dementias. In addition to the usual facilities orientation, which should cover such topics as resident rights, confidentiality, emergency procedures, infection control, facility philosophy related to Alzheimer's disease/dementia care, and wandering/egress control, the eight hours of classroom orientation should include the following topics: a general overview of Alzheimer's disease and related dementias, communication basics, creating a therapeutic environment, activity focused care, dealing with difficult behaviors, and family issues.

## **Medication Administration**

Unlicensed staff who have successfully completed a training program approved by the licensing agency may administer medications and/or treatments. All residents are assessed for their ability to self-administer medications or their need for assistance. A standard curriculum for training in medication administration was adopted for use statewide.

## **Public Financing**

Maine covers services in RCFs under the Medicaid state plan. The state plan program provides reimbursement for personal care services through contracts with Private Non-Medical Institutions (PNMIs). A PNMI is defined "as an agency or facility that is not, as a matter of regular business, a health insuring organization, hospital, nursing home, or a community health care center, that provides food, shelter, and treatment services to four or more residents in single or multiple facilities or scattered site facilities."

MaineCare (Medicaid) reimburses assisted living providers for the services based on individual case-mix or resource group classifications. The \$42 base price per day is adjusted based on the resource group assigned. The base price is the price set for reimbursement for assisted living services for all members receiving a MaineCare weight of 1.0, based on the minimum data set-assisted living services (MDS-ALS) assessment tool. The base price is then adjusted by a resource group weight to calculate a resource adjusted price. Each resident receives a score of "0" or "1" for each of nine indicators from the MDS-ALS including: use of incontinence supplies, medication administration, depression, resident did not administer PRN medications, resident needs help with phoning or arranging transportation, physician order changes, or modified cognitive skills. The nine indicators are summed to create the assisted living score (ALS), ranging from 0-9. Indicators for need for assistance with ADLs and IADLs are scored scores ranging from 0-28. The ALS and ADL/IADL score are used to assign members to one of eight resource groups. They will also assess a \$13.65 program allowance to this

resource-adjusted price, resulting in a range of \$36.59-\$83.24 per day for assisted living services. Individuals in resource group “7-9” (ALS of 7-9 and an ADL score of 7-28) is weighted 1.657. The \$42 base price is adjusted by 1.657 to produce the resource-adjusted price of \$69.59.

Resource Weight Group Chart			
Resource Group	Order	Description	MaineCare Weight
Assisted living score 7-9	1	ADL = 7-28	1.657
	2	ADL = 0-6	1.210
Assisted living score 5-6	3	ADL = 7-8	1.360
	4	ADL = 0-6	1.027
Assisted living score 2-4	5	IADL = 12-18	0.924
	6	IADL = 10-11	0.804
Assisted living score 0-1, or assisted living score 2-4 and IADL 0-9	7	IADL = 0-9	0.551
Unclassified	8	Unclassified	0.551

Medicaid Participation					
2007		2004		2002	
Facilities	Participation	Facilities	Participation	Facilities	Participation
211	4,571	150	3,762	151	3,096

The state SSI payment standard \$623 which includes PNA of \$70/month (\$50 if there is no earned income). State general fund are available to supplement the resident’s room and board payment when the allowable cost of room and board exceeds the resident cost of care. A state-funded demonstration program is now a permanent part of the Medicaid program<sup>2</sup> and serves beneficiaries in affordable ALPs.

## Staffing

### *Administrators*

*Assisted living programs.* The sponsor must assure that services will be provided to residents in accordance with individual service plans. Administrators must hold a professional license related to residential or health care or have a combination of five years of related education and experience.

*Residential care facilities.* Level IV administrators must demonstrate capacity to operate and manage the facility and allow access to records of professional licensing boards or registers, any criminal record, child protective record or adult protective record relating to the applicant/licensee and administrator, and other records.

Administrators must successfully complete a Department-approved training program for administrators unless they have a license from the Nursing Home Administrators Licensing Board as a Residential Care Administrator or Multi-Level Facility Administrator. They must obtain 12 hours a year of continuing education.

<sup>2</sup> See regulations at <http://www.maine.gov/sos/cec/rules/10/144/ch101/c2s006.doc>.

## Staff

*Levels I and II.* Operators must have a person available to provide supervision in their absence. Staffing must be adequate to implement service plans. The department may require additional staff based on the needs of residents and the size and lay out of the facility.

*Level III.* Staffing must be adequate to implement service plans. Additional staffing may be required by the Department. The licensing agency has the authority to require that Level I–III facilities obtain services from a consulting nurse, pharmacist or dietician and a consulting dietician for Level IV facilities.

*Level IV.* RCFs serving over ten residents must have two awake staff on duty at night (one must be direct care staff. The rules require a ratio of one direct care staff to 12 residents from 7 a.m. to 3 p.m.; one direct care staff to 18 residents from 3 p.m. to 11 p.m.; and one direct care staff to 30 residents from 11 p.m. to 7 a.m. The revised rules require a RN on staff or contract to observe signs and symptoms; review records, medication records, medication administration practices and procedures, and therapeutic diets; and recommend staff training. The frequency of these activities varies with the size of the facility from weekly for larger facilities to quarterly for smaller facilities.

Level IV facilities with more than ten beds must have a pharmacy consultant no less than quarterly to review written policies and procedures for pharmaceutical services; medication areas for labeling, storage, temperature, expired medications, locked compartment, access to keys and availability and completeness of a first aid kit; review to ensure that only approved drugs and biologicals are used in the facility; review medication records and initial and date the records when reviewed; review adherence to stop orders; and review staff performance in carrying out pharmaceutical policies and procedures.

## **Training**

*Administrators* must successfully complete a department approved training program. On-going training of at least 12 classroom hours annually is required in areas related to care of the population served.

*Staff -- Level I, II, III.* Residential care staff must attend and show evidence of successful completion of any training that the department determines to be necessary.

*Level IV.* All staff, other than CNAs and licensed professional staff, whose job responsibilities include direct service to residents for at least 20 hours per week, shall successfully complete a Personal Support Specialist certification course within 120 days of hiring. Additional training specific to a facility's programs may be identified and required by the Department for any staff.

Any person working in the facility must demonstrate the following: conduct which demonstrates an understanding of, and compliance with, residents' rights; the ability and

willingness to comply with all applicable laws and regulations; the ability to provide safe and compassionate services; and a history of honest and lawful conduct.

Individuals who administer medications in Levels III and IV must complete a training program approved by the department and must have eight hours of refresher training every two years. If the training program is substantially revised, they must be re-certified within one year of the change.

## **Background Check**

During the licensure process, a criminal background check is conducted for the applicant and the administrator. Facilities must contact the CNA Registry and determine that the CNA or CNA-M is on the Registry and has not been annotated. Facilities may not employ a CNA or CNA-M who is not on the Registry, or who has been annotated for abuse, neglect or misappropriation of patient/client/resident funds in a health care setting. Further changes are pending that would expand the types of individuals for whom the registry must be checked and who may not be employed if there is a positive finding.

## **Monitoring**

The department is authorized to make regular and unannounced inspections of all facilities. The regulations specify the grounds for imposition of intermediate sanctions and the method of calculating penalties. The state ombudsman program is authorized to visit facilities and receive and investigate complaints.

## **Fees**

Chapter 1664 sets fees of \$10 per bed for RCFs and \$200 for ALPs.

# MARYLAND

**Citation** Assisted living programs: Title 10.07.14

## General Approach and Recent Developments

Significant revisions to the regulations are expected to be final in 2007. Several bills were enacted into law. Chapter 452 (2006) requires that ALPs have an emergency electrical power generator on the premises by October 2009. Chapter 356 (2006) requires a uniform assisted living disclosure statement which is posted on the Department of Health and Mental Hygiene website. The disclosure describes the purpose of the statement, what is assisted living, where to find the licensing regulations, facility contact information, sources of payment accepted, levels of care, what is a resident agreement, services provider, criteria for discharge or transfer, staff training requirements, staffing patterns and where to file a complaint. Another law makes operating or owning an unlicensed facility a felony.

The opening section of the rules state that the purpose of the chapter is to set minimum, reasonable standards for licensure of ALPs that are intended to maximize independence and promote the principles of individuality, personal dignity, freedom of choice, and fairness for all individuals residing in ALPs.

ALP rules were revised in 2002 to clarify medication administration requirements and to add disclosure provisions for facilities serving residents with Alzheimer's disease. The HCBS waiver has been expanded to include all ALFs.

The uniform assessment tool was revised in 2003. The previous tool did not adequately assess and determine a LOC for people with behavior problems and dementia. As a result, more residents are likely to be assigned to Level III.

## Adult Foster Care

The ALP regulations apply to small facilities that might be considered AFCHs.

Web Address	Content
<a href="http://www.dsd.state.md.us/comar/subtitle_chapters/10_Chapters.htm">http://www.dsd.state.md.us/comar/subtitle_chapters/10_Chapters.htm</a>	Rules
<a href="http://www.mdoa.state.md.us/alintro.html">http://www.mdoa.state.md.us/alintro.html</a>	Guide
<a href="http://www.dhmf.state.md.us/ohcq/alforum/home.htm">http://www.dhmf.state.md.us/ohcq/alforum/home.htm</a>	Provider
<a href="http://dhmf.state.md.us/ohcq/licensee_directory/licensee_directory.htm">http://dhmf.state.md.us/ohcq/licensee_directory/licensee_directory.htm</a>	List
<a href="http://dhmf.state.md.us/ohcq/alforms/alforms.htm">http://dhmf.state.md.us/ohcq/alforms/alforms.htm</a>	Forms
<a href="http://dhmf.state.md.us/ohcq/alforms/al_disclosure.pdf">http://dhmf.state.md.us/ohcq/alforms/al_disclosure.pdf</a>	Disclosure form

Category	Supply					
	2007		2004		2002*	
	Facilities	Units	Facilities	Units	Facilities	Units
Assisted living programs	1,366	20,093	1,248	17,148	2,000	14,273
* The figures included in the 2002 report were based on estimates as the state converted from its previous regulatory structure to one that consolidated several different categories.						

## Definition

An ALP is “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 in performing, the ADLs or IADLs in a way that promotes optimum dignity and independence for the residents.” The term “assisted living program” may not be used in advertising unless the facility is licensed.

## Unit Requirements

Programs licensed after the effective date of the regulations must provide a minimum of 80 square feet of functional space for single occupancy and 120 square feet for double occupancy rooms. No more than two residents may share a room. Facilities previously licensed as domiciliary care homes must provide a minimum of 70 and 120 square feet for single and double occupancy, respectively. Buildings with one to eight occupants must have one toilet for every four occupants and larger buildings must also have at least one toilet on each floor. Showers/baths must be available for every eight occupants.

## Admission/Retention Policy

Facilities are licensed by the level of impairment of residents. Residents are assigned to a level based on an assessment score. The assessment includes 12 questions that cover medical illnesses/conditions and additional questions covering cognitive and psychiatric conditions, treatment requirements, medication management, ADL assistance, risk factor management, and management of problematic behaviors.

In general, programs may not serve anyone who, at the time of admission, requires more than intermittent nursing care; treatment of Stage III or IV skin ulcers; ventilator services; skilled monitoring, testing, and aggressive adjustment of medications and treatments where there is the presence of, or risk for, a fluctuating acute condition; monitoring of a chronic medical condition that is not controllable through readily available medications and treatments; treatment for an active reportable communicable disease; or treatment for a disease or condition which requires more than contact isolation. Residents may 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 which cannot be adequately managed.

A program may request a waiver to care for residents with needs that exceed the licensure level. It must demonstrate that it can meet the resident's needs and others will not be jeopardized.

Waivers for Level I and Level II programs may not be granted for more than 50% of the licensed bed capacity. Level III programs may not receive waivers for more than 20% of capacity or 20 beds, whichever is less.

## **Nursing Home Admission Policy**

Nursing home care is covered when an individual requires health-related services provided on a daily basis by or under the supervision of a nurse due to medical, cognitive or physical disability. The need for intermittent, part-time services does not qualify (for example, home health nursing), nor does the need for unlicensed care (e.g., personal care) even if care is needed full-time. There is some overlap in how the term intermittent nursing care is applied under the licensing and Medicaid LOC policies.

## **Services**

Before move-in, the assisted living manager determines whether the resident may be admitted and whether the resident's needs can be met by the program based on an assessment and an examination by a health care professional. A functional assessment is completed within 30 days of admission that includes: level of functioning in ADLs; level of support and intervention needed, including any special equipment and supplies required to compensate for the individual's deficits in ADLs; current physical or psychological symptoms requiring monitoring, support, or other intervention by the ALP; capacity for making personal and health care-related decisions; presence of disruptive behaviors, or behaviors which present a risk to the health and safety of the resident or others; and specified social factors.

Services include three meals in a common dining area, special diets, personal care, laundry, housekeeping, social and spiritual activities, and medication management. The program must facilitate access to health care and social services (social work, rehabilitation, home health, skilled nursing, physician services, oral health, counseling, psychiatric care, and others).

## **Dietary**

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 are required. As part of the licensing process, facilities submit a four week menu cycle with documentation by a licensed nutritionist or licensed dietician that the menus are nutritionally adequate. Special diets as ordered by a physician or needed by the resident must be provided.

## **Agreements**

Agreements must include a clear and complete reflection of commitments and actual practices and a recommendation for review by an attorney. The agreement includes: the LOC for which the facility is licensed; the LOC needed by the resident; a statement that describes that a resident may be discharged if the LOC increases and a waiver is not approved; a list of services provided and not provided; complaint/grievance procedure; occupancy provisions (i.e., room assignment, relocation, change in roommate, transfer policy, availability of locks for storage); the staff's right to enter a room (if any); resident rights; bed hold policy; admission and discharge policy; obligations of all parties for arranging for and overseeing medical care and monitoring health status.

The agreements must also include financial information that includes: obligations for payment; handling finances; purchase of rental equipment; arranging and contracting for services not provided by the facility; durable medical equipment; and disposition of resident property upon discharge or death. Also included are the rate structure for the service package, fee-for-service rates; notification of changes; third-party payments; person responsible for payment; procedures if the resident is no longer able to pay; and terms governing refunds. If the resident's needs change significantly, the agreement must be amended.

## **Provisions for Serving People with Dementia**

Programs with an ASCU or program must complete the department's disclosure form that describes: a statement of philosophy or mission; staff training and staff job titles, including the number of hours of dementia-specific training provided annually for all staff by job classification and a summary of training content; admission procedures, including screening criteria; assessment and care planning protocol, including criteria to be used that would trigger a reassessment of the resident's status before the customary six month review; staffing patterns, including the ratio of direct care staff to resident for a 24-hour cycle, and a description of how the staffing pattern differs from that of the rest of the program; 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 the activities meet the needs of residents with dementia, and how the activities differ from activities for residents in other parts of the program; the program's fee or fee structure for services provided by the ASCU or program as part of the disclosure form required by the regulation; discharge criteria and procedures; and any services, training, or other procedures that are over and above those that are provided in the existing ALP.

## **Medication Administration**

Aides who have passed required training may administer medications. Untrained aides may assist with self-administration. Management must arrange for quarterly, on-site reviews of medications by a RN, authorized prescriber, or licensed pharmacist for each resident who self-administers medications.

## **Public Financing**

The state administers an HCBS waiver and a state-funded program that serves beneficiaries age 50 and older in residential settings. A waiver amendment included assisted living services as part of a broad package of services available to people 50 years of age or older in their own or in residential settings. Amendments to the waiver raised eligibility to 300% of the federal SSI benefit. Room and board, paid by the resident, is capped at \$420 a month. Medicaid pays the lesser of the provider's usual and customary charge or \$55.74 a day for Assisted Living Level II services (\$41.81 if the resident receives medical day care services) and \$70.31 a day for Level III services (\$52.73 if the resident receives medical day care services). The Level I licensing LOC does not qualify for the Medicaid waiver. Non-SSI beneficiaries are allowed a PNA of \$64 and all additional income is applied to the cost of care. SSI beneficiaries retain SSI benefits above the amount paid for rent and do not pay toward the cost of services. The Medicaid waiver program served 1,798 beneficiaries in 975 facilities, up from 1,473 beneficiaries in 763 facilities in 2004.

Additional payments are available for assistive equipment. Medicaid will pay the actual costs and payment is capped at \$1,000 per participant for 12 months. Medicaid will pay 67% of the costs of environmental modifications (the provider pays 33%), up to a maximum of \$3,000 per participant. Exceptions to the maximum are allowed at the discretion of the Department on Aging.

The state-subsidized Senior Assisted Living Group Home Subsidy program provides access to assisted living in small group homes which are licensed by the Department of Health and Mental Hygiene for 4-16 residents. The subsidy supports the cost of services provided in assisted living, including meals, personal care and 24-hour supervision for elderly residents who are frail and unable to live independently.

The program served 300 participants in 2007 and 350 in 2004. Participants with incomes no greater than 60% of the statewide median income and assets no greater than \$11,000 for a single person and \$14,000 for a couple apply their income (less a \$64 needs allowance) toward the cost of care. State-funded subsidies may cover the difference between the participant's contribution and the monthly fee, up to a maximum of \$650 a month.

The law directs the Office of Aging to develop ALPs in conjunction with public or private, profit or non-profit entities, maximizing the use of rent and other subsidies available from federal and state sources. These activities can include finding sponsors; assisting developers formulating design concepts and meeting program needs; providing subsidies for congregate meals, housekeeping and personal services; developing eligibility requirements in connection with the subsidies; adopting regulations governing eligibility; and reviewing compliance with relevant regulations.

Medicaid Participation						
	2007		2004		2002	
	Facilities	Participation	Facilities	Participation	Facilities	Participation
Medicaid	975	1,798	763	1,473	362	730
State	300	528	NR	350	259	520

Medicaid Payment Rates (2007)		
	Level II	Level III
Services	\$1,672/20.66	\$2,109.30
Room and board	\$420	\$420
Total	\$2,092.20	\$2,529.30
Assistive equipment add-on	up to \$1,000	up to \$1,000

## Staffing

Based on the number of residents to be served and their needs, the facility develops a staffing plan that identifies the type and number of staff needed to provide the services required. The staffing plan includes on-site staff sufficient in number and qualifications to meet the 24-hour scheduled and unscheduled needs of the residents. A staff member must be present when a resident is in the facility.

Programs must have staff capacity to deliver the care for which they are licensed (see table below). Facilities contracting with Medicaid must have one staff member for every eight residents during daytime hours.

## Training

*Administrators.* After January 2006, assisted living managers of programs with five or more beds must complete a management training course approved by the Department that includes 80 hours of course work and an examination and may include not more than 25 hours of Internet, correspondence courses, tapes or other methods that do not require direct interaction between faculty and participants. The curriculum must cover the philosophy of assisted living; the aging process and its impact; assessment and LOC waivers; serving planning; clinical management; admission and discharge criteria; nutrition and food safety; dementia, mental health and behavior management; end of life care; management and operations; emergency planning; quality assistance and the survey process. Managers must complete 20 hours of annual training.

*Staff* must receive initial and on-going training program to ensure that residents receive services that are consistent with their needs and generally accepted standards of care for the specific conditions of those residents to whom staff will provide services. Staff must receive initial and on-going training in: fire and life safety; infection control, including standard precautions; basic food safety; basic first aid; emergency disaster plans; and individual job requirements as appropriate to their job.

Staff must have knowledge in: health and psycho-social needs of the population served as appropriate to their job responsibilities; resident assessment process; use of service plans; and resident rights.

If job duties involve the provision of personal care services, staff must have knowledge in cuing, coaching, and providing assistance with ADLs. Staff working with people with cognitive impairments and mental illness must have training in a series of areas related to the population served.

Facilities participating in the Medicaid waiver: staff must complete eight hours of training on medication administration and pass a performance test.

## **Background Check**

Applicants must document any felony conviction of the applicant, assisted living manager, or household member (in small, owner-occupied facilities). Management must conduct either a criminal history records check or a criminal background check consistent with §19-1901 et seq. Annotated Code of Maryland.

## **Monitoring**

Under the law, the Department of Health and Mental Hygiene may delegate monitoring and inspection of programs to the Office on Aging and the Department of Human Resources or to local health departments through an interagency agreement. Survey findings and plans of correction must be posted in the facility.

## **Fees**

\$25 a year for programs monitored by the Department of Human Resources or the Department on Aging; \$100 a year for programs inspected and monitored by the Department of Health and Mental Hygiene. Programs with 16 beds or more pay \$100 a year plus \$6 for each bed over 15. Fees will be increased under the pending regulations.

<b>Maryland Level-of-Care Differences -- Staff Capacities</b>			
<b>Area</b>	<b>Level I -- Low (0-25)</b>	<b>Level II -- Moderate (26-60)</b>	<b>Level III -- High (61+)</b>
Health and wellness	Ability to recognize the cause and risks associated with a resident's health condition once these factors are identified by a health care professional.  Provide occasional assistance in accessing and coordinating health services and interventions.	Ability to recognize and accurately describe and define a resident's health condition and identify likely causes and risks associated with the resident's condition.  Provide or ensure access to necessary health services and interventions	Ability to recognize and accurately describe and define a resident's health condition and identify likely causes and risks associated with the resident's condition.  Provide or ensure on-going access to coordination of comprehensive health services and interventions
Functional	Provide occasional supervision, assistance, support, set up, or reminders with some but not all ADLs.	Provide or ensure substantial support with some, but not all, ADLs or minimal supports with any number of ADLs.	Provide or ensure comprehensive support as frequently as needed to compensate for any number of ADLs.
Medication and treatment	Ability to assist with self-administration of medications or coordinate access to necessary medications and treatments.	Provide or ensure assistance with self-administration of medications or administer necessary medications and treatments, including monitoring their effects.	Provide or ensure assistance with self-administration of medications or administer necessary medications and treatments, including monitoring or arranging for monitoring the effects of complex medication and treatment regimens.
Behavioral	Monitor and provide uncomplicated intervention to manage occasional behaviors that are likely to disrupt or harm the resident or others.	Monitor and provide or ensure intervention to manage frequent behaviors which are likely to disrupt or harm the resident or others.	Monitor and provide or ensure on-going therapeutic intervention or intensive supervision to manage chronic behaviors which are likely to disrupt or harm the resident or others.
Psychological	Monitor and manage occasional psychological episodes or fluctuations that require uncomplicated intervention or support.	Monitor and manage frequent psychological episodes or fluctuations that may require limited skilled interpretation or prompt intervention or support.	Monitor and manage a variety of psychological episodes involving active symptoms, condition changes, or significant risks that may require some skilled interpretation or immediate interventions.
Social and recreational	Occasional assistance in accessing social and recreational services	Ability to provide or ensure on-going assistance in accessing social and recreational services.	Provide or ensure on-going access to comprehensive social and recreational services.

# MASSACHUSETTS

**Citation** Assisted living: 651 CMR 12.00 et seq.  
Residential care facility Level IV (rest homes): 105 CMS 150.000 et. seq.

## General Approach and Recent Developments

Further revisions to the regulations were issued in 2006. A consumer guide was prepared and is available at [http://www.mass.gov/Eelders/docs/assisted\\_consumer\\_guide.pdf](http://www.mass.gov/Eelders/docs/assisted_consumer_guide.pdf).

The revised rules include a purpose section that describes the state’s philosophy: “The purpose of these regulations is to promote the availability of services for elderly or disabled persons in a residential environment; to promote the dignity, individuality, privacy and decision making ability of such persons and to provide for their health, safety, and welfare; and to promote continued improvement of ALRs.” To be certified, residences must submit information such as the number of units and number of residents per unit, location of units, common spaces, and egress by floor; base fees to be charged; services to be offered and arrangement for delivering care; number of staff to be employed; and other information required by the Executive Office of Elder Affairs. The buildings are considered residential use for applying appropriate building codes.

## Adult Foster Care

AFC is covered as a Medicaid state plan service and is regulated by the MassHealth (Medicaid) program. Regulations are available at: [http://www.mass.gov/Eeohhs2/docs/masshealth/regs\\_provider/regs\\_adultfostercare.txt](http://www.mass.gov/Eeohhs2/docs/masshealth/regs_provider/regs_adultfostercare.txt).

Web Address	Content
<a href="http://www.mass.gov/?pageID=eldersterminal&amp;L=3&amp;L0=Home&amp;L1=Regulations+and+Statistics&amp;L2=Housing+%2f+Assisted+Living&amp;sid=Eelders&amp;b=terminalcontent&amp;f=reg_651cmr12_final&amp;sid=Eelders">http://www.mass.gov/?pageID=eldersterminal&amp;L=3&amp;L0=Home&amp;L1=Regulations+and+Statistics&amp;L2=Housing+%2f+Assisted+Living&amp;sid=Eelders&amp;b=terminalcontent&amp;f=reg_651cmr12_final&amp;sid=Eelders</a>	Rules, Q&A, incident report
<a href="http://170.63.97.68/portal/site/massgovportal/menuitem.db805ceae7e631c14db4a11030468a0c/?pageID=elderssubtopic&amp;L=3&amp;L0=Home&amp;L1=Housing&amp;L2=Assisted+Living&amp;sid=Eelders">http://170.63.97.68/portal/site/massgovportal/menuitem.db805ceae7e631c14db4a11030468a0c/?pageID=elderssubtopic&amp;L=3&amp;L0=Home&amp;L1=Housing&amp;L2=Assisted+Living&amp;sid=Eelders</a>	Consumer, list, guide

Category	Supply					
	2007		2004		2002	
	Facilities	Units	Facilities	Units	Facilities	Units
Assisted living programs	190	11,900	171	10,585	139	9,796
Residential care facilities (rest homes)	95	2,969	NR	NR	NR	NR

## Definition

*Assisted living residence* is any entity, however organized, whether conducted for profit or not for profit, which meets all of the following criteria:

Provides room and board; provides, directly by its employees or through arrangements with another organization which the entity may or may not control or own, personal care services for three or more adult residents who are not related by consanguinity of affinity to their care provider; and collects payments or third-party reimbursements from or on behalf of residents to pay for the provision of assistance with the ADLs.

## **Unit Requirements**

Units must be single or double occupancy with lockable doors. New construction must provide for private baths. Existing buildings may qualify if they provide private half baths and one bathing facility for every three persons. All facilities must provide, at a minimum, either a kitchenette or access to cooking capacity for all living units. Cooking capacity is defined as each resident having access to a refrigerator, sink, and heating element. Facilities must comply with all federal and state laws and regulations regarding sanitation, fire safety, and access by persons with disabilities. The Secretary of Elder Affairs is authorized to waive the requirements for bathrooms and bathing facilities when determined to meet public necessity and to prevent undue economic hardship as long as the residence provides a home-like environment and promotes privacy, dignity, choice, individuality, and independence.

## **Admission/Retention Policy**

The statute does not allow people needing 24-hour skilled nursing supervision to be admitted or retained in an ALR. Facilities may admit and retain residents in need of skilled nursing care *only if* the care will be provided by a certified provider of ancillary health services or by a licensed hospice, *and* the provider does not train the residence staff to provide skilled nursing care.

To qualify for reimbursement under the Medicaid GAFC program, tenants must require daily assistance with at least one ADL and assistance with managing medications as documented by a physician and a nursing assistant; be at risk of requiring nursing home placement; be chronically disabled; and require 24-hour supervision.

## **Nursing Home Admission Policy**

Individuals must need one skilled service daily from a specified list or have a medical or mental condition requiring a combination of at least three services including at least one nursing service. The nursing services that must be performed at least three days a week include: specified physician ordered skilled services; positioning while in bed or chair; measurement of intake or output based on medical necessity; administration of oral or injectable medications that require a RN to monitor the dosage, frequency, or adverse reactions; staff intervention requirements for selected types of behavior considered dependent or disruptive, unable to avoid

simple dangers, wandering; physician ordered occupational, speech, or physical therapy; nursing observation and/or vital signs monitoring; or treatment involving prescription medication for uninfected post-operative or chronic conditions or routine dressing changes that require nursing care and monitoring. Two services may be required for assistance with bathing (i.e., direct care, attendance or constant supervision), dressing (i.e., direct care, attendance or constant supervision), toileting, bladder or bowel control for incontinence, scheduled assistance, or routine catheter/ostomy care, transfers, mobility/ambulation or eating.

## **Services**

The regulations require that residences provide or arrange for opportunities for socialization and access to community resources; supervision or assistance with ADLs identified in a service plan (at a minimum residences must offer support for bathing, dressing, ambulation and similar tasks); IADLs; self-administered medication management (SAMM); timely assistance to urgent or emergency needs by 24-hour per day on-site staff, personal emergency response systems, or any additional response systems required by the Executive Office of Elder Affairs; up to three regularly scheduled meals per day (minimum of one meal per day). The administrator may arrange for the provision of ancillary health services in the residence but may not use residence staff for these services unless the staff is an employee of a certified provider of ancillary health services and/or an employee of a licensed hospice. Nursing services provided by a certified provider of ancillary health services such as injection of insulin or other drugs used routinely for maintenance therapy of a disease may be provided to residents. Optional services include local transportation, barber or beauty services, money management and limited medication administration (LMA).

Twenty-four hour nursing services are not allowed. Skilled services may only be provided by a certified home health agency on a part-time or intermittent basis. Medical conditions requiring services on a periodic, scheduled basis are also allowed. In addition, residents may “engage or contract with any licensed health care professional and providers to obtain necessary health care services ... to the same extent available to persons residing in private homes.”

All residents must have an individual services plan that is developed prior to admission and reviewed/reassessed at least every six months or when health status or family circumstances change. The plan is based on information from the resident, family members and the physician, including diagnosis, medications, allergies and dietary needs. It includes the services needed, the resident’s goals and the frequency and duration of services to meet the resident’s physical, cognitive, psychological and social needs and behavioral concerns as well as how the residence will provide for 24-hour staffing. If provided by the residence, the plan describes the type of assistance with medication that will be provided.

## **Dietary**

A minimum of one meal a day must be provided (facilities may provide three meals a day). Menus for ALRs should meet the current DRI established by the Food and Nutrition Board,

Institute of Medicine, NAS, and the Dietary Guidelines for Americans published by the Secretaries of HHS and USDA. At a minimum, these dietary plans must allow a resident to adhere to sodium-restricted, sugar-restricted, and low-fat diets. The residence's menus or meal plans shall be evaluated at least every six months by a qualified dietician. Residences must disclose to residents and prospective residents the types of special diets they can accommodate and any additional costs associated with providing this service as well as limitations on addressing food allergies. Dietary needs must be reviewed every six months and included in the resident service plan. The residence is not responsible for ensuring that the resident follows the diet plan but must provide enough food choices and information so that the resident can adhere to the diet if he or she chooses.

Staff managing dietary services must complete a food service sanitation certification course. Therapeutic diets must be reviewed by a qualified dietician and evaluated every six months unless otherwise specified by a physician.

## **Agreements**

Resident agreements include: charges, expenses, and other assessments for resident services; personal care services; lodging and meals; resident's agreement to make payment; arrangements for payment; grievance procedure and the right to contact the ombudsman; sponsor's covenant to comply with applicable federal and state laws; provisions for terminating the agreement; reasonable rules for staff, management, and resident behavior; a copy of the residents rights; services in the base fee and all other bundled services and those available at additional charge; refund policy; and an explanation of any limitations on the services the residence will provide, specifically including any limitations on services to address specific ADLs and behavioral management. Additionally, it must include the specific unit number in which the resident will reside; a signature of parties, term of agreement; liability (the residence may not require a resident to maintain liability insurance); a right to privacy; and a right to contract with outside providers.

A Disclosure of Rights and Services (disclosure statement) is delivered to prospective residents at the time of or prior to the execution of the residency agreement, or at the time of or prior to the transfer of any money to a sponsor by or on behalf of a prospective resident. The disclosure statement is required to be issued only once, and is delivered as an independent document. Included in the disclosure is the grievance procedure; an explanation of any limitations on services; a description of the role of the nurse; policy concerning self-administration and limited administration of medications; rules of conduct for staff, management and residents; provisions of the resident agreements; and nursing and personal care worker staffing levels by shift.

## **Provisions for Serving People with Dementia**

An ALR must prepare a plan to operate a special care residence. The plan includes a description of the physical design of the structure and the units, physical environment,

specialized safety features, enrichment activities, and trained staff. In addition, entry and exit doors in the common use areas must be secured, staff must be trained; the ALR must have a 24-hour preparedness plan by assessing the needs of each occupant of the Special care residence for emergency assistance, and devise an appropriate method to provide the necessary assistance; and other requirements. Special care residences must also have a planned activity program that includes daily activities, to address resident needs and cover gross motor activities, self-care activities, social activities; and sensory and memory enhancement activities.

Special care residences must have sufficient staff qualified by training and experience awake and on duty at all times to meet the 24-hour per day scheduled and reasonably foreseeable unscheduled needs of all residents. Managers must be at least 21 years of age, must have a minimum of two years experience working with elders or disabled individuals, knowledge of aging and disability issues, demonstrated experience in administration, and demonstrated supervisory and management skills.

*Orientation.* All new employees who work within a Special Care Residence and have direct contact with residents must receive seven hours of additional training on topics related to the specialized care needs of residents (e.g., communication skills, creating a therapeutic environment, dealing with difficult behaviors, competency, sexuality, and family issues).

## **Medication Administration**

When assisting a resident to self-administer medication the individual performing SAMM *must*:

- Remind resident to take medication;
- Check the package to ensure that the name on the package is that of the resident;
- Observe the resident while they take the medication; and
- Document in writing the observation of the resident’s actions regarding the medication.

The individual performing SAMM may open prepackaged medications and/or opened bottles, read the name of the medications and directions to the resident and respond to questions the resident may have concerning the directions on the label. The residence may assist a resident with SAMM from a medication container that has been removed from its original pharmacy-labeled packaging or container by another person, however if this service is performed, full written disclosure of the risks involved and consent by the resident or legal representative shall be provided. SAMM shall only be performed by an individual who has completed personal care service training. Central storage of resident medications (the storage of medication in an area outside of the resident’s unit) is prohibited in an ALR.

LMA is an optional service. ALRs must disclose the availability of this service and the cost in the residency agreement and/or Disclosure of Rights and Services. LMA may only be provided in ALRs by a family member or by a practitioner or a nurse registered or licensed under state law. Nurses may administer non-injectible medications to residents. LMA requires

detailed documentation including the resident’s service plan. All medication must be kept in the resident’s unit.

## Public Financing

Services for eligible low income tenants in residences that contract with Medicaid are subsidized through the GAFC program. GAFC is a service available under the “state plan” rather than a Medicaid waiver. The program serves adults over age 22 who have a physician’s authorization confirming they are at risk of entering an institution. Participants must have at least one ADL impairment. GAFC is available in ALRs and conventional elderly housing.

GAFC provides an average of \$37.75 per day for services and administrative costs. Participants receive assistance with ADLs and IADL; a multidisciplinary care team; access to 24-hour scheduled and unscheduled care; and minimum professional staffing of 3.5 hours per week per resident. The rate assumes participants receive one hour of personal care a day. In addition to GAFC services, participants may also receive up to two days of adult day health services or eight hours of home health aide services with prior approval.

To support low income residents who do not have sufficient income to pay for room and board, the state has created a special SSI living arrangement for ALRs. The SSI payment standard is \$1,077 a month for a single individual. In 2007, the program contracted with 147 GAFC providers and served 5,161 individuals. Of this number, 112 providers were ALRs. The number of participants living in ALRs was not available.

Medicaid Participation					
2007		2004		2002	
Facilities	Participation	Facilities	Participation	Facilities	Participation
112	NR	101	1,120	44	922

## Staffing

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.

## Training

*Administrators.* The manager of an ALR must be at least 21 years old and have demonstrated administrative, supervisory and management experience. The manager must have a Bachelor’s degree or equivalent experience in human services management, housing management, and/or nursing home management. The service coordinator of a residence must have a minimum of two years of experience working with elders or disabled individuals and a Bachelor’s degree or equivalent experience.

*Staff.* Employees receive an initial seven hour orientation and on-going in-service training. The orientation covers:

- Philosophy of independent living in an ALR;
- Resident bill of rights;
- Elder abuse, neglect, and financial exploitation;
- 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;
- Resident health and related problems;
- Job requirements;
- SAMM; and
- Sanitation and food safety.

On-going training. A minimum of ten hours per year of on-going education and training is required for all employees, with at least two hours on the specialized needs of residents with Alzheimer’s disease. Employees working in a Special Care Residence must receive an additional four hours of training per year related to the residents’ specialized needs.

All staff providing assistance with personal care services shall be trained in the residence’s policy on emergency response to acute health issues and first aid, and must also complete at least one hour of on-going education and training per year on the topic of SAMM. All employees and providers shall receive on-going in-service education and on-the-job training aimed at reinforcing the initial from among the following topics:

- Communication and teamwork;
- The aging process, including physical and cognitive changes;
- The causes and prevention of falls, and related injuries;
- The effects of dehydration;
- Alzheimer’s disease and cognitive impairments;
- Behavior management, including prevention of aggressive behavior and de-escalation techniques;
- Conflict resolution;
- Resident rights;
- Defining, recognizing and reporting elder abuse;
- SAMM;
- Death and dying;
- Maintaining skin integrity;
- Nutrition;
- Emergency procedures; and
- Training which addresses topics required in the general orientation.

ALR staff and contracted providers of personal care services 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. The 20 hours of personal care training must be conducted by a qualified RN with a valid Massachusetts license. The 54 hours of training must include, but not be limited to, the following topics:

- Personal hygiene;
- SAMM;
- The effects of dehydration;
- Elimination;
- Maintaining skin integrity;
- 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.

## **Background Check**

Applicants must assure 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 reasons of the individual's relationship to an ALR.

No person working in an ALR may have been convicted of a felony.

## **Monitoring**

The Executive Office of Elder Affairs conducts compliance reviews of ALRs at least every two years. The reviews include inspections of the common areas, living quarters (by consent of the resident), inspection of the service plans, and a review of the resident satisfaction survey. Compliance reviews may be initiated at any time with probable cause.

The following sanctions may be imposed if an ALR is not in compliance with the regulations: ban on new enrollments; reduction in the number of residents served; changing the staffing patterns, levels of qualifications; requiring additional training of the manager or staff; and state may also modify, suspend, revoke or refuse to renew a certification. The type of sanction is based on past non-compliance; risk to resident health, safety and welfare; nature, scope, severity, number and frequency of the instances of non-compliance; failure to correct

violations; on-going patterns of non-compliance; previous enforcement actions and the result of past corrective action plans or order.

## **Fees**

Fees are set by the Secretary of Administration and Finance based on the number of units. The current application fee is \$200. Residences pay a certification of \$125 per unit every two years.

# MICHIGAN

- Citation** Home for the Aged: Michigan Comp. Law §333.20106(3); 333.21301 et seq.;  
Michigan Administrative Rules 325.1901 et seq.  
Adult Foster Care: Michigan Comp. Law 400.701 et seq.  
Adult Foster Care Family Homes: Administrative Rules 400.1401 et seq.  
Adult Foster Care Small Group Homes: Administrative Rules 400.14101 et seq.  
Adult Foster Care Large Group Homes: Administrative Rules 400.15101 et seq.  
Adult Foster Care Congregate Facilities: Administrative Rules 400.2101 et seq.

## General Approach and Recent Developments

The state licenses homes for the aged and AFC. There has been a prohibition of new adult foster congregate homes since the 1980s. There are only 11 congregate AFC facilities remaining licensed for 20+ residents. More than half of the AFCHs in Michigan are licensed for six or fewer beds. New home for the aged rules became effective August 1, 2004. New legislation regarding criminal background checks for home for the aged and AFC direct access staff became effective April 1, 2006.

Medicaid personal care coverage under the state plan is available to beneficiaries in AFC and homes for the aged. Waiver services are available to beneficiaries living in housing that may be operated as an unlicensed facility, that is, a facility or building that does not provide personal care services and therefore is not required to be licensed. Since these unlicensed settings are considered a person's home, services can be received from providers of one's choice.

## Adult Foster Care

AFC varies based on the capacity of the home. AFC family homes "means a private residence with the approved capacity to receive six or fewer adults to be provided with foster care for five or more days a week and for two or more consecutive weeks. The AFC family home licensee shall be a member of the household, and an occupant of the residence." Owners of AFC small and large group homes do not have to reside on site.

Web Address	Content
<a href="http://www.michigan.gov/afchfa">http://www.michigan.gov/afchfa</a>	Rules, lists, forms, surveys
<a href="http://www.legislature.mi.gov/(S(bdqszm451ppjsg55zz33jz55))/mileg.aspx?page=getObject&amp;objectName=mcl-400-726b">http://www.legislature.mi.gov/(S(bdqszm451ppjsg55zz33jz55))/mileg.aspx?page=getObject&amp;objectName=mcl-400-726b</a>	Dementia disclosure (Adult Foster Care)
<a href="http://www.legislature.mi.gov/(S(jcesbg452qetlk55aeyd52ak))/mileg.aspx?page=getObject&amp;objectName=mcl-333-20178">http://www.legislature.mi.gov/(S(jcesbg452qetlk55aeyd52ak))/mileg.aspx?page=getObject&amp;objectName=mcl-333-20178</a>	Dementia disclosure (Homes for Aged)

Category	Supply					
	2007		2004*		2002*	
	Facilities	Units	Facilities	Units	Facilities	Units
Adult foster care -- family homes	1,201	5,663	1,247	5,825	1,266	5,913
Adult foster care -- small group homes	2,809	18,967	2,527	17,610	2,529	17,727
Adult foster care -- large group homes	495	6,414	485	9,001	477	8,839
Adult foster care -- congregate homes	11	398	13	491	13	491
Homes for the aged	190	14,653	190	14,588	191	14,656

\* The figures were revised from the 2004 report.

## Definition

*Home for the Aged* means a supervised personal care facility, other than a hotel, AFC facility, hospital, nursing home, or county medical care facility, that provides room, board, and supervised personal care to 21 or more unrelated, non-transient individuals 60 years of age or older. Home for the aged includes a supervised personal care facility for 20 or fewer individuals 60 years of age or older if the facility is operated in conjunction with and as a distinct part of a licensed nursing home.

*Adult Foster Care.* An AFC facility is a governmental or non-governmental establishment that provides foster care to adults. AFC facilities include AFC family homes, small and large group homes, and congregate homes who serve residents who are aged, mentally ill, developmentally disabled, or physically handicapped and require supervision on an on-going basis but who do not require continuous nursing care. There are four types of adult foster homes: family homes serving six or fewer residents and the licensee resides in the home; small group homes serving between one and 12 residents; large group homes serving between 13 and 20 residents; and congregate homes serving 21 or more residents.

*Specialized Programs* means a program of services or treatment provided in an AFC facility that is designed to meet the unique programmatic needs of the residents of that home or set forth in the assessment plan for each resident and for which the facility receives special compensation. Adult foster homes may apply for a certification for specialized programs for the mentally ill, developmentally disabled, or both populations. This certification is required in order to contract with community mental health agencies. Licensed AFC facilities must meet a higher standard to be certified to provide specialized services.

## Unit Requirements

*Home for the Aged.* A single resident room must be a minimum of 80 square feet of usable space and 100 square feet for new construction. Multiple-bed resident rooms must provide a minimum of 70 square feet per bed of usable floor space and 80 square feet for new construction.

*Adult Foster Care.* A single bedroom must have at least 80 square feet of usable floor space; a multi-bed room must have at least 65 square feet of usable floor space per bed. A maximum of two beds are allowed per bedroom unless the facility has been continuously licensed since 1994 and the residents have agreed to reside in the multi-occupancy room, the

home is in compliance with all state fire safety and environmental standards, and the bedroom provides no less than 70 square feet of usable floor space per bed.

## **Admission/Retention Policy**

*Homes for the aged* may not admit or retain an individual whose needs cannot be adequately met within the scope of the home's program statement. Prior to admission, a written service plan is completed by the home in cooperation with the individual identifying the person's specific needs for care, maintenance, services, and activities. The home may not accept a resident with a mental condition disturbing to other residents or personnel.

A resident who after admission to the home shows serious mental disturbance must be removed from the home. A resident in the home who becomes ill, injured, or disabled following admission, and requires intensive nursing care or nursing care on a 24-hour basis, may not remain in the home unless the resident's family, physician, and the facility consent to the resident's continued stay and agree to cooperate in providing the needed LOC and the necessary services. HFA residents may be transferred or discharged only for medical reasons, for his or her welfare or that of other residents, or for non-payment of his or her stay, except as provided by Title XVIII or Title XIX.

*Adult Foster Care* may not accept, retain, or care for residents who require continuous nursing care. This does not preclude the accommodation of a resident who becomes temporarily ill while in the home but does not require continuous nursing care, or accommodation of a person who is a hospice patient. Prior to admission, the licensee must complete a written assessment of the resident and determine that: the amount of personal care, supervision and protection that is required by the resident is available in the home; the kinds of services, skills, and physical accommodations that the resident requires are available in the home; and the resident appears to be compatible with other residents and members of the household.

## **Nursing Home Admission Policy**

The criteria were revised in 2004. The state has adopted a system that uses seven "doors" to eligibility (see table).

## **Services**

*Homes for the aged* provide supervised personal care. "Supervised personal care," means guidance of or assistance with ADLs provided to the resident by a home or an agent or employee of a home. "Supervision" means guidance of a resident in the ADLs, and includes all of the following: reminding a resident to maintain his or her medication schedule in accordance with the instructions of the resident's licensed health care professional, reminding a resident of important activities to be carried out, assisting a resident in keeping appointments, being aware

of a resident's general whereabouts, even though the resident may travel independently about the community, and supporting a resident's personal and social skills.

A home shall provide a resident with necessary assistance with personal care such as, but not limited to, care of the skin, mouth and teeth, hands and feet, and the shampooing and grooming of the hair. A home shall afford a resident the opportunity and instructions when necessary for daily bathing, oral and personal hygiene, daily shaving, and hand washing before meals. A home shall ensure that a resident bathes at least weekly and more often if necessary.

*Adult Foster Care* includes supervision, protection, personal care, medication administration, social activities, and assistance with ADLs. Homes must arrange for transportation services. "Foster care" means the provision of supervision, personal care, and protection in addition to room and board, for 24-hours-a-day, five or more days a week, and for two or more consecutive weeks for compensation. "Personal care" means personal assistance provided by a licensee or an agent or employee of a licensee to a resident who requires assistance with dressing, personal hygiene, grooming, and maintenance of a medication schedule as directed and supervised by the resident's physician, or the development of those personal and social skills required to live in the least restrictive environment. "Protection" means the continual responsibility of the licensee to take reasonable action to insure the health, safety, and well-being of a resident, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the licensee or an agent or employee of the licensee, or when the resident's assessment plan states that the resident needs continuous supervision. "Supervision" means guidance of a resident in the ADLs, including all of the following: reminding a resident to maintain his or her medication schedule, as directed by the resident's physician, reminding a resident of important activities to be carried out, assisting a resident in keeping appointments, and being aware of a resident's general whereabouts even though the resident may travel independently about the community.

## **Dietary**

*Home for the Aged.* A home shall meet the food and nutritional needs of a resident in accordance with the recommended daily dietary allowances of the Food and Nutrition Board of the National Research Council of the NAS, adjusted for age, gender, and activity, or other national authority acceptable to the department, except as ordered by a licensed health care professional.

A home shall offer three meals daily to be served to a resident at regular meal times. A home shall make snacks and beverages available to residents. A home shall work with residents when feasible to accommodate individual preferences. A home shall assure that the temporary needs for meals delivered to a resident's room are met. Medical nutrition therapy, as prescribed by a licensed health care professional and which may include therapeutic diets or special diets, supplemental nourishments or fluids to meet the resident's nutritional and hydration needs, shall be provided in accordance with the resident's service plan unless waived in writing by a resident

or a resident's authorized representative. A home shall prepare and serve meals in an appetizing manner.

*Adult Foster Care.* Administrators and/or licensees must have competency in nutrition. Homes serving seven or more residents must have a specific staff person who is experienced in food preparation by education or experience. Three nutritious meals must be provided according to the recommended daily allowances contained in the “Basic Nutrition Facts: A Nutrition Reference” published by the Michigan Department of Health. Special diets must be provided and prescribed by a physician.

## **Agreements**

*Home for the Aged.* A home shall have a written resident admission contract, program statement, admission and discharge policy and a resident's service plan for each resident. At the time of an individual's admission, a home shall complete a written resident admission contract between the resident and/or the resident's authorized representative, if any, and the home. The resident admission contract shall, at a minimum, specify all of the following: that the home shall provide room, board, protection, supervision, assistance, and supervised personal care consistent with the resident's service plan; the services to be provided and the fees for the services; the notice to be provided by the home to the resident and/or the resident's authorized representative, if any, upon any change in fees; the transportation services that are provided, if any, and the fees for those services; the home's admission and discharge policy; the home's refund policy; and the resident's rights and responsibilities. If there is a change in a term or condition in the written resident admission contract, then the home or home's designee shall review the change with the resident and the resident's authorized representative, if any.

*Adult Foster Care.* The agreement includes: the assurance of the provision of care, supervision, and protection; description of services provided and the fee; costs in addition to the basic fee; description of the transportation services provided and the fee; agreement by the resident/family to provide necessary intake information; agreement to provide a current health care appraisal; agreement to follow house rules; agreement to respect and safeguard residents' rights and to provide a written copy of discharge policies and procedures, refund policy, statement of how funds and valuables are handled, and a statement that the home is licensed to provide care.

## **Provisions for Serving People with Dementia**

*Home for the Aged and Adult Foster Care* facilities that represent to the public that they provide care and services to persons with Alzheimer's disease or related conditions are required to provide each prospective resident or surrogate decision maker a written description of the services provided by the facility to residents that include, but not limited to, all of the following:

- The overall philosophy and mission reflecting the needs of residents with Alzheimer's disease or related condition.

- The process and criteria for placement in or transfer, or discharge from a program for residents with Alzheimer’s disease or related condition.
- The process used for assessment and establishment of a plan of care and its implementation.
- Staff training and continuing education practices.
- The physical environment and design features appropriate to support the function of residents with Alzheimer’s disease or related condition.
- The frequency and types of activities for residents with Alzheimer’s disease or related conditions.
- Identification of supplemental fees for services provided to patients or residents with Alzheimer’s disease or related conditions.

## **Medication Administration**

*Home for the Aged and Adult Foster Care.* A licensee, with a resident’s cooperation, shall follow the instructions and recommendations of a resident’s physician or other health care professional with regard to medication.

Medication shall be given, taken, or applied pursuant to labeling instructions or signed orders by the prescribing licensed health care professional. The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan. If a home or the home's administrator or direct care staff member supervises the taking of medication by a resident, then staff shall be trained in the proper handling and administration of medication, complete an individual medication log containing each medication’s dosage, label instructions, time to be administered, initials of the person who administered the medication, and a resident's refusal to accept prescribed medication or procedures. For each medication prescribed on an as needed basis initiate a review process to evaluate a resident's condition if a resident requires the repeated and prolonged use of a medication that is prescribed on an as needed basis. Staff is not to adjust or modify a resident's prescription medication without written instructions from the prescribing licensed health care professional. Staff shall record, in writing, any instructions regarding a resident's prescription medication, and follow the instructions given. Upon discovery, contact the resident's licensed health care professional if a medication error occurs. If a resident requires medication while out of the home, then the staff shall assure the resident, or the person who assumes responsibility for the resident, has all of the appropriate information, medication, and instructions. A home shall take reasonable precautions to assure prescription medication is not used by a person other than the resident for whom the medication is prescribed. Prescription medication that is no longer required by a resident shall be properly disposed.

## Public Financing

Medicaid personal care coverage has been available since 1983 through the state plan. Personal care services are provided to approximately 10,300 residents living in homes for the aged and AFC. The current rate is \$184.38 a month. AFC residents receive \$780.50 from SSI and the state supplement that includes a \$44 PNA. Homes for the aged residents receive \$802.30 from SSI and the state supplement, including a \$44 a month PNA.

Eligible beneficiaries may receive Medicaid waiver services in unlicensed ALFs and elderly housing buildings. Participation data is not tracked separately for persons in unlicensed facilities. Waiver coverage in licensed settings is under consideration.

In 2006, the legislature passed Public Act 345 which clarifies state policy on supplementation. The act states that “AFC facilities providing domiciliary care or personal care to residents receiving SSI or homes for the aged serving residents receiving SSI shall not require those residents to reimburse the home or facility for care for rates in excess of those legislatively authorized. To the extent permitted by federal law, AFC facilities and homes for the aged serving residents receiving SSI shall not be prohibited from accepting third-party payments in addition to SSI provided that the payments are not for food, clothing, shelter, or result in a reduction in the recipient’s SSI payment.”

Medicaid Participation					
2007		2004		2002	
Facilities	Participation	Facilities	Participation	Facilities	Participation
NA	10,300	NA	14,138	NA	13,000

## Staffing

*Home for the Aged.* The home shall have a competent administrator who is responsible for operating the home in accordance with the established policies of the home. The home shall designate one person on each shift to be supervisor of resident care during that shift. The supervisor of resident care shall be fully dressed, awake, and on the premises when on duty. The supervisor of resident care on each shift shall do all of the following: assure that residents are treated with kindness and respect, protect residents from accidents and injuries, and be responsible for safety of residents in case of emergency. The home shall have adequate and sufficient staff on duty at all times who are trained and capable of providing for resident needs consistent with the resident service plans.

In addition the fire safety rules for existing homes for the aged require staffing as follows: 19-100 residents requires two attendants; 101-180 residents requires three attendants; 181-260 requires four attendants; each additional 80 residents requires one additional attendant.

*Adult Foster Care.* The ratio of direct care staff to residents shall be adequate as determined by the department to carry out the responsibilities defined in the act and administrative rules but not less than one staff to 15 residents during waking hours, and one staff

to 20 residents during normal sleeping hours for facilities licensed for 13-20 residents, and no less than one staff per 12 residents for facilities licensed for 1-12 residents. In all facilities there must be sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's care agreement and assessment plan.

## **Training**

*Home for the Aged.* The owner, operator, and governing body of a home shall appoint a competent administrator who is responsible for operating the home in accordance with the established policies of the home. An administrator shall be at least 18 years old and have education, training, and/or experience related to the population served by the home and be capable of assuring program planning, development, and implementation of services to residents consistent with the home's program statement and in accordance with the residents' service plan and agreements.

*Adult Foster Care* administrators must have at least one year of experience working with persons who are mentally ill, developmentally disabled, physically handicapped, or aged. Both the licensee of the home and the administrator must complete either 16 hours of training approved by the Michigan Department of Human Services or six credit hours at an accredited college or university in an area approved by the Michigan Department of Human Services.

A licensee and administrator must be trained and competent in the proper handling and administration of medication, nutrition, first aid, CPR, safety and fire prevention, financial and administration management, knowledge of the needs of the population served, resident rights, prevention and containment of communicable disease, and the Adult Foster Care Licensing Act and Administrative Rules.

A licensee or administrator shall provide in-service training or make training available to direct care staff and assure their competency before performing assigned tasks.

### Staff Training

*Homes for the Aged.* The home shall establish and implement a staff training program based on the home's program statement, the residents service plans, and the needs of employees including reporting requirements and documentation, first aid, personal care, resident rights and responsibilities, safety and fire prevention, containment of infectious disease and standard precautions, and medication administration, if applicable. The home's administrator or its designees are responsible for evaluating employee competencies.

*Adult Foster Care.* Direct care staff shall be able to complete required reports and follow written and oral instructions that are related to the care and supervision of residents suitable to meet the physical, emotional, intellectual, and social needs of each resident, and capable of appropriately handling emergency situations. Direct care staff must receive in-service training and be competent before performing assigned tasks in all of the following areas: reporting

requirements, first aid, CPR, personal care, supervision and protection, resident rights, safety and fire prevention, and prevention and containment of communicable diseases. Direct care staff must be trained in the proper handling and administration of medication before supervising the taking of medication by a resident.

AFCHs certified to provide a specialized program for either developmentally disabled or mental ill individuals must meet additional training requirements. All staff who work independently or staff who function as lead workers must have successfully completed a course of training which imparts basic concepts required in providing specialized dependent care and which measures staff comprehension and competencies to deliver each client's individual plan of service as written. Basic training must cover all of the following areas: an introduction to community residential services and the role of direct care staff, and an introduction to the special needs of clients who have developmental disabilities or have been diagnosed as having a mental illness. Training shall be specific to the needs of residents served by the home and basic interventions for maintaining and caring for a resident's health, for example, personal hygiene, infection control, food preparation, nutrition and special diets, and recognizing signs of illness. Additional training is also needed for the prevention of, preparing for, and responding to, environmental emergencies, for example, power failures, fires, and tornados, and non-aversive techniques for the prevention and treatment of challenging behavior of residents. Training shall be obtained from individuals or training organizations that use a curriculum that has been reviewed and approved by the department.

## **Background Check**

As of April 1, 2006, a home for the aged or an AFCH shall not employ, independently contract with, (or grant clinical privileges -- Homes for the Aged only) to an individual who regularly has direct access or provides direct services to residents if the prospective employee has been convicted of a felony or misdemeanor, unless a certain period of time has elapsed since the conviction (in case of a felony all terms of either parole or probation must also have been satisfied). The criminal background check includes both a state, as well as a FBI fingerprint check.

Small and large AFC group homes must also submit the name of any employee or volunteer who is on a court-supervised probation or parole or who has been convicted of a felony. All AFC license applicants, licensee designees, administrators and household members must also have their criminal records evaluated by the department to determine good moral character.

## **Monitoring**

AFCHs are inspected by the Department of Human Services, Department of Labor and Economic Growth for fire safety inspections, and local health authorities. Homes for the aged are inspected annually by the Department of Human Services and the Department of Labor and Economic Growth for fire safety.

The Department of Human Services minimally inspects AFCHs every two years. All facilities licensed for 7+ residents also have annual fire safety inspections.

## Fees

Licensing Fees		
Type	Original	Renewal
Adult foster care home (1-6)	\$65	\$25
Adult foster care small group (1-6)	\$105	\$25
Adult foster care small group (7-12)	\$135	\$60
Adult foster care large group (13-20)	\$170	\$100
Adult foster care congregate (21+)	\$220	\$150
Home for the aged (21+)	\$3.135*	\$6.27**
* Per bed.		
** Per bed per year.		

Michigan Level-of-Care Criteria		
Door	Areas Scored	Threshold
1: ADLs	(A) Bed mobility, transfers, toilet use; and (B) eating.	Score of 6: (A) independent or supervision, 1; limited assistance, 3; extensive or total, 4; did not occur, 8. (B) independent/supervision, 1; limited assistance, 2; extensive or total, 3; did not occur, 8.
2: Cognitive performance	Short-term memory, cognitive skills for daily decision making, communication.	Must have severely impaired decision making, memory problems and moderate or severely impaired decision making, or memory problem and sometimes or rarely understood.
3: Physician involvement	Under care for an unstable medical condition.	Based on frequency of physician visits and orders.
4: Treatments and conditions	Stage III or IV pressure sores; IV or parenteral feedings; IV medications; end-stage care; daily trach care, respiratory care, or suctioning; pneumonia; daily oxygen therapy; daily insulin with 2 order changes in past 14 days; peritoneal or hemodialysis.	At least 1 of 9 conditions.
5: Skilled rehabilitation therapies	Speech, occupational, or physical therapy.	Requires at least 45 minutes of active therapy in last 7 days and continues to require therapy.
6: Behavior	Wandering, physical/verbal abuse, socially inappropriate/disruptive, resists care, delusions/hallucinations.	Either has delusions/hallucinations or exhibits other behaviors at least 4 of last 7 days.
7: Service dependency	Currently receiving services in a nursing facility or waiver program.	Must be a participant for 1 year.

# MINNESOTA

**Citation**      Housing with services establishments (registration): MS §144D.01 et seq.  
 Home care licensure: MS §144A.43 to 144A.48.  
 Assisted living title protection: MS §144G. 01 et. seq. Minnesota rule, Chapter 4468 et seq. and Chapter 4669

## General Approach and Recent Developments

The state registers housing with services establishments and licenses the service provider. Chapter 282, article 19 of the Acts of 2006 made changes in the licensing of service agencies. Health care services in housing with services establishments must be provided by a Class A professional home care agency or a Class F home care agency (previously called an assisted living home care provider). The law requires that only establishments that comply with MS 144 G may use the term assisted living. A template was developed to allow consumers to compare providers. Chapter 37 of the Acts of 2003 established training requirements for assisted living home care providers and housing with services establishments that serve people with Alzheimer’s disease or related disorders.

## Adult Foster Care

Adult foster homes are licensed by the Department of Human Services as a residence operated by an operator who, for financial gain or otherwise, provides 24-hour foster care to no more than four functionally impaired residents and a residence with five or six residents. Rules are available at:

[http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id\\_028245](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_028245).

Web Address	Content
<a href="http://www.revisor.leg.state.mn.us/arule/4668/">http://www.revisor.leg.state.mn.us/arule/4668/</a>	Rules
<a href="http://www.health.state.mn.us/divs/fpc/profinfo/cms/als/UCIG_july2007.doc">http://www.health.state.mn.us/divs/fpc/profinfo/cms/als/UCIG_july2007.doc</a>	Guide
<a href="http://www.health.state.mn.us/divs/fpc/profinfo/cms/alhcp/alhcpsurvey.htm">http://www.health.state.mn.us/divs/fpc/profinfo/cms/alhcp/alhcpsurvey.htm</a>	Provider, FAQs
<a href="http://www.health.state.mn.us/divs/fpc/ohfcinfo/filecomp.htm">http://www.health.state.mn.us/divs/fpc/ohfcinfo/filecomp.htm</a>	Complaints
<a href="http://www.health.state.mn.us/divs/fpc/consumerinfo/MNHCBORAL_eng_lg.pdf">http://www.health.state.mn.us/divs/fpc/consumerinfo/MNHCBORAL_eng_lg.pdf</a>	Bill of rights
<a href="http://www.health.state.mn.us/divs/fpc/profinfo/cms/alhcp/alhcpsurveyresults.htm">http://www.health.state.mn.us/divs/fpc/profinfo/cms/alhcp/alhcpsurveyresults.htm</a>	Class F service provider survey results
<a href="http://www.health.state.mn.us/divs/fpc/profinfo/cms/als/alsreviewresults.html">http://www.health.state.mn.us/divs/fpc/profinfo/cms/als/alsreviewresults.html</a>	Housing establishment survey results
<a href="http://www.health.state.mn.us/divs/fpc/profinfo/cms/hcacla/hcacla_index.html">http://www.health.state.mn.us/divs/fpc/profinfo/cms/hcacla/hcacla_index.html</a>	Class A service providers
<a href="http://www.health.state.mn.us/divs/fpc/profinfo/cms/als/alsindex.html">http://www.health.state.mn.us/divs/fpc/profinfo/cms/als/alsindex.html</a>	Assisted living requirements

Category	Supply					
	2007		2004		2002	
	Facilities	Units	Facilities	Units	Facilities	Units
Housing with services establishments	1,239*	NA	931	NA	600	NA
* NOTE: 859 housing with services establishments indicated that they will be the term assisted living and comply with MS 144G. The remaining establishments serve non-elderly populations and do not plan to use the term assisted living.						

## **Definition**

A *housing with services* establishment means an establishment providing sleeping accommodations to one or more adult residents, at least 80% of which are 55 years of age or older, and offering or providing for a fee one or more regularly scheduled health-related services and two or more regularly scheduled supportive services, whether offered or provided directly by another entity arranged for by the establishment.

MS 144G defines assisted living as 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 this chapter.

The state’s Medicaid waiver program defines *assisted living services* as a group of services provided by or arranged for by the management of a Housing with Services Establishment or a residential center, or contracted for by the county with a Class A home care agency. Services provided or arranged for by the assisted living provider may include supervision, supportive services, individualized home care aide tasks, individualized home health aide-like tasks, and individualized home management tasks. Assisted living plus services are assisted living services with additional requirements. Assisted living plus services providers must provide 24-hour supervision and must be registered with the Department of Health as Housing with Services Establishments.

## **Unit Requirements**

*Housing with services.* No requirements stated. Buildings must meet the appropriate building and fire codes for the structure.

## **Admission/Retention Policy**

*Housing with services.* The statute requires written contracts between facilities and tenants that describe the registration status; terms; a description of services to be provided directly or through other arrangements; fee schedules; a description of the process through which the contract may be modified, amended, or terminated; complaint procedures; retention policies; and other items.

*Medicaid waiver and state program.* Participants for the Alternative Care (AC) and Medicaid waiver programs must be screened by the county pre-admission screening team and must meet the nursing home LOC criteria. The AC program, funded solely with state revenues, was implemented in 1991 and supports certain home and community services for persons age 65 and over, who are at risk of nursing home placement, have low levels of income and assets, but do not meet Medicaid financial criteria.

## **Nursing Home Admission Policy**

Professional judgment based on the assessment.

### **Services**

MS 144G requires the following services at a minimum: health-related services that include assistance with self-administration of medication or medication administration and assistance with at least three of the following seven ADLs: bathing, dressing, grooming, eating, transferring, continence care, and toileting; provides necessary assessments of the physical and cognitive needs of assisted living clients by a RN; has and maintains a system for delegation of health care activities to unlicensed assistive health care personnel by a RN, including supervision and evaluation of the delegated activities; provides staff access to an on-call RN 24 hours per day, seven days per week; has and maintains a system to check on each assisted living client at least daily; provides a means for assisted living clients to request assistance for health and safety needs 24 hours per day, seven days per week, from the establishment or a person or entity with which the establishment has made arrangements; has a person or persons available 24 hours per day, seven days per week, who is responsible for responding to the requests of assisted living clients for assistance with health or safety needs, who shall be: awake; 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; capable of communicating with assisted living clients; capable of recognizing the need for assistance; capable of providing either the assistance required or summoning the appropriate assistance; and capable of following directions; and offers to provide or make available at least the following supportive services to assisted living clients -- two meals per day; weekly housekeeping; weekly laundry service; upon the request of the client, reasonable assistance with arranging for transportation to medical and social services appointments, and the name of or other identifying information about the person or persons responsible for providing this assistance; upon the request of the client, reasonable assistance with accessing community resources and social services available in the community, and the name of or other identifying information about the person or persons responsible for providing this assistance; and periodic opportunities for socialization.

Establishments must offer to arrange a nursing assessment by a RN of the physical and cognitive needs of a prospective resident before a contract is signed.

Assisted living plus is a group of Medicaid services, one of which must be 24-hour supervision, delivered in three settings: one to five unrelated people in a residential unit; five or more unrelated people in a setting which is licensed as a board and lodge; or a residential center which is a building or complex of adjacent buildings with separate living units which clients rent or own. Providers must be registered as a housing with services establishment and licensed as a Class A home care agency or a Class F home care provider. Assisted living can be delivered in the same settings but does not include 24-hour supervision.

[NOTE: An amendment to the Housing with Services Act allows residential care settings that do not have at least 80% elderly persons to voluntarily register as Housing with Services Establishments, thus enabling their residents to be served with the Assisted Living Plus package.]

Under the Elderly Waiver program (and the AC program), residents may also receive home health and skilled nursing services, which are reimbursed separately from the payment for assisted living services. However, individuals receiving assisted living services may not receive homemaking and personal care services, as well as assisted living services.

## **Dietary**

Not specified.

## **Agreements**

The registration statute requires contracts between the housing operator and tenants that include: name and address of the establishment and owners; a statement describing the registration and licensure status of the establishment; term of the contract; description of the services provided and the base rate; fee schedules for any additional services; process for modifying, amending, or terminating the contract; complaint process; billing and payment procedures; resident's designated representative; criteria for determining who may reside in the establishment; statement regarding the ability of tenants to receive services from providers that do not have an arrangement with the establishment; and a statement regarding the availability of public funds.

Home care regulations cover the service agreement which includes a description of the service 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.

MS §144A.441 added the right to reasonable notice of changes in services or charges and at least a 30 day notice of termination of services to the resident's bill of rights.

## **Provisions for Serving People with Dementia**

Housing with Services Establishments are required to disclose the form of care or treatment, the treatment philosophy, unique features for screening, admission and discharge, assessment, care planning and implementation, staffing patterns, the physical environment, security features, frequency and type of activities, opportunities for family involvement, and the costs of care. Direct care staff must receive four hours of training within the first month of employment and four hours a year. The statute specifies that training is required in the following areas: an explanation of Alzheimer's disease and related disorders; assistance with ADLs;

problem solving with challenging behaviors; and communication skills. The licensee shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered.

## Medication Administration

The assisted living home care provider rules allow medication administration. Staff administering medications must be instructed by a RN, the instructions must be written, and the person must demonstrate competence in following the instructions.

## Public Financing

Services for low income residents have been covered through the Medicaid HCBS waiver program since 1993. Rates for services are negotiated between the county and the provider with limits based on the client’s case-mix classification. Coverage through the state-funded Alternate Care Program was dropped in September 2005. The HCBS waiver program served 3,486 beneficiaries in 588 facilities in FY 2007.

Coverage of services in residential settings was changed July 1, 2007 based on legislation passed in 2006 and 2007. Services in residential settings are now called “customized living services” and “24-hour customized living services.” Rates are negotiated within caps based on the case-mix classification system (see table) and are based on the service to be delivered rather than a base rate. Customized living service is a package of component services individually designed to meet the assessed needs of a waiver participant living in a qualified setting.<sup>3</sup> The components can include home management tasks, supportive services, home care aide tasks, home health aide-like tasks, central storage of medications, incidental nursing services and supervision.

	Participation					
	2007		2004 (FY 03)		2002 (FY 01)	
	Facilities	Participation	Facilities	Participation	Facilities	Participation
Home and community-based services	588	3,486	396	4,114	281	2,895
Alternative care	NA	NA	325	2,328	247	1,588

<sup>3</sup> Bulletin #07-25-01. Comprehensive Policy on Elderly Waiver customized (formerly Assisted) Living. Available at [http://www.dhs.state.mn.us/main/groups/publications/documents/pub/dhs16\\_138636.pdf](http://www.dhs.state.mn.us/main/groups/publications/documents/pub/dhs16_138636.pdf).

Minnesota Case-Mix Categories and Maximum Statewide Rate Limits for Assisted Living and All Other Waiver Services -- Effective July 1, 2006-September 30, 2007			
Case-mix	Average Assisted Living Payment <sup>a</sup>	Total Rate Limits for All Services <sup>b</sup>	Description
A	\$1,086	\$2,170	Up to 3 ADL dependencies <sup>c</sup>
B	\$1,234	\$2,470	3 ADLs + behavior
C	\$1,448	\$2,897	3 ADLs + special nursing care
D	\$1,589	\$2,993	4-6 ADLs
E	\$1,650	\$3,301	4-6 ADLs + behavior
F	\$1,700	\$3,401	4-6 ADLs + special nursing care
G	\$1,755	\$3,510	7-8 ADLs
H	\$1,979	\$3,960	7-8 ADLs + behavior
I	\$1,041	\$4,064	7-8 ADLs + needs total or partial help eating (observation for choking, tube, or IV feeding and inappropriate behavior)
J	\$2,164	\$4,332	7-8 ADLs + total help eating (as above) or severe neuromuscular diagnosis or behavior problems
K	\$2,524	\$5,049	7-8 ADLs + special nursing
<p>a. Statewide average customized living monthly payment by case-mix classification.</p> <p>b. Rate limits must include customized living services, which the residence is responsible for providing or arranging and all other waiver services provided to the client.</p> <p>c. ADLs include bathing, dressing, grooming, eating, bed mobility, transferring, walking, and toileting.</p>			

The SIS or 300% eligibility option, for all Elderly Waiver recipients during state FY 2007, is \$1,869. The maintenance allowance that residents retain for their expenses is \$816 which includes an \$82 PNA (equal to the PNA for nursing facility residents), and the remaining \$737 pays for room and board costs. Any income above the \$816 maintenance allowance is applied toward the cost of waiver services. Elderly Waiver participants who have a gross monthly income which exceeds 300% of SSI may not use the SIS when determining their Medicaid budget but must pay a medical spend-down (all monthly income greater than the state's Medically Needy standard for aged, blind and disabled 75% of the federal poverty level, or \$613) toward all incurred medical expenses.

## Staffing

The Department of Health's standards for home care services licenses do not apply to the building itself. Housing with services providers may not accept anyone for whom services cannot be provided and must provide adequate staff to meet the needs of clients/residents.

## Training

*Staff.* Orientation and training are required based on the tasks performed by the worker.

Training requirements are specified for staff performing home care aide tasks, home management tasks, and delegated nursing tasks. Each person who applies for a license and/or provides direct care, supervision of direct care, or manages services for a licensee must receive an orientation to home care requirements covering: the general approach of the statute and regulations, handling of emergencies, reporting abuse/neglect, home care bill of rights, handling and reporting of complaints, and services of the ombudsman.

Training and a competency evaluation are required for unlicensed people who perform assisted living home care tasks. The curriculum includes: a general overview of the Minnesota

statutes; recognition and handling of emergencies and use of emergency services; reporting the maltreatment of vulnerable adults; home care bill of rights; handling of complaints; services of the ombudsman; observation, reporting, and documentation of client status and of the care or services provided; basic infection control; maintenance of a clean, safe, and healthy environment; communication skills; basic elements of body functioning and changes in body function that must be reported to an appropriate health care professional; and the physical, emotional, and developmental needs of clients.

Staff who provide medication administration and active assistance with medications must complete the above training program, pass a competency test, and be instructed by a RN in the procedures to administer the medications to each client/resident. The instruction is specific to each resident.

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.

## **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 clients 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.

## **Monitoring**

Class F home care providers are surveyed before a license is approved or renewed. A licensee that has been licensed for at least two consecutive years and that has been in substantial compliance with this chapter and Minnesota Statutes, Sections 144A.43 to 144A.47, and has had no serious violations in that period, may be surveyed every second license term rather than during each license term.

## **Fees**

Housing with services establishment registration fees were increased to \$155 effective July 1, 2007. Chapter 282 requires a surcharge based on the capacity of the establishment to be determined by the Department of Health to pay for the costs of bringing actions for injunctive relief. Class F home care service agencies pay a graduated fee based on average census:

- \$125 annually for those providers serving a monthly average of 15 or fewer clients, and for assisted living providers of all sizes during the first year of operation;

- \$200 annually for those providers serving a monthly average of 16-30 clients;
- \$375 annually for those providers serving a monthly average of 31-50 clients; and
- \$625 annually for those providers serving a monthly average of 51 or more clients.

# MISSISSIPPI

- Citation**      Personal care homes -- assisted living: Mississippi regulations Part I §101.1 et seq.  
                      Personal care homes -- residential living: Mississippi regulations Part I §101.1 et seq.  
                      Personal care homes -- Alzheimer’s Disease/Dementia care unit: Part I §101.1 et seq.

## General Approach and Recent Developments

Revisions to the rules were adopted in 2005 and 2007. Regulations covering Alzheimer’s disease units were adopted July 2001. The rules create two types of PCHs: assisted living and residential living. Homes licensed after August 13, 2005 must have a sprinkler system. A Medicaid waiver has been implemented.

## Adult Foster Care

HB 2416, enacted in 2007, defines an AFC facility as a home setting for vulnerable adults in the community who are unable to live independently due to physical, emotional, developmental or mental impairments, or in need of emergency and continuing protective social services for purposes of preventing further abuse or neglect and for safeguarding and enhancing the welfare of the abused or neglected vulnerable adult. AFC programs shall be designed to meet the needs of vulnerable adults with impairments through individual plans of care, which provide a variety of health, social and related support services in a protective setting, enabling participants to live in the community. AFC programs may be traditional, where the foster care provider lives in the residence and is the primary caregiver to clients in the home; corporate, where the foster care home is operated by a corporation with shift staff delivery services to clients; or shelter, where the foster care home accepts clients on an emergency short-term basis for up to 30 days. The Department of Health issued regulations in October 2007 to implement the law. The rules are available at:

<http://www.msdh.state.ms.us/msdhsite/ static/resources/2347.pdf>.

Web Address	Content
<a href="http://www.msdh.state.ms.us/msdhsite/ static/30,0.83.60.html">http://www.msdh.state.ms.us/msdhsite/ static/30,0.83.60.html</a>	Rules

Category	Supply					
	2007		2004		2002	
	Facilities	Units	Facilities	Units	Facilities	Units
Personal care homes	185	5,133	194*	4,197*	207	5,137
* July 2003.						

## **Definition**

*Assisted living* means the provision of personal care and the addition of supplemental services to include, but not be limited to, the provision of medical services (i.e., medication procedures and medication administration) and emergency response services.

*Facility* means any home or institution that: (1) has sought or is currently seeking designation as a licensed facility under the terms of these regulations; or (2) is operating a home or institution unlawfully which, by its nature and operational intent, is required to be a licensed facility under the terms of these regulations.”

*Personal care home -- residential living.* The terms “personal care home -- residential” and “residential personal care home” are defined as any place or facility operating 24-hours-a-day, seven 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 ADLs. Regulations by the licensing agency for such facilities are governed by the “Regulations Governing Licensure of Personal Care Homes -- Residential.”

*Personal care home -- assisted living.* The terms “personal care home -- assisted living” and “assisted living personal care home” are defined as any place or facility operating 24-hours-a-day, seven days a week, accepting individuals who require assisted living services as governed by the state’s regulations.

## **Unit Requirements**

There must be at least 80 square feet for each resident in a bedroom. Residents shall not have to enter one bedroom through another bedroom. No more than four residents may share a bedroom. Separate toilet and bathing facilities shall be provided on each floor for each sex: one bathtub/shower for every 12 residents, and one lavatory and toilet for every six residents.

## **Admission/Retention Policy**

Personal care residential living homes may not admit non-ambulatory residents, or anyone that requires physical restraints; poses a serious threat; requires nasopharyngeal and/tracheotomy suctioning; gastric feedings; IV fluids, medications or feedings; indwelling catheter; sterile wound care or treatment of decubitous ulcers or exfoliative dermatitis.

Personal care assisted living homes may admit residents whose needs can be met by the licensed facility. An appropriate resident for assisted living PCHs is primarily an aged ambulatory person who requires domiciliary care and who may require non-medical services, medical services such as medication assistance, emergency response services, and home health services as prescribed by a physician’s order and as allowed by law. Residents who are unable to descend stairs unassisted may not be placed above the ground floor.

Tenants cannot be admitted or retained if they: require physical restraints; pose a serious threat to themselves or others; or require nasopharyngeal and/or tracheotomy suctioning; gastric feedings; IV fluids, medications, or feedings; an indwelling urinary catheter; sterile wound care; or treatment of decubitus ulcers or exfoliative dermatitis.

Aging-in-place legislation passed in 2001 that allows residents who need skilled services to continue to reside in the facility, if approved in writing by a licensed physician. No more than two residents, or 10% of residents in the facility, whichever is greater, may receive skilled services.

## **Nursing Home Admission Policy**

Beneficiaries qualify for the waiver if they need assistance in three ADLs (i.e., eating, toileting, bathing, personal hygiene, ambulation, transferring, and/or dressing) or two ADLs plus a diagnosis of dementia. The assessment form is completed by a physician.

## **Services**

*Assisted living* means the provision of personal care and the addition of supplemental services to include but not be limited to, the provision of medical services (i.e., medication procedures and medication administration) and emergency response. Social services and daily activities are also required.

## **Dietary**

Facilities must provide three well-planned, attractive, and satisfying meals a day 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 at least once every 30 days and files a consulting report. All facilities must have an employee dedicated to meal preparation and food service.

## **Agreements**

The agreement must be signed prior to or on admission and must contain: basic charges agreed upon (i.e., room, board, laundry, and personal care); the period covered by the charges; services for which special charges are made; agreement regarding 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 which require transfer and discharge; or operators who have been designated as a resident's responsible party shall ensure prompt and efficient action to meet resident's needs.

In addition, facilities must give written notice when basic charges or facility policies change.

## **Provisions for Serving People with Dementia**

Rules were adopted in 2001 that define Alzheimer's disease as a "chronic progressive disease of unknown causes that attacks brains cells or tissues."

The rules require three hours of nursing care per resident per day and require an RN or LPN on all shifts. Two staff must be available at all times. Staff orientation must cover the facility's philosophy of dementia care; a description of the dementias; policies and procedures; and common behaviors and recommended behavior management. In-service training must be provided quarterly on a variety of dementia-related topics, including the development of comprehensive and individual care plans, which must be appropriate and meaningful to each resident and be based on cultural and lifestyle differences. Topics are detailed in the training section.

A complete health assessment and an assessment by a licensed practitioner, whose practice includes assessment of cognitive, functional, and social abilities, must be carried out.

Therapeutic activities must be provided seven days a week by a certified therapeutic recreation specialist. Activities include leisure, self-care, and productive activities in the following areas: structured large and small groups; spontaneous intervention; domestic tasks; life skills; work; relationships/social; leisure; seasonal; holidays; personal care; meal time; and intellectual, spiritual, creative and physically active pursuits.

Physical environments rules require visual contrast between tables and dining utensils. Rooms can be individually identified to assist with recognition. Facilities must have policies and procedures to deal with residents who may attempt to wander outside the facility.

## **Medication Administration**

Licensed staff may administer medications in assisted living settings. When the nurse is not on-duty, staff may use medication day planners and may pass medications to residents. In residential settings, since a nurse is not required, trained staff may assist with self-administration. Staff may determine which medication is to be taken, the dosage, or the time at which the medication is to be taken.

## **Public Financing**

A Medicaid waiver was implemented as a pilot program in seven counties in 2001 to serve older adults, people with disabilities, and people with dementia. Services included in the payment are personal care; homemaker services; chore services; attendant care services;

medication oversight; therapeutic, social and recreational programs; intermittent skilled nursing services; transportation and attendant call systems. In 2006, coverage was expanded statewide. Fourteen facilities contract with the Medicaid program and serve 200 residents. Facilities receive a per diem rate of \$33.18. The rate was developed based on case-mix adjusted rates paid to nursing homes for less impaired residents (PA1 and PA2). Average rates were computed for four nursing home rate components: direct standard care, care related rate, administrative costs, and operating costs. The payment rate consists of 40% of the direct care standard, 10% of the care related rate, and 50% of the administrative and operating rates. The remaining nursing home costs were considered to apply to room and board costs which are not covered by the Medicaid service rate.

Medicaid Participation					
2007		2004		2002	
Facilities	Participation	Facilities	Participation	Facilities	Participation
14	200	6	68	1	15

## Staffing

Personal care assisted living homes must have one attendant per 15 or fewer residents from 7 a.m. to 7 p.m. and one attendant per 25 residents from 7 p.m. to 7 a.m. A licensed nurse must be on the premises eight hours a day.

Personal care residential living homes are not required to have a licensed nurse on staff.

## Training

*Administrator.* Must be full-time and at least 21 years old and have a high school diploma or GED and must not be listed on the nurses aide abuse register.

*Staff.* Personnel shall receive on a quarterly basis appropriate training on the topics and issues related to the population being served. The training must be documented by a narrative of the content and the signatures of those attending.

An orientation for staff in dementia care facilities must be provided that covers the facility's philosophy, a description of the disease, the facility's policies and procedures regarding the general approach to care including therapies provided; treatment modalities; admission, discharge and transfer criteria; basic services provided; policies regarding restraints, wandering, and egress control; medication management; nutrition management techniques; staff training; family activities; and common behavior problems and recommended behavior management.

Quarterly in-service training must be provided that covers 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.

## **Background Check**

The administrator and all direct care staff must document that they are not listed on the Nurses Aide Abuse Registry. Effective October 2003, a criminal background check must be completed for all new employees who provide direct patient care or services and employees employed prior to July 2003 who have documented disciplinary action by the present employer. The regulations list 14 offenses for which a person may not be employed.

## **Monitoring**

Facilities are inspected by the Mississippi Department of Health at such intervals as the Department may direct. Operators are required to spend two concurrent days with the licensing agency for training and mentoring within six months of employment. The operator may be assigned within central offices or with a survey team. Surveyors who have passed the Surveyor Minimum Qualifications Test are also required to spend two concurrent days with a licensed facility for training and mentoring within six months of employment.

## **Fees**

The initial application fee is \$100 and \$15 per bed. Renewal fees are \$15 per bed. A fee is charged for modifications, renovations, expansions, conversions, or replacements at the rate of \$50 per hour for review and/or inspection, not to exceed \$5,000.

# **RESIDENTIAL CARE AND ASSISTED LIVING COMPENDIUM: 2007**

**The remainder of Section 3 (State Summaries)  
-- states Missouri through Wyoming --  
is available at:**

<http://aspe.hhs.gov/daltcp/reports/2007/07alcom3b.pdf>

---

## **Other Files Available for This Report**

MAIN REPORT (*including Acknowledgements, Acronyms and SECTION 1. Overview of Residential Care and Assisted Living Policy*)

HTML: <http://aspe.hhs.gov/daltcp/reports/2007/07alcom.htm>  
PDF: <http://aspe.hhs.gov/daltcp/reports/2007/07alcom.pdf>

SECTION 2. Comparison of State Policies

HTML: <http://aspe.hhs.gov/daltcp/reports/2007/07alcom2.htm>  
PDF: <http://aspe.hhs.gov/daltcp/reports/2007/07alcom2.pdf>

SECTION 3. State Summaries

HTML: <http://aspe.hhs.gov/daltcp/reports/2007/07alcom3.htm>  
PDF: <http://aspe.hhs.gov/daltcp/reports/2007/07alcom3.pdf>

Each state's summary can also be viewed separately at:

Alabama <http://aspe.hhs.gov/daltcp/reports/2007/07alcomAL.pdf>  
Alaska <http://aspe.hhs.gov/daltcp/reports/2007/07alcomAK.pdf>  
Arizona <http://aspe.hhs.gov/daltcp/reports/2007/07alcomAZ.pdf>  
Arkansas <http://aspe.hhs.gov/daltcp/reports/2007/07alcomAR.pdf>

California	<a href="http://aspe.hhs.gov/daltcp/reports/2007/07alcomCA.pdf">http://aspe.hhs.gov/daltcp/reports/2007/07alcomCA.pdf</a>
Colorado	<a href="http://aspe.hhs.gov/daltcp/reports/2007/07alcomCO.pdf">http://aspe.hhs.gov/daltcp/reports/2007/07alcomCO.pdf</a>
Connecticut	<a href="http://aspe.hhs.gov/daltcp/reports/2007/07alcomCT.pdf">http://aspe.hhs.gov/daltcp/reports/2007/07alcomCT.pdf</a>
Delaware	<a href="http://aspe.hhs.gov/daltcp/reports/2007/07alcomDE.pdf">http://aspe.hhs.gov/daltcp/reports/2007/07alcomDE.pdf</a>
District of Columbia	<a href="http://aspe.hhs.gov/daltcp/reports/2007/07alcomDC.pdf">http://aspe.hhs.gov/daltcp/reports/2007/07alcomDC.pdf</a>
Florida	<a href="http://aspe.hhs.gov/daltcp/reports/2007/07alcomFL.pdf">http://aspe.hhs.gov/daltcp/reports/2007/07alcomFL.pdf</a>
Georgia	<a href="http://aspe.hhs.gov/daltcp/reports/2007/07alcomGA.pdf">http://aspe.hhs.gov/daltcp/reports/2007/07alcomGA.pdf</a>
Hawaii	<a href="http://aspe.hhs.gov/daltcp/reports/2007/07alcomHI.pdf">http://aspe.hhs.gov/daltcp/reports/2007/07alcomHI.pdf</a>
Idaho	<a href="http://aspe.hhs.gov/daltcp/reports/2007/07alcomID.pdf">http://aspe.hhs.gov/daltcp/reports/2007/07alcomID.pdf</a>
Illinois	<a href="http://aspe.hhs.gov/daltcp/reports/2007/07alcomIL.pdf">http://aspe.hhs.gov/daltcp/reports/2007/07alcomIL.pdf</a>
Indiana	<a href="http://aspe.hhs.gov/daltcp/reports/2007/07alcomIN.pdf">http://aspe.hhs.gov/daltcp/reports/2007/07alcomIN.pdf</a>
Iowa	<a href="http://aspe.hhs.gov/daltcp/reports/2007/07alcomIA.pdf">http://aspe.hhs.gov/daltcp/reports/2007/07alcomIA.pdf</a>
Kansas	<a href="http://aspe.hhs.gov/daltcp/reports/2007/07alcomKS.pdf">http://aspe.hhs.gov/daltcp/reports/2007/07alcomKS.pdf</a>
Kentucky	<a href="http://aspe.hhs.gov/daltcp/reports/2007/07alcomKY.pdf">http://aspe.hhs.gov/daltcp/reports/2007/07alcomKY.pdf</a>
Louisiana	<a href="http://aspe.hhs.gov/daltcp/reports/2007/07alcomLA.pdf">http://aspe.hhs.gov/daltcp/reports/2007/07alcomLA.pdf</a>
Maine	<a href="http://aspe.hhs.gov/daltcp/reports/2007/07alcomME.pdf">http://aspe.hhs.gov/daltcp/reports/2007/07alcomME.pdf</a>
Maryland	<a href="http://aspe.hhs.gov/daltcp/reports/2007/07alcomMD.pdf">http://aspe.hhs.gov/daltcp/reports/2007/07alcomMD.pdf</a>
Massachusetts	<a href="http://aspe.hhs.gov/daltcp/reports/2007/07alcomMA.pdf">http://aspe.hhs.gov/daltcp/reports/2007/07alcomMA.pdf</a>
Michigan	<a href="http://aspe.hhs.gov/daltcp/reports/2007/07alcomMI.pdf">http://aspe.hhs.gov/daltcp/reports/2007/07alcomMI.pdf</a>
Minnesota	<a href="http://aspe.hhs.gov/daltcp/reports/2007/07alcomMN.pdf">http://aspe.hhs.gov/daltcp/reports/2007/07alcomMN.pdf</a>
Mississippi	<a href="http://aspe.hhs.gov/daltcp/reports/2007/07alcomMS.pdf">http://aspe.hhs.gov/daltcp/reports/2007/07alcomMS.pdf</a>
Missouri	<a href="http://aspe.hhs.gov/daltcp/reports/2007/07alcomMO.pdf">http://aspe.hhs.gov/daltcp/reports/2007/07alcomMO.pdf</a>
Montana	<a href="http://aspe.hhs.gov/daltcp/reports/2007/07alcomMT.pdf">http://aspe.hhs.gov/daltcp/reports/2007/07alcomMT.pdf</a>
Nebraska	<a href="http://aspe.hhs.gov/daltcp/reports/2007/07alcomNE.pdf">http://aspe.hhs.gov/daltcp/reports/2007/07alcomNE.pdf</a>
New Hampshire	<a href="http://aspe.hhs.gov/daltcp/reports/2007/07alcomNH.pdf">http://aspe.hhs.gov/daltcp/reports/2007/07alcomNH.pdf</a>
New Jersey	<a href="http://aspe.hhs.gov/daltcp/reports/2007/07alcomNJ.pdf">http://aspe.hhs.gov/daltcp/reports/2007/07alcomNJ.pdf</a>
New Mexico	<a href="http://aspe.hhs.gov/daltcp/reports/2007/07alcomNM.pdf">http://aspe.hhs.gov/daltcp/reports/2007/07alcomNM.pdf</a>
New York	<a href="http://aspe.hhs.gov/daltcp/reports/2007/07alcomNY.pdf">http://aspe.hhs.gov/daltcp/reports/2007/07alcomNY.pdf</a>
Nevada	<a href="http://aspe.hhs.gov/daltcp/reports/2007/07alcomNV.pdf">http://aspe.hhs.gov/daltcp/reports/2007/07alcomNV.pdf</a>
North Carolina	<a href="http://aspe.hhs.gov/daltcp/reports/2007/07alcomNC.pdf">http://aspe.hhs.gov/daltcp/reports/2007/07alcomNC.pdf</a>
North Dakota	<a href="http://aspe.hhs.gov/daltcp/reports/2007/07alcomND.pdf">http://aspe.hhs.gov/daltcp/reports/2007/07alcomND.pdf</a>
Ohio	<a href="http://aspe.hhs.gov/daltcp/reports/2007/07alcomOH.pdf">http://aspe.hhs.gov/daltcp/reports/2007/07alcomOH.pdf</a>
Oklahoma	<a href="http://aspe.hhs.gov/daltcp/reports/2007/07alcomOK.pdf">http://aspe.hhs.gov/daltcp/reports/2007/07alcomOK.pdf</a>
Oregon	<a href="http://aspe.hhs.gov/daltcp/reports/2007/07alcomOR.pdf">http://aspe.hhs.gov/daltcp/reports/2007/07alcomOR.pdf</a>
Pennsylvania	<a href="http://aspe.hhs.gov/daltcp/reports/2007/07alcomPA.pdf">http://aspe.hhs.gov/daltcp/reports/2007/07alcomPA.pdf</a>

Rhode Island	<a href="http://aspe.hhs.gov/daltcp/reports/2007/07alcomRI.pdf">http://aspe.hhs.gov/daltcp/reports/2007/07alcomRI.pdf</a>
South Carolina	<a href="http://aspe.hhs.gov/daltcp/reports/2007/07alcomSC.pdf">http://aspe.hhs.gov/daltcp/reports/2007/07alcomSC.pdf</a>
South Dakota	<a href="http://aspe.hhs.gov/daltcp/reports/2007/07alcomSD.pdf">http://aspe.hhs.gov/daltcp/reports/2007/07alcomSD.pdf</a>
Tennessee	<a href="http://aspe.hhs.gov/daltcp/reports/2007/07alcomTN.pdf">http://aspe.hhs.gov/daltcp/reports/2007/07alcomTN.pdf</a>
Texas	<a href="http://aspe.hhs.gov/daltcp/reports/2007/07alcomTX.pdf">http://aspe.hhs.gov/daltcp/reports/2007/07alcomTX.pdf</a>
Utah	<a href="http://aspe.hhs.gov/daltcp/reports/2007/07alcomUT.pdf">http://aspe.hhs.gov/daltcp/reports/2007/07alcomUT.pdf</a>
Vermont	<a href="http://aspe.hhs.gov/daltcp/reports/2007/07alcomVT.pdf">http://aspe.hhs.gov/daltcp/reports/2007/07alcomVT.pdf</a>
Virginia	<a href="http://aspe.hhs.gov/daltcp/reports/2007/07alcomVA.pdf">http://aspe.hhs.gov/daltcp/reports/2007/07alcomVA.pdf</a>
Washington	<a href="http://aspe.hhs.gov/daltcp/reports/2007/07alcomWA.pdf">http://aspe.hhs.gov/daltcp/reports/2007/07alcomWA.pdf</a>
West Virginia	<a href="http://aspe.hhs.gov/daltcp/reports/2007/07alcomWV.pdf">http://aspe.hhs.gov/daltcp/reports/2007/07alcomWV.pdf</a>
Wisconsin	<a href="http://aspe.hhs.gov/daltcp/reports/2007/07alcomWI.pdf">http://aspe.hhs.gov/daltcp/reports/2007/07alcomWI.pdf</a>
Wyoming	<a href="http://aspe.hhs.gov/daltcp/reports/2007/07alcomWY.pdf">http://aspe.hhs.gov/daltcp/reports/2007/07alcomWY.pdf</a>