

**Teresa Koehler**

Att 8

**From:** Thomas Salow  
**Sent:** Thursday, February 28, 2013 11:00 AM  
**To:** Patti Cordova; Valerie Grina; Ruthann Smejkal; Teresa Koehler  
**Subject:** FW: LeadingAge Arizona ALRules 2013) doc  
**Attachments:** LeadingAge Arizona ALRules 2013) doc; ATT00001. htm

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**From:** Will Humble  
**Sent:** Thursday, February 28, 2013 10:57 AM  
**To:** Cara Christ, MD; Thomas Salow  
**Subject:** Fwd: LeadingAge Arizona ALRules 2013).doc

Sent from my iPhone

Begin forwarded message:

**From:** Genny Rose <[GRose@leadingageaz.org](mailto:GRose@leadingageaz.org)>  
**Date:** February 28, 2013 10:37:25 AM MST  
**To:** Will Humble <[Will.Humble@azdhs.gov](mailto:Will.Humble@azdhs.gov)>  
**Subject:** FW: LeadingAge Arizona ALRules 2013).doc



Will Humble  
150 N. 18<sup>th</sup> Ave., Suite 500  
Phoenix, AZ 85007

Re: List of Concerns for Non-Behavioral Assisted Living Providers

LeadingAge Arizona thanks you for the opportunity to discuss the Behavioral Health Rule changes allowed per HB2634. The Proposed Draft 2-6-2013 Rule changes as presented will increase monetary and regulatory costs on Assisted Living Providers that do not offer both Behavioral and physical health services.

There are many areas of concern for providers who do not offer both behavioral and physical health services, nor accept Medicare or Medicaid, that should be reviewed and revised before the final rule changes are adopted. Those changes are outlined in part as follows:

**Remove the Registered Nurse (RN) change and return it to nurse per R9-10-701. Definitions**

74. "Nurse" means an individual licensed and in good standing as a registered nurse or a practical nurse as prescribed in A.R.S. Title 32, Chapter 15.

**Reason:** The RN requirement will dramatically increase non-behavioral Assisted Living Providers costs plus cause hundreds of LPN's to lose employment. Since October 1998 the "Arizona Model" for Assisted Living has used LPN's effectively and has seen exponential growth compared to the institutional model and with a proven positive record. Therefore, increasing monetary costs and upping regulations in this area is not consistent with HB2634.

**Definition: Change the word Assessment to Evaluation wherever it appears.**

**R9-10-701. Definitions**

8. "Assessment" means a written analysis of a resident's abilities; preferences; and need for supervisory care services, personal care services, or directed care services.

Change to read:

8. "Evaluation" means a written analysis of a resident's abilities; preferences; and need for supervisory care services, personal care services, or directed care services

This change in terms will remove confusion surrounding an LPN's scope of practice. This proposed change is will reduce monetary or regulatory costs on person or individuals and streamline the regulation process consistent with HB2634.

**R9-10-703 D (page 20). Quality Management Program- REMOVE**

This is a new requirement that will dramatically increase the cost to Providers as well as the workload. This Rule will in no way streamline the operations of the Provider and will increase the time for each annual survey. The increase time of survey will increase DHS cost. This proposed rule does is not consistent with item one of HB2634. R9-10-703D increases monetary or regulatory costs on person or individuals and does not streamline the regulation process.

R9-10-705 A. 1. (Page 26) **New Rules do not define "Employee"** What is the definition of an Employee? The old rules read: **R9-10-701. Definitions 41.** "Employee" means a licensee, manager, caregiver, or assistant caregiver who provides or assists in the provision of supervisory care services, personal care services, or directed care services to residents.

**R9-705 B.4. (Page 26) Revert to original rule R9-10-706 A.**

A licensee shall ensure that:

1. At the starting date of employment or service and every 12 months from the starting date of employment or service, each support staff and volunteer who interacts with a resident on a regular basis and each employee submits one of the following as evidence of being free from pulmonary tuberculosis:
  - a. A report of a negative Mantoux skin test administered within six months of submitting the report; or
  - b. A written physician's statement dated within six months of submitting the statement, indicating freedom from pulmonary tuberculosis, if the individual has had a positive skin test for tuberculosis.

The new rule as written may increase a person's exposure to radiation and or Mantoux skin tests which is not consistent with reducing monetary or regulatory costs on person or individuals and streamline the regulation process.

**R9-705 B. 6. 2. (Page 27) The new rule reads:**

2. Provides documentation of having received first aid training and cardiopulmonary resuscitation training specific to adults within the previous 12 months.

**The proposed rule should be changed to read:**

2. Provides documentation of having received first aid training and cardiopulmonary resuscitation training specific to adults that is current.

Reason: The rule as written requires those affected to have training annually which increases monetary or regulatory costs on persons or individuals and does not streamline the regulation process which is contrary to HB2634.

R9-10-708 A 3. g. (Page 38) **Reads as follows: g.** Any health care directives:

This provision does not relate to the new definition of "service plan" and therefore is not consistent and is duplicative and should be removed.

**Reason:** Health care directives are already considered elsewhere in the proposed new rules. The rule as written does not reduce monetary or regulatory costs on persons or individuals and does not streamline the regulation process per HB2634.

R9-10-710 D. 3. a-b. (Page 45) The proposed new rule should be deleted it is duplicative does not provide meaningful information is a burdensome regulation. Therefore, since it does not reduce monetary or regulatory costs on persons or individuals and streamline the regulation process per HB2634 it should be deleted.

R9-10-710 A. 3. a. (Page 45) **Recorded only by Caregiver or an assistant caregiver.**

What about the other people who interact with the caregiver concerning resident records such as the manager, nurse, therapist, doctors, or any other pertinent medical professional?

New wording could read: An entry into the record is:

- a. Recorded only by those authorized by policies and procedures to make the entry;

**Reason:** Changing the proposed rule would reduce monetary or regulatory costs on persons or individuals and streamline the regulation process consistent with HB2634.

R9-10-711A 3. b. (page 48) **The new proposed rule should be changed to reflect the FDA national standards and read as follows:**

- b. Foods requiring cooking are cooked to heat all parts of the food to a temperature of at least 140° F, except that:
  - i. Poultry (chicken, turkey, stuffed meats) are cooked at least to 165° F, ground meats (hamburger, meat loaf, sausage, chorizo, gyros) at least 155°F, eggs not consumer right away (custard, scrambled eggs on a buffet line) at least 155°F, non-ground meats (steaks, roasts, pork chops, corned beef) at least 145°F, seafood (fish filet, shrimp,

mussels) at least 145°F, eggs consumed right away (eggs over easy, scrambled eggs to order) at least 145°F.

ii. Raw shell eggs....

**Reason:** Making the change will keep the minimum cooking temperatures in the same classifications and same temperatures as Maricopa County. The change will also allow dietary staff to operate under the same rules that they train and are required to test under thereby reducing monetary or regulatory costs on persons or individuals and streamlining the regulation process consistent with HB2634 (see Food Safety Manual for the Food Service Worker revised December 2011).

R9-10-711 C.2.8. (Page 50) A manager shall ensure that:

8. A resident has a self-help device, such as a plate guard, rocking fork, or assistive hand device, if the resident needs the self-help device;

The rule should be deleted or changed to read:

8. Cleaning and washing of a resident's self-help devices shall be available, such as a plate guard, rocking fork, or assistive hand device;

**Reason:** Making the change will allow the provider to clean and wash resident owned self-help devices as a service without passing the cost of the device onto the provider. Frail assisted living residents need many assistive devices such as, walkers, scooters, hearing aids, special caption telephones, etc. none of which are the obligation of the provider to provide, maintain or keep in inventory. Adopting this change will reduce monetary or regulatory costs on persons or individuals and streamline the regulation process consistent with HB2634.

R9-10-712 6 D.c. iii. (Page 55) A bathroom that provides privacy when in use and contains:

iii. A working bathtub or shower and a clean usable shower curtain;

The proposed rule should be changed to read:

"A working bathtub or shower with or without an appropriate screen per the resident's service plan."

**Reason:** Shower curtains are often used by residents as a hand bar to catch themselves if they become unsteady and should be removed in many cases for the resident's safety. Only the provider in consultation with those involved in preparing the service plan are capable of determining the risk/reward of a clean usable shower curtain therefore, to reduce monetary or regulatory costs on person or individuals and streamline the regulation process the wording needs to be changed to prevent a "one size fits all mentality" which is consistent with HB2634.

R9-10-712 6 f. i. ii (Page 55) If not furnished by a resident:

i. An armchair, and

- ii. A table where a resident may eat a meal; and

Should be deleted or changed to read:

Unless the resident provides their own furnishings the licensee provides the following when appropriate per the resident's service plan.

- i. One armchair or side chair; and
- ii. One table where a resident may eat a meal; and

**Reason:** Only the provider in consultation with those involved in preparing the service plan are capable of determining the risk/reward of an armchair or side chair and a table where a resident may eat a meal. Memory Support providers endeavor to keep residents out of their rooms except for sleeping. Therefore, to reduce monetary or regulatory costs on persons or individuals and streamline the regulation process the wording needs to be changed to prevent a "one size fits all mentality" which is consistent with HB2634

Pages 21 Finally, R9-10-705 Resident Rights see R9-10-703 F 1. States a manager shall ensure that the following are conspicuously posted:

- 1. A list of resident rights. Where is the new list of resident rights???

Respectfully Submitted by:

Genny Rose, Executive Director, LeadingAge Arizona

Jon Scott Williams, Chair, Policy and Governmental Affairs Committee,  
LeadingAge Arizona

Don Isaacson, Lobbyist, LeadingAge Arizona

Part 8

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Collector: Health Care Institution Licensing  
Rulemaking (Web Link)

Custom Value: empty

IP Address: 24 121 227 115

Response Started: Monday, February 25, 2013 4:13:45 PM

Response Modified: Monday, February 25, 2013 4:25:08 PM

1. If you have any comments or concerns about the rulemaking process or general comments about the rules, please provide your comments or concerns below:

R9-10-702 1- This rule does not make good sense R9-10-703.A 8.- Very burdensome for larger Corporations to deal with. R9-10-703 C 1 c - The rule is not consistent within itself ..R9-10-703 D 1 a. Over-reporting makes things more complex R9-10-706.B1.b iii - Needs more clarification...R9-10-708-A.3.a- Needs to be more defined R9-10-708-C 1.f - Needs to be deleted R9-10-710-A 3 a - DO not agree with this rule. R9-10-712B 5 and 7- Should not be moved R9-10-716: Requires further discussion.

Art 8

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**Respondent Type:** Normal Response

**Collector:** Health Care Institution Licensing Rulemaking (Web Link)

**Custom Value:** empty

**IP Address:** 67 1 74 213

**Response Started:** Saturday, February 23, 2013 1:45:50 PM

**Response Modified:** Saturday, February 23, 2013 1:46:57 PM

1. If you have any comments or concerns about the rulemaking process or general comments about the rules, please provide your comments or concerns below:

As a current LPN, I was doing all my own service plans, you are proposing for a RN to start doing them, that would put a very big burden on my company. Please reconsider!!

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Respondent Type: Normal Response

Collector: New Link (Web Link)

Custom Value: *empty*

IP Address: 159 36 0 199

Response Started: Friday, February 22, 2013 4:15:11 PM

Response Modified: Friday, February 22, 2013 4:32:25 PM

**1. What parts of the draft rules do you believe are effective?**

We appreciate all of the revisions so far that the rules committee have put in place. Thank you for listening to the community.

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**2. How can the draft rules be improved?**

The ALF community voices concern that Service Plans will need to be updated by a Registered Nurse. Many assisted living facilities have Wellness Directors that have successfully utilized LPN's. LPN's have proved to be a valuable asset to providing Service Plans to our community. The fear is the cost to the facility which will be passed onto the resident. ALTCS facilities have to carry the cost of the service plan and updates on their own shoulders. We understand the intent of the new change to go to the Registered Nurse however in the old rules a nurse could be either RN or LPN. We hate to see that choice go away. There will be many nurses who will lose their jobs if this rule remains. We would ask you to please reconsider putting nurse back in lieu of Registered Nurse. Thank you.

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**3. Has anything been left out that should be in the rules?**

N/A

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Custom Value: *empty*

IP Address: 68 14 252 70

Response Started: Friday, February 22, 2013 4:13:43 PM

Response Modified: Friday, February 22, 2013 4:13:47 PM

## 1. What parts of the draft rules do you believe are effective?

No Response

## 2. How can the draft rules be improved?

Proposed Rules Changes for Assisted Living Facilities Title 9, Chapter 10, Article 7 While Sun Valley Lodge has already submitted comments 2 days ago on DHS's most recent February revisions we wish to add additional comments today. 1 Pg. 15 R9-10-703 A 9 We are opposed to the adoption of a Quality Management plan due to the excessive costs and labor required to implement such. There is no federal mandate for Quality Management in Assisted Living. This requirement is contrary to HB 2634. 2 Pg. 19 R9-10-703 C 1 b i We are opposed to orientation requirements for volunteers who do not provide care to residents due to costs and labor involved. 3. Pg. 19 R9-10-703 C 1 c i, ii, iii, iv and d and e and f i, ii and iii and h and k and Pg. 20 n and q We are opposed to all of this as it is totally unnecessary, duplicating and costly and labor intensive. When something is required why is it necessary to have a policy in it. Very burdensome and not at all useful. Contrary to HB 2634. 4 Pg. 26 R9-10-705.B 4 We are opposed to volunteers who do not provide care being required to have freedom from TB. 5 Pg. 28 R9-10-705 D 1 a-d and 2 We are opposed to these record requirements and its contents for volunteers who do not provide care due to costs, labor intensive and ongoing upkeep. Contradicts HB 2634. 6. Pg. 39 R9-10-708 A 5.c We are opposed to the RN requirements. 7. Pg. 43 R9-10-709 A 1 e We are opposed to a Quality Management Plan for all the reasons we have already stated. 8 We are opposed to any rules or regs related to volunteers who do not provide actual care to residents. This is very costly and burdensome and an additional regulations since you have proposed a change to the definition of the term "volunteer" Respectfully Submitted by Sun Valley Lodge 2/22/13

## 3. Has anything been left out that should be in the rules?

No Response

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Custom Value: empty

IP Address: 98 225 127 89

Response Started: Friday, February 22, 2013 9:20:57 AM

Response Modified: Friday, February 22, 2013 3:27:06 PM

**1. What parts of the draft rules do you believe are effective?**

Addition of the requirement for health care directives to be included in the service plan is a positive addition. The inclusion of a resident receiving Respite Services is a positive addition and makes it clear to providers that there are requirements for residents receiving these services. The requirements for medication services policies & procedures are more in depth than previously and provide additional specifics that are to be included that previously were not in rule.

**2. How can the draft rules be improved?**

Definitions are difficult to find with so many different references. R9-10-701: Definition of caregiver excludes that a caregiver could be a family member. A caregiver could be an employee in a home where a family member had been placed. R9-10-702: Some owners as defined by the rule, who have been & are currently licensed & do not provide hands on care to residents, may not pass a fingerprint clearance. R9-10-703: C1 b ii: Specific criteria & number of hours for ongoing education for caregivers has been deleted. Without a guideline for what topics & hours that should be included in ongoing education there is a potential for an increase in quality of care issues as well as potential for lack of review/refresher for important topics that should be reviewed annually. R9-10-703 D 1-3: Will ADHS provide training & technical assistance to facilitate success with the requirement for a Quality Management Program? This is a more involved process than the incident reporting process has been and providers will need additional training and support to meet these requirements. R9-10-704: Previous rules required report to ADHS within 24 hours of receipt of allegations re alleged abuse, neglect, or exploitation. The draft changes would require submission of a copy of the facility investigative report within 5 days of submitting the report to APS or law enforcement. This would delay awareness & investigation by ADHS and would significantly delay notification to AHCCCS. R9-10-705 B6: This draft has deleted the requirement for CPR & First Aid certifications for those providing Supervisory Care. If a resident sustains an injury requiring immediate first aid or an emergency requiring CPR isn't the caregiver still required to provide either first aid or CPR? R9-10-705 C1: The draft requires an individual residing in the home who is not a resident, manager, caregiver or assistant caregiver either obtains a fingerprint clearance or interacts with residents only under the supervision of an individual with a fingerprint clearance. Supervision is defined in 36-401 as "direct overseeing & inspection of the act of accomplishing a function or activity. This impacts providers with children & other family living in the home, particularly in AFC settings. Is the expectation that children & other family members including elderly parents of the provider obtain fingerprint clearance or have direct supervision when interacting with residents? R9-10-705 D1dii: Draft requires documentation of work experience. The rule previously required in R9-10-706 E4 submission of 2 personal references & two professional references if the individual had previous work experience & verification or good faith effort to contact each reference. There is no requirement in the draft for submission of references & verification or good faith effort to contact/verify the references which are important aspects when hiring new employees. R9-10-706 B1A: Within 90 days before an individual is accepted by an ALF, the individual's needs are determined by a Physician, Registered Nurse Practitioner, RN, or PA: There could be potential to impact emergency placements from all sources in order to meet this requirement prior to admission. R9-10-706 D: Enrolled members of the Arizona Long-Term Care System (ALTCS) were previously excluded from the Residency Agreement (R9-10-709 A). The exclusion is not stated in the draft. How does that exclusion affect ALTCS members? There is a standardized Residency Agreement for ALTCS members utilized by the health plans for members in ALF settings. Some of the terms of this agreement are not consistent with the draft requirements for Residency Agreements. The draft does not provide direction or criteria for what is acceptable or not acceptable regarding refunds. The current Residency Agreement used for ALTCS members requires refunds within 30 days after the date of termination of residency. There are other differences including charges that may or may not be charged to ALTCS members & the current agreement does not list services as required in the draft rules. R9-10-708 A2c & A3d: RN requirement to participate in the development of service plans if the resident is receiving nursing services medication administration, or is unable to direct self care & the requirement for an assessment by an RN if the resident is receiving intermittent nursing services or medication administration will be very difficult if not impossible in some cases to meet this requirement due to the lack of RN availability. The RN requirement is also very costly to providers. The previous rule provided for a "nurse" to participate in the service plan for the reasons as stated above. The definition of "nurse" included LPN however the draft no longer includes LPN. R9-10-708 A3g: Addition of the requirement for health care directives to the service plan is a positive addition for the service plan requirements. R9-10-708 B4: For a resident receiving respite, the service plan must be completed no later than 3 days after the date of acceptance. The addition of respite requirements is a positive addition and will provide clear direction for providers. The 3 day timeframe may be challenging if an RN is needed to participate in accordance with the RN requirements in the draft. This again could be particularly difficult to complete in the rural areas. R9-10-708 D: A manager of an ALF that provides adult day health shall ensure that adult day health care services are provided as specified in R9-10-509 which requires an administrator. Where is the definition of an administrator & will a manager qualify as the administrator? R9-10-709 A1: The

requirements for medication policies are more in depth than previously and a process is required for review of any medication administration errors & adverse reactions to a medications through the quality management program While these additions are good they will require more assistance from licensed professionals which will impact the cost to the providers R9-10-709 A2: A current drug reference guide is available for use by caregivers & assistant caregivers The definition of "current" is "up to date extending to the present time." There is no specific language related to the time frame/copyright date Previous requirement was within 2 years of the copyright date of the drug reference guide. R9-10-709 B3. The language in the draft excluded that medications cannot be pre-poured. The previous rule (R9-10-713 B5 stated that "except for medication organizers, resident medication is not pre-poured Could this language be added back as pre-pouring of medications should not be permitted? R9-10-709 D 3a &b: Requires documentation that identifies if a medication was administered to the resident or if assistance with self administration was provided Does this mean that it must be documented with each dose by each caregiver or could the identification in the service plan meet the requirement? R9-10-710 B 12: Documentation of all services provided by the facility to the residents: Is the expectation that the facility will need to develop and use ADL forms, document intake, activities, etc or does documentation of services in the service plan meet this requirement? R9-10-712 B 12: This language states that the key to the door of a lockable bathroom, bedroom, or residential unit is available to caregivers The previous rule identified for an ALH that if the door was capable of being locked from the inside an employee shall have a key & access to the bedroom or bathroom at all times "locking from the inside" is not included in the draft language This is concerning because if there is a lock that can be locked from the outside, the resident could potentially be locked in the room R9-10-712D 4b: This addresses that a resident's sleeping area is not used as a passageway to a common area, another sleeping area, or a common bathroom In the previous rules this was allowed with written consent from the resident/representative to allow passage through a resident's bedroom The draft rule will impact many of the assisted living homes and adult foster care homes as some need access to a resident's bedroom in order to access a common bathroom If the draft is approved as stated, some of the homes would have to decrease their census or provide structural change to comply with the requirement R9-10-713 E4b: Reference to smoke detectors--battery operated or hard wired: This rule doesn't identify that smoke detectors have to be hard wired if there has been 2 violations in the past 24 months as did the original rules Is this no longer required? R9-10-714 D: The language in this rule is in reference to installing an intercom or mechanical means to alert staff to residents needs or emergencies Previously the rule stated the bedroom be equipped with a bell, intercom, or other mechanical means to alert employees to a resident's needs or emergencies. This is a potential financial expense to providers specific to having the system installed in the bedrooms vs having the bedroom equipped with a bell, intercom or other mechanical means to alert staff of resident needs R9-10-716 2bi: References R9-10-114 R9-10-114 was repealed R9-10-716 2b ii: References R9-10-1013 (B) & (C). There is no section "B" in the draft dated 01/09/2013 R9-10-1013 C: Refers to an administrator of an outpatient treatment center Does this mean that an ALF that chooses to provide BH services will be an outpatient treatment center? R9-10-1013 C: An administrator of an outpatient treatment center that provides behavioral health services shall ensure: This section reviews requirements for an assessment, counseling sessions, respite services etc These requirements seem to be out of the scope of an ALF (assessment and counseling sessions) They do not have BH technicians, BH professionals or BH paraprofessionals The cost to the facility to provide these services seems cost prohibitive. Will there be any specific revisions for the ALF that is providing BH services vs being an "outpatient treatment center"?

### 3. Has anything been left out that should be in the rules?

The draft does not identify a requirement for submission of references & verification / good faith effort to verify references for employees Draft language does not identify that medications cannot be pre-poured except for pre-set medications sets Notification to ADHS within 24 hours of an allegation of abuse, neglect, exploitation has been deleted and notification is now within 5 days of submitting the report to APS or law enforcement This would delay awareness & investigation by ADHS & would delay notification to AHCCCS CPR and First Aid certification for caregivers at the Supervisory Level of Care. Case Managers participation in the Service Plans previously required has been excluded.



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**2. How can the draft rules be improved?**

Differentiate the difference between a volunteer, a volunteer assistant caregiver and a volunteer caregiver. The verbage is confusing in regards to the CPR and FA requirement. I strongly disagree with the RN requirements. This is the wrong way to try to improve quality care. An RN is not required to be on staff so you are going to have an RN signing who is not routinely on site sign off on service plans, etc. but they will not be able to see that the care is carried out. This is just a bandaid. Please, please reconsider and remove the RN's part in A.L. In my opinion LPN's are much more feasible. They are qualified to meet the requirements of A.L. RN's are an unnecessary expense.

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**3. Has anything been left out that should be in the rules?**

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**2. How can the draft rules be improved?**

It is not necessary to have registered nurses reeval assessments and service plans in assisted living environment. This is costly and can be done effectively by Managers and LPN's in the community. The cost of hiring RN's to provide this service will only take away resources that can be better utilized in other areas of AL.

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**3. Has anything been left out that should be in the rules?****No Response**

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**2. How can the draft rules be improved?**

AHCA wishes to weigh in on one additional concern that we inadvertently omitted from our earlier comments. The current assisted living rules allow nurses to assist with the development of service plans, review these plans and assist with revisions, and the current rules state that service plans are developed with assistance and review from "a nurse, if the resident is receiving nursing services, medication administration, or is unable to direct self-care." The draft rules have changed nurse to registered nurse in all of these circumstances. This would place an enormous economic impact on the provider, and in addition could have negative consequences on LPN employment and cause potential RN shortages. There is no indication that the current level of oversight and review is not sufficient. AHCA strongly recommends that this change to require RNs in the assisted living review and implementation of service plans be removed. This change would be entirely contrary to the intent of this revision process.

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**3. Has anything been left out that should be in the rules?****No Response**

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**IP Address:** 174 79 48 50

**Response Started:** Friday, February 22, 2013 10:46:34 AM

**Response Modified:** Friday, February 22, 2013 10:57:31 AM

### 1 What parts of the draft rules do you believe are effective?

I agree with streamlining and making a more efficient regulatory process

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### 2. How can the draft rules be improved?

Please remove the new requirement for a RN in 708 2 c, 708 3 d, 706 B 1.a ii, and 709 C 2 Previous regulations allowed an LPN to to evaluate, supervise, and participate as the nurse for an assisted living The new requirement of an R.N will add an undue financial hardship for most assisted livings, along with forcing layoffs of many of the talented and dedicated LPNs many of which are certified by AALNA to be a nurse in assisted living Plus create a demand for RNs that are already in demand due to a R N shortage and will force most assisted livings to operate with no nurse instead while they are trying to compete for R.N.s Please have the abuse requirements be uniform across the board between SNF, AL, etc.

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### 3. Has anything been left out that should be in the rules?

No Response

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Custom Value: empty

IP Address: 68 109 168 30

Response Started: Friday, February 22, 2013 10:08:06 AM

Response Modified: Friday, February 22, 2013 10:10:41 AM

**1. What parts of the draft rules do you believe are effective?**

The Arizona Health Care Association appreciates the opportunity to weigh in on these draft rules for assisted living facilities. It is our belief that the intent of the rule revision to create an integrated licensure model as well as streamline the regulation process and reduce monetary or regulatory costs is a positive effort.

**2. How can the draft rules be improved?**

There needs to be further review, analysis and stakeholder dialogue related to the behavioral health component. We are deeply concerned that there is a lack of understanding in the draft about the current environment of behavioral health care provided in the assisted living setting much related to the care provided in the nursing care institution setting. The distinctions are unclear as to whether assisted living facilities would know whether to participate in an integrated licensure format for behavioral health. Those that are providing behavioral health services now are currently reimbursed for behavioral care by the AHCCCS health plans and there are no indications that the plans would be willing to pay behavioral health rates to assisted living facilities. We believe strongly that this discussion should be continued. In reading through the draft rules, many sections are added that make the rules more complex and insert additional burden on the provider as opposed to meeting the intent of HB2634 which was to reduce monetary or regulatory costs on persons or individuals and streamline the regulation process. In the examples listed below, there are many that come under this category. The document in its entirety is inconsistent in its approach. Some rules are prescriptive, detailed, and provide an over-reach into the regulatory process while others are one line guidance. There should be a consistency to the rule-making process and the final outcome. The reader should not have one section narrowly defined and another broadly defined. Specific Concerns: R9-10-702 1 Supplemental Application Requirements – fingerprint clearance cards. The draft rules have inserted these supplemental requirements that were not in the existing rules. While the statute under A.R.S. §36-411 includes owners in the requirement for fingerprinting to obtain a license, it is unclear how the 10% measure was arrived at by the department. This would be burdensome for many providers with corporate out-of-state owners who are large chains and may have many owners with a 10% share in the company. A much higher value should be considered. R9-10-703 A 8 Fingerprint Clearance Cards for Owners with a 10% or greater ownership. This again is burdensome for large corporations where getting this information, and requiring fingerprint cards for out-of-state owners seems unnecessary when the onsite manager and caregivers are required to have fingerprint cards in compliance with AZ laws. R9-10-703.C 1 c Cardiopulmonary resuscitation. This is an example where the rule is far too prescriptive in comparison to other rules within the same category. This rule relates to policies and procedures that must be established, documented and implemented. This section goes into great detail about the method of training, including demonstrating how the training should be performed, the qualifications of trainers, timeframes for renewal, and the documentation required. In the very next policy and procedure required, there is one line that requires policies that cover staffing and recordkeeping with no explanation or clarification. The next policy required covers resident acceptance, resident rights and termination of residency, again with no clarification. Please make the rule consistent within itself. R9-10-703 D 1 a re: incidents. We are requesting that the department consider redefining the word "incident" which is extremely hard to quantify or comply with for all provider types. The current definition states that an incident is "an occurrence or event that has the potential to cause harm to a resident". Under the SNF rules, an incident is "an unexpected occurrence that poses a threat to the health and safety of residents". It is requested that this definition be uniform across provider types and that some clarification of what constitutes an "incident" be given. Currently facilities struggle with what to report and are frequently cited for not reporting when required. This leads to over-reporting for all providers and causes an increased regulatory burden, rather than simplifying the process. R9-10-706 B. 1 b iii re: behavioral health services. This rule states that if an individual needs behavioral health services, the individual's behavioral health issue is secondary to a need for supervisory care services, personal care services, or directed care services. Currently there are assisted living facilities that provide primarily behavioral health services and the placement of residents is driven by the AHCCCS health plans and there is no requirement that their behavioral need is not primary. This needs further clarification and discussion between licensing and AHCCCS to assure that the drivers of care placement are not in conflict with the rule makers and enforcers in the survey process. R9-10-708 A.3 a – the rule as written requires a summary of the resident's medical or health problems, including physical, mental, and emotional conditions or impairments. Emotional conditions or impairments needs to be defined. R9-10-708 C.1 f – the rule requires that a caregiver interacts with a resident to detect deficits in the resident's cognitive awareness and reinforce remaining cognitive awareness. While this may refer to a best practice approach to managing residents with dementia, it does not define how or what a facility should do to comply with this requirement. We would request that this be deleted, or clearly defined. R9-10-710 A.3. a – the rule states that entries into the resident record may only be made by a caregiver or an assistant caregiver. This would clearly eliminate nurses, physicians, therapists, and nurse practitioners among others to document in the resident record. We would recommend eliminating a because anyone with a need should be able to document in the record. R9-10-712B 5 and 7 – These two rules relate to room and facility temperatures and hot water temperatures. The department has indicated that these will be moved to article 1 and made consistent across all provider types. R9-10-716. Re behavioral health services. The rule refers to behavioral health services that comply with R9-10-114 and R9-10-1013 (B) and (C). As indicated earlier in these comments,

we feel strongly that there needs to be a serious overview of the driver of care placement at the AHCCCS and plan level and the rule making level. This inconsistency with care provision, payment, and rules puts residents and providers in the center of state systems that are not in alignment and cannot lead to quality care. We respectfully request that the department address this discussion further.

**3 Has anything been left out that should be in the rules?**

The rules do not address a concern that has arisen when residents receiving personal care have an appointed guardian. The licensing office has generously assisted in working through such situations but there should be in our opinion, some clarification of an assessment that an individual's needs clearly cannot be met based on objective criteria and an assessment by providers, physicians and families as well as surveyors, and not simply because they have a guardian appointed.

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**Respondent Type:** Normal Response

**Collector:** New Link (Web Link)

**Custom Value:** empty

**IP Address:** 66 224 86 164

**Response Started:** Friday February 22, 2013 9:21:50 AM

**Response Modified:** Friday, February 22, 2013 9:25:22 AM

**1. What parts of the draft rules do you believe are effective?**

No Response

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**2. How can the draft rules be improved?**

c The registered nurse who assisted in the preparation or review of the service plan, if applicable Majority of assisted livings have an LPN for the nurse. Is this rule requiring an RN on staff?

---

**3. Has anything been left out that should be in the rules?**

No Response

---

## Browse Responses

[Filter Responses](#) [Download Responses](#) [View Summary](#)Displaying 23 of 32 respondents [« Prev](#) [Next »](#) Jump To: 23 [Go »](#)**Respondent Type:** Normal Response**Collector:** New Link (Web Link)**Custom Value:** empty**IP Address:** 24 251 153 14**Response Started:** Thursday February 21, 2013 10:26:22 PM**Response Modified:** Thursday, February 21 2013 11:14:03 PM**1. What parts of the draft rules do you believe are effective?**

I am a Registered Dietitian active in AZ and involved nationally I am providing input on the Food Services portion of the draft rules R9-10-711 Food Services The addition of assistive devices C # 8 is excellent as we see more residents needing this to promote independence.

---

**2. How can the draft rules be improved?**

R9-10-711 Food Services # 1 - 7 are all part of the food code 9 A.A.C. 8, Article 1 Thus, these do not have to be repeated A statement stating that food code 9 A.A.C. 8, Article 1 will suffice. Some of these draft rules also conflict with food code food code 9 A.A.C. 8, Article 1 such as: Draft rules for freezer temperature of zero, pork cooking temperatures of 160 F, and hot holding temperatures of 140 F are in conflict with the food code 9 A.A.C. 8, Article 1 and are not evidenced based. They are also in conflict with the 2009 FDA food code. <http://www.fda.gov/food/foodsafety/retailfoodprotection/foodcode/foodcode2009/> It is recommended that "frozen foods shall be frozen," that ground pork be cooked to 155 F for 15 seconds, that whole pork like steaks, roasts, and chops be cooked to 145 F for 15 seconds and that hot holding temperatures be set at 135 F This is from the FDA 2009 model food code which is current and evidenced based.

---

**3. Has anything been left out that should be in the rules?**

References are made to ensuring resident nutritional needs are met, and that menus are planned according to Food and Nutrition Council and that therapeutic diets are provided according to orders, but there is no reference to who will assist in ensuring nutritional needs are ensured All other DHS Licensing Units (SNF - R9-10-912 B, Home Health - R9-10-1102 B9b, Behavioral health - R9-20-407B8c, Hospice - R9-10-808 #4, 810 A, Hospital - R9-10-227 #10)) - reference a Registered Dietitian that reviews the menus once a year to ensure nutritional adequacy; or counsels resident on nutritional needs; reviews Diet Manual, etc Since acuity in Assisted Living Communities is increasing, the need for a Registered Dietitian's involvement is crucial in ensuring resident health and wellness. Several evidenced based research shows this Registered Dietitian services is financially reasonable Since all other Licensing Units have included Registered Dietitians in the rules, in one form or another, adding this to AL rules will make it more cohesive and seamless through all units. Thank you for allowing comments.

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Respondent Type: Normal Response

Collector: New Link (Web Link)

Custom Value: empty

IP Address: 68 14 252 70

Response Started: Wednesday, February 20, 2013 3:54:48 PM

Response Modified: Wednesday, February 20 2013 3:55:11 PM

## 1. What parts of the draft rules do you believe are effective?

No Response

## 2. How can the draft rules be improved?

Issues With the Proposed DHS Rules 2/2013 Draft For Article 7, Assisted Living Facilities 1 Pg 26 R9-10-705 A 1 The term 'employee' is not defined anywhere that we can find. The current definition in the Assisted Living Rules for 'employee' is and was acceptable. If the intent is to now fingerprint all employees this would be very costly. This would be a terrific expense to facilities, which goes against the Department's intent and should only apply to those who provide care. Many employees have no contact with residents whatsoever. This also goes against the Legislature's Directive to "reduce monetary or regulatory costs". We cannot afford this new interpretation of what employee means. 2 Pg. 55 R9-10-712 D 6.c iii We are opposed to the requirement of a shower curtain being put up. Some units have shower doors instead of shower curtains. To replace all shower doors with shower curtains would be extremely costly. This cost would be passed down to our residents which goes against the Legislature's Directive to "reduce monetary or regulatory costs to persons or individuals". This also goes against Resident's Rights because based on personal preference, some residents actually prefer a shower door instead of a shower curtain. We cannot afford this requirement. 3 Pg 45 R9-10-709 D 3 a & b We are opposed to documenting this on the MAR. This would be costly, time consuming & impractical. It is located on the service plan. The cost to implement this would be labor intensive and would have to be passed down to the residents. This would go against the Legislature's Directive to "reduce monetary or regulatory costs to persons or individuals". 4. Pg 38 R9-10-708 A 3.d We are opposed to the requirement of a registered nurse completing an assessment for those on medication administration. We are not opposed to a registered nurse being involved for those residents requiring nursing services. The word "nurse" for those residents who are on medication administration is acceptable to us. The requirement of a registered nurse conducting an assessment for residents requiring medication administration would be costly and the cost would have to be passed down to the resident. This would go against the Legislature's Directive to "reduce monetary or regulatory costs on persons or individuals". 5 Pg 2 What is the definition for the word "assessment"? It is missing from the revised rules. 6. Pg. 19 R9-10-703 C 1 a We are opposed to job descriptions, duties and qualifications for volunteers, including required education, experience, skills & knowledge. It would be costly and labor intensive to implement this and not necessary. We are fine with requiring an orientation for volunteers. 7 Pg 20 R9-10-703.1 q, 2 & 3 We are opposed to the idea of forming a quality management program for Assisted Living. It is our understanding that the Legislature's Directive is to "reduce monetary or regulatory costs on persons or individuals". Forming a quality management program would be costly and would force the facility to pass this cost down to the residents and their families. 8 Pg. 20 R9-10-703 D.1.b The wording "including the oversight of employees and volunteers" should be removed. We believe the content should not be dictated. 9 Pg 21 R9-10-703.G We are opposed to this in regards to D 2, because it is overly specific to the resident which is confidential information. 10 Pg. 37 R9-10-708 A 2 c We are opposed to a registered nurse being required to assist & review a service plan for those on medication administration services. The word "nurse" is acceptable to us. Requiring a registered nurse would be costly, which is going against the Legislature's Directive to "reduce monetary or regulatory costs on persons or individuals". 11 Pg 38 R9-10-708.A 3.g This does not relate at all to your definition of "service plan" and is not consistent with your definition. We are opposed to this because it is impractical to require it to be in the service plan and is already required elsewhere in the chart. 12 Pg 43 R9-10-709 A 2 We are opposed to a current drug reference guide being available. Currently the rule states that there must be a drug reference guide with a copyright date within 2 years. To get a new drug reference guide book every year, there would be an extra cost to the facility because these books are not cheap. 13 Pg. 45 R9-10-710 A.3 a We are opposed to only a caregiver/caregiver assistant being able to document in the resident record. The Manager and Nurse should also be able to document in the resident record. 14 Pg 57 R9-10-713.A.5 b We are opposed to the requirement of all residents being involved in fire drills. This is impossible and impractical. The wording "all available residents" would be acceptable. 15 Pg 58 R9-10-713.A 6 a v We are opposed to this requirement because it is extensive, burdensome and unnecessary documentation. 16 Pg 69 R9-10-714.A 2 What about a home health agency? 17 Pg. 70 R9-10-714.E 1 Sometimes a resident who is receiving personal care services is not receiving services that allow caregivers to observe skin status. Sometimes its very difficult to prevent a bruise or injury. Residents sometimes do not notify staff of bruises. Respectfully Submitted by Sun Valley Lodge on 2-21-13

## 3. Has anything been left out that should be in the rules?

No Response



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Respondent Type: Normal Response

Collector: New Link (Web Link)

Custom Value: *empty*

IP Address: 207 108 136 244

Response Started: Wednesday, February 20, 2013 9:06:54 AM

Response Modified: Wednesday, February 20, 2013 9:21:58 AM

**1. What parts of the draft rules do you believe are effective?****No Response****2. How can the draft rules be improved?**

Under residents rights: A 1 a iii: Correspondence, communications, and visitation, including unopened mail A 3 c: right to access records, including clinical records, within 24 hours of oral or written request, and right to purchase photocopies of records at a cost not to exceed the community standard within two business days

**3. Has anything been left out that should be in the rules?**

The following residents' rights should be included: The right to be treated with dignity, respect, consideration, and fairness (rather standard in AL rules across the nation) The right to refuse services, unless such services are court ordered or the health, safety, or welfare of other individuals is endangered by the refusal of services The right to have a resident's representative (or family member or responsible party) informed by the facility of significant changes in the resident's cognitive, medical, physical, or social condition or needs The right to leave the facility at any time The right to be fully informed in a language and in a manner the resident and/or their legal representative understand of the resident's health status and rights Teresa Teeple, Arizona State Long Term Care Ombudsman (602) 542-6454 tteeple@azdes.gov

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[Go »](#)**Respondent Type:** Normal Response**Collector:** New Link (Web Link)**Custom Value:** empty**IP Address:** 68 230 51 187**Response Started:** Tuesday, February 19, 2013 7:57:36 PM**Response Modified:** Tuesday, February 19, 2013 8:08:49 PM**1. What parts of the draft rules do you believe are effective?**

I like the verbage changes that use "care givers"

---

**2. How can the draft rules be improved?**

I feel it would be a big detrement to the lives of many seniors to have "nurse" change to Registerd Nurse. There are many LPN's that have been improving the lives of our seniors for many years. Look at our ADHS team that utilizes LPN' (even our surveyors) How would this benifit facilities and most important our residents? I am apalled that this is the biggest change and could affect the care and lives of so many of our seniors. LPN's are practicing within there license and are great fits in our AL buildings. Are you going to change all the AZDHS staff to RN's? This would be a big mistake for all parties involved. Leave the verbage as "nurse" defined as LPN or RN to oversee the care of our seniors. LPN's are nurses!

---

**3. Has anything been left out that should be in the rules?**

There are still many areas that are interperative not specific.

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[Go »](#)**Respondent Type:** Normal Response**Collector:** New Link (Web Link)**Custom Value:** *empty***IP Address:** 74 203 63 252**Response Started:** Tuesday February 19, 2013 1:21:57 PM**Response Modified:** Tuesday, February 19, 2013 2:24:27 PM**1. What parts of the draft rules do you believe are effective?**

Most section are fine the way you have them updated with the exception of needing an RN when an LPN is sufficient to meet the needs of assisted living residents

---

**2. How can the draft rules be improved?**

You need to take out the RN in the enire draft and leave how you had previously. Just say nurse!

---

**3. Has anything been left out that should be in the rules?**

No

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Respondent Type: Normal Response

Collector: New Link (Web Link)

Custom Value: empty

IP Address: 63 232 79 42

Response Started: Friday, February 15, 2013 4:31:22 PM

Response Modified: Friday, February 15, 2013 4:58:58 PM

**1 What parts of the draft rules do you believe are effective?**

1) I believe the new changes regarding relocation of a resident based on condition is necessary. So often families do not see the major changes that a professional staff sees day in and day out. 2) I believe the language regarding being able to detect/determine deficits in the resident's cognitive awareness is a positive change--could also be strengthened. So many assisted living communities are keeping their residents with memory deficits even though they cannot provide quality services.

---

**2 How can the draft rules be improved?**

1) I believe that the requirement for an RN is not necessary. There is no evidence that an RN can perform the duties of assisted living which is primarily not a medical model as is a nursing home. An LPN can fulfill the requirements just as effectively. In addition the economy would greatly be impacted by this change. There are a great number of LPNs already working in assisted living industry and releasing them of their duties will cause an increase in AZ unemployment rate as well as a financial hit to assisted livings due to needing to pay a higher salary imposing higher rates on those we serve. It will be a devastating trickle down effect. 2) I believe that a NURSE or a GENERAL MANAGER should be able to perform an EVALUATION of services not an ASSESSMENT of services. An assessment is highly clinical/medical an evaluation is more generalized. In addition by only having one person being able to do the evaluations puts stress on the employee as assisted livings are called at all days and times to do evaluations on people for emergency placement. 3) I believe that Behavioral Health Services should not be lumped into assisted living but remain its own category. Behavioral health requires a much higher level of care especially medically due to the medication required. I definitely agree that an RN would need to be on staff to serve this population. 4) I believe the assisted living community should not have to be responsible for providing an armchair and table for a resident room. This should be the responsibility of the family to furnish such items. This again is an extra expense to the community which ultimately may be passed on to the family. 5) Clarification on the self-help device. Coming from a rehabilitation background normally a consultation would be made to an OT and this would get ordered through OT/Medicare. Maybe changing up the language to reflect this a little would be clearer?

---

**3 Has anything been left out that should be in the rules?**

Thank you for your hard work and for reading my comments. If you can only support one or two changes--it would be for the registered nurse to be removed from the language and put back nurse and also allowing the general manager to continue with doing evaluations for community placement. Thank you again.

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Respondent Type: Normal Response

Collector: New Link (Web Link)

Custom Value: *empty*

IP Address: 174 17 158 236

Response Started: Wednesday, February 13, 2013 7:34:10 PM

Response Modified: Wednesday, February 13, 2013 7:48:07 PM

**1. What parts of the draft rules do you believe are effective?**

R9-10-706 B. 1. The revised rule states that assessments of a potential resident is to be "assessed by a Registered Nurse"

---

**2. How can the draft rules be improved?**

Assisted Livings do not employ Registered Nurses at this time. It is not realistic for an assisted living to employ a Registered Nurse to do the admission assessments that have been done by the Manager or LPN of the facility.

---

**3. Has anything been left out that should be in the rules?**

No Response

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**Respondent Type:** Normal Response

**Collector:** New Link (Web Link)

**Custom Value:** *empty*

**IP Address:** 70 184 75 107

**Response Started:** Wednesday, February 13, 2013 3:36:49 PM

**Response Modified:** Wednesday, February 13, 2013 3:37:30 PM

**1 What parts of the draft rules do you believe are effective?**

Requirements for training and behavioral health inclusion

---

**2. How can the draft rules be improved?**

Take out the need for Registered Nurses and completion of care plans LPN's are currently doing this very effectively.

---

**3. Has anything been left out that should be in the rules?**

No Response

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[Filter Responses](#) [Download Responses](#) [View Summary](#)Displaying 15 of 32 respondents [« Prev](#) [Next »](#) Jump To: 15 [Go »](#)**Respondent Type:** Normal Response**Collector:** New Link (Web Link)**Custom Value:** empty**IP Address:** 98 165 168 121**Response Started:** Tuesday, February 12, 2013 10:17:23 PM**Response Modified:** Tuesday, February 12, 2013 10:33:18 PM**1 What parts of the draft rules do you believe are effective?****No Response**

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**2 How can the draft rules be improved?**

Draft rules for freezer temperature of zero, pork cooking temperatures of 160 F, and hot holding temperatures of 140 F are in conflict with the food code 9 A.A.C. 8, Article 1 and are not evidenced based. They are also in conflict with the 2009 FDA food code. It is recommended that "frozen foods shall be frozen," that ground pork be cooked to 155 F for 15 seconds, that whole pork like steaks, roasts, and chops be cooked to 145 F for 15 seconds and that hot holding temperatures be set at 135 F. This is from the FDA 2009 model food code. This code is evidenced based. Cathy Shumard RD shumard@cox.net Cell: 602-908-6011

---

**3. Has anything been left out that should be in the rules?****No Response**

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**2. How can the draft rules be improved?**

Under food service pork at 160 degrees is well above the FDA recommendation of 145 degrees and ground beef above FDA recommendations of 160 degrees ( E coli dies instantly at 158) Revise to science based temperatures Food in a form to meet needs including cut, chopped, ground, pureed and thickened will require significant equipment expense and many upscale communities decide not to alter textures, provide adaptive devices or thicken liquids as this has a negative impact on the dining room environment and residents requiring these things are not retained Will it be required that all communities offer these textures? Commerical robot coupes, blenders, choppers, plate guards and silverware etc are very expensive

---

**3. Has anything been left out that should be in the rules?**

Will all assisted living facilities, even group homes of under 11 beds be required to meet county food safety standards? Many small ones will not have the needed industrial equipment and hood/venting equipment needed.

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Respondent Type: Normal Response

Collector: New Link (Web Link)

Custom Value: empty

IP Address: 209.119.105.226

Response Started: Friday, February 8, 2013 2:31:49 PM

Response Modified: Friday, February 8, 2013 2:45:29 PM

**1. What parts of the draft rules do you believe are effective?**No Response

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**2. How can the draft rules be improved?**

1) The registered nurse requirement for service planning is going to significantly drive up the price of assisted living and may make many quit taking ALTC funding, too. We do not receive the funds that skilled nursing facilities do. We all can't afford to hire RN's, and would have to pass this cost on to the resident for a contract nurse, who is not going to be as familiar as a nurse who is an employee. I have an LPN who has been here 10 years and cut her teeth on AL and does a fantastic job. These regulations would prevent her from doing what she is currently doing. Also, looking at the use of the term of evaluation instead of assessment. 2) The requirement for us to provide a place to eat and an armchair in the apartments if not provided by the resident, I feel, is inappropriate. If a resident chooses not to have an arm chair, we are both penalized in cost as well as the residents' right to not have it. We encourage everyone to eat in a supervised dining room. 3) If a resident refuses to use a self help device for eating, we still have to provide it? That is how this requirement reads.

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**3. Has anything been left out that should be in the rules?**Awake staff at night.

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Respondent Type: Normal Response

Collector: New Link (Web Link)

Custom Value: *empty*

IP Address: 159 87 117 5

Response Started: Friday February 8, 2013 10:23:58 AM

Response Modified: Friday, February 8, 2013 11:57:25 AM

**1. What parts of the draft rules do you believe are effective?****No Response**

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**2. How can the draft rules be improved?****No Response**

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**3. Has anything been left out that should be in the rules?**

From the Nursing Care Board of Examiners: R9-10-703(A)(3) was deleted limiting a manager to manage no more than two facilities. As the current draft rules are written, it is very concerning that a governing authority can designate a single manager to oversee an unlimited number of their own facilities or that a manager can be designated by multiple governing authorities in multiple locations to oversee operations. However, in the draft "Nursing Care Institution" rules, under R9-10-403(B) the governing authority may NOT appoint an administrator in more than one health care institution. It seems inconsistent that the nursing care institutions would be limited to one administrator, but the assisted living facilities are not limited as to how many facilities a manager can manage. Both are responsible for the health, welfare and safety of their residents. Recommendation: Limit the governing authority to appoint a manager to no more than two assisted living facilities. Thank you, Allen Imig Executive Director Nursing Care Board of Examiners

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Respondent Type: Normal Response

Collector: New Link (Web Link)

Custom Value: empty

IP Address: 159 87 117 5

Response Started: Monday, February 4, 2013 1:15:48 PM

Response Modified: Monday, February 4, 2013 2:16:24 PM

## 1. What parts of the draft rules do you believe are effective?

No Response

## 2. How can the draft rules be improved?

No Response

## 3. Has anything been left out that should be in the rules?

Submitted by the Executive Director of the Board of Examiners for Nursing Care Institution Administrators and Assisted Living Facility Managers Draft rule R9-10-703(A)(4) as the draft is written a governing authority who is a manager or manager can oversee the operations of an unlimited number of facilities Struck out was the current requirement that a manager can manager no more than two facilities not more than 40 miles apart In numerous disciplinary cases that came before the Board, the underlying problems were that a manager was unable oversee two facilities at the same time leading to health and safety issues By not limiting the number of facilities a manager can oversee could only lead to more and more serious health and safety issues We would recommend that you consider at the minimum leaving the current requirement in place and to improve the current rule by requiring a minimum time component at each of the two facilities they manage Drat rule R9-10-703(B)(3) as the draft is written a manager designee has to only be "available" and not necessarily present when the manager is not "available" vs. not present We would recommend that you consider changing the word "available" to "present" Drat rule R9-10-703(B)(3) as drafted, the designated person must be a caregiver as defined in R4-10-704(B) who is 18 years old and with no experience and no language proficiency requirement In essence a manager could designate an inexperienced 18 year old to oversee the services provided by the facility without any guidance for an extended period of time and without any management training We would recommend that you consider at a minimum leaving in the current manager designee requirements and consider adding a manager training component.

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Respondent Type: Normal Response

Collector: New Link (Web Link)

Custom Value: empty

IP Address: 207 108 136 244

Response Started: Friday, February 1, 2013 9:55:45 AM

Response Modified: Friday, February 1, 2013 10:04:29 AM

**1 What parts of the draft rules do you believe are effective?****No Response**

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**2. How can the draft rules be improved?**

Do not delete reference to the LTC Ombudsman Program (various locations through out- pgs 13,14-15, 31) Will this be in "posting requirements" section? More guidance to facilities with regards to termination of residency (notices, non payment, etc), as well as refunds Pg 46 C 1 b. - Change to "Easily seen by residents" as you did for the activity calendar, pg 37

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**3. Has anything been left out that should be in the rules?**

I am still working on drafting more specific rules related to residents' rights for ALFs based on discussion with DHS Specifically, pg 33 B 1 -Teresa Teeple, SLTCO

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**Custom Value:** empty

**IP Address:** 68 14 252 70

**Response Started:** Tuesday January 29, 2013 12:21:15 PM

**Response Modified:** Tuesday, January 29, 2013 12:22:40 PM

**1. What parts of the draft rules do you believe are effective?**

No Response

**2. How can the draft rules be improved?**

Here are Sun Valley Lodge's comments about the proposed rules for Assisted Living

- We are strongly opposed to the new proposed definition for volunteer found in Title 9, Chapter 10, Article 1 General. The current definition found in the current rules for Assisted Living is acceptable to us. It is clear what the department's intent was at the time years ago when they defined volunteer. It means someone who was providing actual care to a resident. In the current rules for nursing care institutions the definition for volunteer has a typo in it. There was supposed to be a comma after the words "family member". We say this for 2 reasons. It makes the definition for volunteer consistent in both the current rules for Assisted Living and for N C I's. The second reason is that it does not make sense that DHS would be describing what level of care a family member would be providing. We have no problem with D H S holding volunteers who provide actual care to higher standards. We are strongly opposed to these higher standards being enforced on volunteers who provide no actual care. Our volunteers are elderly, and they will leave Sun Valley Lodge; and our residents will suffer. Suggested wording for the definition of volunteer "means an individual authorized by a health care institution to provide health related services without compensation"
- We are opposed to using the term volunteer in the following places in the rules for Assisted Living unless DHS changes the definition for volunteer. These locations are: i Pg 17 C 1.a & b ii Pg 18 C 2 iii Pg 23 A 2 & 3 (Pg 24 at the top) iv Pg 24 B 4 v Pg 25 D 1 & 2 3 R9-10-702 1 on Pg 12 is very confusing. Applicant is defined as governing authority whose definition is also confusing. We are not for profit so there is no ownership interest. If the applicant is the manager this makes sense. If it's our corporation, it does not make sense.
- R9-10-703 A7 on Pg 14 is very confusing. Same issue as #3 above.
- R9-10-703 A8 on Pg. 14 we are opposed to the adoption of a Quality Management Plan due to costs to the facility. Residents will have to foot the bill.
- R9-10-703 C1 c on Pg 17 It should not be required for Assisted Living to create and maintain a policy and procedure to cover staffing and record keeping. This seems burdensome and unnecessary as DHS looks at our records and staffing.
- R9-10-703 C 1 e on Pg 17 It should not be required for Assisted Living to create and maintain a policy on something that is already required elsewhere in the rules.
- R9-10-703 C1.i. on Pg. 18 This is not necessary as it's already required to be part of the Residency Agreement.
- R9-10-703 C1 j. on Pg 18 This should not be required as already DHS requires advanced directives in the resident record.
- R9-10-703 C1 m on Pg 18 There is a contract in place. Why is it necessary to have a policy on contract services when the contract can be reviewed?
- R9-10-703 C 1 p on Pg 18 We are opposed due to costs for a Quality Management Plan.
- R9-10-703 D 1, 2 & 3 and E on Pg. 18-19 There is no federal mandate for Quality Management in Assisted Living. Resident's costs would increase to satisfy the requirement. We are opposed to this because of costs to residents. We are unclear why DHS would be reviewing actual minutes and documentation from Quality Management activities.
- R9-10-705 B 4 b viii on Pg 24 & 25 We are opposed to this because facility staff are not certified nor qualified to teach or evaluate the proper demonstration of CPR/First Aid. Why would training for CPR/First Aid be required at orientation when a facility has just hired a new employee who has furnished to the facility a current CPR/First Aid training card?
- R9-10-706 B 1 on Pg 27 is unacceptable due to significant costs. The word 'nurse' would be acceptable.
- R9-10-706 E 1 c on Pg. 31 We are opposed to this requirement of a procedure to be provided to the resident as advanced directives are already required to be in the record.
- R9-10-707 B 3 d iv on Pg 34 We are opposed to this as advanced directives are required to be in the resident record. This is burdensome and unnecessary.
- R9-10-708 A 5 f on Pg. 35 We are opposed to this. It does not make sense to have advanced directives in the service plan. They are already located elsewhere in the chart.
- R9-10-709 A.1 e on Pg 39 We are opposed to this as we feel it's a complete overreach of using specifics that is thought to belong in a Quality Management Plan.
- R9-10-709 B 1 b on Pg. 40 We are opposed to this if the refrigerator is behind a locked door.
- R9-10-713 A.5 b on Pg 54 is unacceptable because it is impossible to get all of the residents to cooperate.
- R9-10-714 E. 1 & 2 on Pg 67 is unacceptable for Assisted Living to be addressed in the service plan.
- R9-10-714 E 4 b, c & d on Pg 68 We are opposed to this as its burdensome and unnecessary because all of this information is located elsewhere in the resident record.
- R9-10-714 E 5 a on Pg 68 We are opposed to this as it's located elsewhere in the resident record.
- R9-10-712 D 5 c iv on Pg 51 We are strongly opposed to this requirement of shatter proof mirrors due to the cost factor. We cannot afford to do this. The current requirement asks for a mirror which is acceptable to us.
- R9-10-711 A 3 b ii & iv on Pg 45 We are opposed to the increase in temperature for pork from 145 degrees to 160 degrees, as well as the increase in the temperature for ground meats from 160 degrees to 165 degrees. The FDA food code established the current temperatures and it does not make sense to change them without reason to do so.

Respectfully Submitted by Sun Valley Lodge

**3. Has anything been left out that should be in the rules?**

No Response



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Requiring fingerprints for owners will be impossible to meet when owned by out of state corporations requiring to provide QA documents from the QA required meetings defeats the purpose of an effective QA program and is NOT a mandate for SNF portfolios, nor is it discoverable. facilities will have problems with this rule and no focus on the task at hand demanding what is in a first aid kit should be a "minimum" standard and not an area for deficiencies

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**2. How can the draft rules be improved?**

see above with more clear expectations

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**3. Has anything been left out that should be in the rules?**

not to my knowledge at this time

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Respondent Type: Normal Response

Collector: New Link (Web Link)

Custom Value: empty

IP Address: 65 129 176 60

Response Started: Wednesday, January 23 2013 3:44:43 PM

Response Modified: Wednesday, January 23, 2013 5:48:17 PM

**1 What parts of the draft rules do you believe are effective?**

The new Fire & Safety rules are very good: changes in Fire Drills, testing smoke detectors, etc Thank you Adding soap in a dispenser to be available in bathrooms is very good, as well as specifying paper towels Thank you Thank you for defining what needs to be in the written disaster preparedness plan This has not been done and many homes are clueless on what to do This will help immensely Thank you for supporting the homes in their efforts to get documentation from hospices and homecares on the services they provide, each time they show up (R9-10-715 G 3 c)

**2. How can the draft rules be improved?**

It is confusing with the constant changing of the terms caregiver, personnel member, and employee Can you please be more specific in your definitions? Personnel member definition can be interpreted to mean any outside agency person coming in to provide services, including the service plan nurse. You've removed the definition for employee, yet you use it in the rules. R9-10-703.A.4 Does not address how many ALFs the manager may be limited to Current rules limit to 2 and not more than 40 miles apart While there are many conscientious and ethical managers out there, there are many who just "hang" their certificate and show up every 2-4 weeks for a few minutes/couple of hours to collect a paycheck. I believe the old restrictions are good ones R9-10-703 D This QM program, while a good idea in theory, is not appropriate for ALF homes I acknowledge that Incident reporting is poor and lacking, but a QM program that involves collecting, extrapolating, and analyzing data in order to then put changes into effect is quite beyond the capabilities of an ALF Centers have their corporate offices do this for them What of the homes? I do believe the current rule needs to be cleaned up a bit, but could the new rules not address this by: having a standard form all ALFs need to use so all of the information needed is on it provide massive education to managers regarding incident reporting As a former ALF licensing inspector and now provider of education to managers and caregivers, as well as a service plan nurse and consultant to ALFs, I spend a lot of time reviewing incident reports: how to fill them out, when, why, and what to do with the information I agree with you that this has to be addressed, but a QM program is not an appropriate intervention R9-10-704 The current rules require the Department be notified within 24 hours of suspected/alleged abuse, neglect, or exploitation. This is now absent from the draft Instead, a report of the investigation by the ALF is expected to be submitted to the Department within 5 working days of the immediate reporting to other entities What is the intent of this? Does DHS want to get out of investigating serious allegations of harm to residents? Often times APS and the police do nothing if there is no actual harm or the sum of the financial exploitation is not high enough DHS should be notified immediately as well, if only to ensure other entities are also involved R9-10-705 B 4 b viii The current rule requires caregivers and managers to have documentation of current CPR and first aid training. The new rule reads that the manager shall ensure that within the 1st week of employment, a personnel member receives orientation that includes training on CPR and 1st aid Does this mean the manager has to provide the training on CPR & first aid? Would it not be better to state that within the first week of employment etc the manager ensures the personnel member provides documentation of current CPR and first aid? Or better yet, take this out completely as you state in 709 D.1 d.v that personnel record for each employee or volunteer includes documentation of current training in 1st aid & CPR, but change this to include part of B 4 viii that describes what CPR is (includes a demo etc ) ALSO ongoing training for caregivers and managers is not addressed Managers need to meet NCIA Board requirements What in-service education is going to be given if not required? I agree that the current rules mandating specific 5 topics every year is not effective, but I do believe that a specific amount of hours per year should be maintained and that those hours should address specific hours in each level of care I believe that the hours should still be based on the starting date of employment and not a calendar year, and that managers should decide what is needed in their home based on the needs of the residents and caregivers BUT if you do not require a certain amount of hours in each category of care (Sup, Pers, Dir), it will not be done in the majority of the homes. R9-10-706 B 1 Why was this added? If the intent is to ensure that a health care professional has evaluated the individual for ALF living having a RN do this on the day of acceptance, or before, will only drive up costs that will be passed on to the resident/family or home if the resident is ALTCS Using this assessment to base the service plan on is also non-realistic. As I stated above, I am an RN still active in providing direct patient care I worked for DHS in Tucson for 3 years as an ALF licensing surveyor I now provide many services to ALFs, service plans being one of them Seeing a resident on the day they move in, or before (and what does before mean? how long before?) would require scheduling to a calendar already filled with scheduled routine visits for updates and may not be feasible. Also, more RNs would need to be "hired" to meet the demand Costs would increase significantly I would need to charge double to triple my current charge in order to see the resident twice in a 14 day period You go on to state in B 3 that for a resident needing personal or directed care services, as indicated by the assessment in B.1, the PCP will provide documentation supporting the resident's needs may be met by the ALF This is excellent Why can't this be done PRIOR to the resident entering the ALF vs having an RN provide an assessment? An ALF requires many things in place before they SHOULD take a resident, but in reality, they oftentimes do not have everything needed. If it is mandated that the PCP, or another health care professional (this could be a MD or NP from a SNF or hospital if the resident is coming directly from a SNF or hospital) needs to perform an assessment of needs and that the individual is appropriate to receive services from the particular ALF, would this not suffice? This would support the home's efforts to obtain orders and reinforce the practice that individuals should not enter the ALF unless all needed documentation has been obtained. The service plan nurse would still be notified of the admission and would arrange to see the resident after the resident has had a chance to begin to adjust and the caregivers a chance to get to know the resident's true capabilities and needs This is the current practice in Tucson with service plan nurses. When a home calls and informs the service plan nurse of a new resident and there are concerns at the beginning, the service plan nurse usually goes out sooner to ascertain appropriateness at the ALF. I am also concerned about liability An assessment is only good for that moment in time. If the nurse documents the

resident is appropriate at the ALF on that first day, but the resident later harms himself or others, the nurse could be held liable. A first day assessment can often be valueless when working with ALFs. The individuals are there for services, not care. A nursing care plan is very different from a service plan. The emphasis being on service, not care. Care is provided in a SNF or hospital setting. Services are provided in a less formal setting. R9-10-708 4 thru 7 A service plan should be based upon a number of things, but to base it on a day one, or before the resident entered the ALF, is not responsible. The initial service plan should be based upon an assessment by a Registered Nurse is valid, and updates by a nurse (RN or LPN) is valid. 5 d Makes no sense. An assessment by the PCP needs to be included IN the Service Plan for those receiving intermittent nursing services? Would it not be better to state that for a resident who requires intermittent nursing services information regarding the service is included in the service plan? You have already addressed the amount, type, and frequency in 5 c. Can you define what the difference is between amount and frequency? I have never understood this. Type is what is it. Frequency is how often is it. What is Amount? R9-10-709 A 2 Current rule says the drug reference guide needs to be no more than 2 years old. This is now absent from the draft, it states "Current". What does current mean? New drugs and information about existing ones change yearly. Should you not mandate how old of a reference book should be used if you are mandating one has to be present? R9-10-709 B 1 c State all meds in original bottles and takes out the "except for medication organizers", yet in B 3 you state that medication organizers may be used. While I understand you want to ensure meds are not stored in anything other than their original container for safety leaving out the "except for medication organizers" makes it confusing to homes. Can they use medisets or can't they? C 1. c Does this mean you expect the ALF to request an order from the PCP that specifically names each caregiver that is allowed to perform med administration? Currently, the ALFs get a blanket statement that is signed and dated by the PCP that states that qualified caregivers in the home may provide any medication administration or treatment ordered by him/her. The manager designates those caregivers based on any training or education the caregiver has received. We hold the manager responsible to provide documentation that shows the caregiver received any special training for that particular med admin or treatment. Requesting a signature for each caregiver may be met with resistance from the PCP. C 2 does this mean med reconciliation is only needed if a resident is receiving med admin, regardless of level of care, change in condition, or nursing services? D does this mean the documentation has to individually note whether each pill, capsule, tablet, liquid, suppository, eye gtts, nose preps, topical preps, inhaled preps, etc were assist with self-admin or med admin? This is a lot of extra documentation that would not only take an inordinate amount of time, but all of the ALFs would need to design a new MAR to accommodate this. Would it not make more sense that since this is already supposed to be on the service plan, it just gets transferred to the MAR? i e : Med Admin for all topical, rectal, eye, SL (and so on) preparations or Crush appropriate meds and feed to resident in pudding, or whatever is appropriate. R9-10-712 C 3 Shatter proof mirrors are a good idea, but is this really needed in the ALF population? If homes are required to replace all existing mirrors, and cabinets with mirrors, with shatterproof material, this is be a great expense and undertaking. R9-10-714.B 2 Lists all the requirements for accepting or retaining a resident who is confined to a bed/chair etc. There is not an OR for a through d. Does this mean ALL the requirements listed in B 2.a thru d need to be met or the resident can't stay? Requiring the resident who needs physical help in getting up/down from a chair or in/out of bed to be under the care of a nurse, home care or hospice is unrealistic. Many residents are in this category and do not need to be under the care of a nurse, HC, or hospice, nor would they qualify under Medicare or other insurance for these services just because they need help. Can you not take "d" out? Needing a nurse/agency if the resident has a Stage III or IV ulcer is most appropriate. Could you not take "d" out and add it to C? R9-10-714 G 3 c Does this mean you want documentation of the date & time EACH treatment was started and ended, every time that treatment is given? Or do you mean that there should be documentation of when the treatment course was started and then finished (DC'd)?

### 3. Has anything been left out that should be in the rules?

See above. Thank you for allowing me the opportunity to express my concerns. Most of the ALFs here in Tucson are not aware of this draft and the changes that will be happening in the near future. Many of the homes here do not have internet, and/or are not able to articulate their concerns. I know if they were to try to navigate through the current 79 page document, they would be very confused. Gayle Masada, RN, BSN [gayle@gaylemasada.com](mailto:gayle@gaylemasada.com)

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IP Address: 24 248 84 2

Response Started: Wednesday, January 23, 2013 10:41:13 AM

Response Modified: Wednesday, January 23, 2013 10:57:09 AM

**1. What parts of the draft rules do you believe are effective?**

R9-10-706-B-1 A 'Registered Nurse' to do the pre-admit assessment? This is unreasonable. What AL would have an RN on-staff? What AL could afford one? The assessment would end up being performed by a contracted RN for a one-off assessment. Would this RN be familiar with the day-to-day operation of the AL? Assessing whether the needs of a resident can be met by a community is based on many factors, not just a numeric score. I feel this is a poor solution.

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**2. How can the draft rules be improved?**

The assessment process would benefit from a review by a Nurse, but would it have to be an RN? Clinical complexity is obvious to RN's and LPN's alike. I think a Manager who knows the limits of his staff (while taking into consideration the current population of the community) and the logistics of a community would do an equally thorough assessment. Perhaps a better solution would be to make available a standardized form for the assessment. This would enable a documented process for meeting the residents needs (Similar to the MDS used in Skilled Nursing)

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**3. Has anything been left out that should be in the rules?**

No Response

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IP Address: 24 249 167 201

Response Started: Wednesday, January 23, 2013 8:25:31 AM

Response Modified: Wednesday, January 23, 2013 8:27:22 AM

## 1. What parts of the draft rules do you believe are effective?

Issues With the Proposed Changes to Assisted Living Rules & Regs Just as an introduction to the volunteer issue I wanted to let you know the proposed definition for "volunteer" can found in Title 9, Chapter 10, Article 1 called General I can't find anywhere in the proposed rules any definition for "work" The current definition for "volunteer" can be found in the Assisted Living Rules or crossed out in the proposed rules. It is clear the intent of the rules current definition would be that only unpaid people caring for residents were volunteers This is consistent language with the current definition in the NCI rules definition of volunteers considering the typo I have mentioned 1 We need a clarification on what "governing authority" means Executive Director? Board of Directors? 2 We are strongly opposed to the new language for the definition of "volunteer" The current definition for "volunteer" as defined in the Assisted Living Rules is acceptable to us It is clear what the department's intent at the time years ago when they defined "volunteer" It means someone who is caring for a resident It does not apply to volunteers who are not involved in resident care. We would lose all of our elderly volunteers and our residents would suffer. 3 R9-10-702 (1) on page 12 is very confusing We are a not-for-profit without an owner, therefore this does not make sense to us We need better clarification Applicant is defined as "governing authority" which makes this even more confusing. 4. R9-10-703 (A)(7) on page 14 is very confusing. Please clarify and explain the intent behind this Same issue as #3. 5. R9-10-703 (A)(8) on page 14 we are opposed to. The adoption of a Quality Management Plan for Assisted Living is unnecessary and costly Who will pay this? Our residents will. 6 R9-10-703 (C)(1)(b) on page 17 the word "volunteer" should be eliminated from this section or the definition of "volunteer" should be changed to the current definition of the term "volunteer" as outlined in the current Assisted Living rules for defining "volunteer". 7 R9-10-703 (C)(2) on page 18 the word "volunteer" should be eliminated from this section or the definition of "volunteer" should be changed to the current definition of the term "volunteer" as outlined in the current Assisted Living rules definition of "volunteer". 8 R9-10-703 (C)(1)(c) on page 17 it should not be required for Assisted Living to create and maintain a policy and procedure to cover staffing and record keeping. This would be very costly and is completely unnecessary 9 R9-10-703 (C)(1)(e) on page 17 it should not be required for Assisted Living to create and maintain a policy and procedure to cover the provision of services. This would be very costly and is completely unnecessary 10 R9-10-703 (C)(1)(i) on page 18 it is not necessary as it's already required the grievance or complaint procedure to be part of the Residency Agreement 11 R9-10-703 (C)(1)(j) on page 18 it should not be required for Assisted Living to create and maintain a policy and procedure to cover health care directives. This is already required to be in the resident record 12 R9-10-703 (C)(1)(m) on page 18 it should not be required for Assisted Living to create and maintain a policy and procedure to cover contract services. This would be very costly and is completely unnecessary There is a contract in place, therefore where is the need for a policy? 13 R9-10-703 (C)(1)(p) on page 18 it should not be required for Assisted Living to create and maintain a policy and procedure to cover quality management, including incident documentation. It is not required to have Quality Management in Assisted Living 14. R9-10-703 (C)(1)(#) on page 18 it should not be required for Assisted Living to create and maintain a policy and procedure to cover when informed consent is required and by whom informed consent may be given. This is not appropriate for Assisted Living. 15. R9-10-703 (D) (1), (2), & (3) on page 18 & 19 We are opposed to this change due to there not being a federal mandate for Quality Management in Assisted Living Why would the State of Arizona mandate this creating an additional significant costs to be passed down to the consumer? 16 R9-10-703 (E) on page 19 we are opposed to allowing DHS access to the minutes of any Quality Management meetings or reports 17 R9-10-705(A)(2) on page 23 should either be eliminated or the definition of the word "volunteer" should be changed to the current term "volunteer" in the definitions Volunteers will leave and residents will suffer. 18 R9-10-705 (A)(3) on page 24 should either be eliminated or the definition of the word "volunteer" should be changed to the current term "volunteer" in the definitions as outlined in the current Assisted Living Rules definition 19 R9-10-705(B)(4) on page 24 the word "volunteer" should be eliminated or the definition of the word "volunteer" should be changed to the current definition as outlined in the current Assisted Living Rules definition. 20. R9-10-705(B)(4)(b)(vii) on page 24 & 25 should be removed because facility staff is not certified nor qualified to teach or evaluate the proper demonstration of CPR/First Aid. Why would training for CPR and First Aid be required at orientation when you've just hired a new employee who has furnished a current CPR/First Aid training card? 21 R9-10-705(D) on page 25 the word "volunteer" should be eliminated or the definition of the word "volunteer" should be changed to the current definition in place in the current Assisted Living Rules 22. R9-10-706(B)(1) on page 27 is unacceptable due to significant costs. The wording "RN or LPN" or the wording "a nurse" would be considered acceptable to us. 23 R9-10-706(E)(1)(c) on page 31 it is unnecessary to create and maintain a procedure for this to provide to residents/representatives as Advanced Directives are already required to be in the record 24 R9-10-707(B)(3)(d)(iv) on page 34 it is unnecessary to create and maintain a procedure on health care directives This is burdensome and unnecessary as they are already required in the resident record 25. R9-10-708 (A) (5)(f) on page 35 it does not make sense to have Advanced Directives in the service plan. They are located elsewhere in the chart 26 R9-10-709(A)(1)(e) on page 39 this is a complete overreach of using specifics that is thought to belong in a Quality Management program 27 R9-10-709(B)(1)(b) on page 40 this requirement is unnecessary if the refrigerator is behind a locked door. 28 R9-10-713(A)(5)(b) on page 54 is unacceptable because it is impossible to get all of the residents to cooperate. 29 R9-10-714(E)(1) & (2) on page 67 is unreasonable for Assisted Living residents 30 R9-10-714(E)(4)(b), (c) & (d) on page 68 it is unnecessary to have in the service plan because they are indicated elsewhere in the chart. 31 R9-10-714(E)(5)(a) on page 68 it is unnecessary to have in the service plan because it is indicated elsewhere in the chart 32. R9-10-714(G)(2)(c) on page 68 the wording "precautionary statements" needs to be eliminated as it's not in the scope of practice for Assisted Living 33. R9-10-712(D)(5)(c)(iv) on page 51 we are opposed to the "shatter proof" mirror requirement due to the exorbitant cost to install shatter proof mirrors. The current requirement simply asks for a mirror which is acceptable to us. 34 R9-10-711 (A)(3)(b)(ii) & (iv) on page 45 we are opposed to the increase in temperature for pork from 145 degrees to 160 degrees as well as the increase in the temperature for 160 degrees to

165 degrees The FDA food code established the current temperatures and it does not make sense to change them without reason to do so

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**2. How can the draft rules be improved?**

**No Response**

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**3. Has anything been left out that should be in the rules?**

**No Response**

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IP Address: 68 109 187 236

Response Started: Tuesday, January 22, 2013 4:15:08 PM

Response Modified: Tuesday, January 22, 2013 4:55:15 PM

**1. What parts of the draft rules do you believe are effective?**

No Response

**2. How can the draft rules be improved?**

Richard, Joel Premseelaar here, embarrassed but communicative I am really sorry to have missed the valuable info this morning, but here goes may comments 1. In every instance where the new rules strike the old term, "licensee shall" do this and that, and replaces it with "Manager" I think the Governing Authority/licensee should be reinstated It is just too much pressure and fear of loss of license for a Manager to be the one always accountable It makes dialogue with surveyors difficult when any failure is attributable to the Manager and not the organization No other health care organization (hospitals) has a Managers job on the line like this for this purpose 2 We can not do new ALF rules without DHS having a full understanding of the expectations of the Board of Examiners I have studied this carefully, and the BOE has created a new "super CNA" with their curriculum requirements and the result could put a lot of Alfs out of business, and I am prepared to prove that point It would help if DHS would create the old Assistant Caregiver , whose role would be limited to something less than the "super CNA" 3 As i said last week, I would prefer to drop the "quality assurance" proposal We have that well in hand with all the other regulations But if we must have it, we really need specifics and I would be happy to help craft that language so it has value and meaning and learning attached to it. 4 We still should differentiate between Homes and Centers in terms of intensity of service and, importantly, in terms of specialists and generalists Centers have enough critical mass to have med techs, activities people, chefs, etc. Homes need staff that wear more than one hat, and i wish the BOE would recognize that 5 We really need to use industry lingo in defining RN (registered nurse) and LPN(licensed pract. nurse) because the rules mix the two and it is important to the cost of staff for us to know which we need Right now, technically we do not need a nurse much of the time -- but it is wise to have one, and we do But again, we are assisted living and an RN is wholly unnecessary 6 We should be clear on continuing ed requirements Right now, the hours for caregivers are stated and, in our case, we have a BOE sanctioned and secondary Board sanctioned trainer (our Manager) Right now, DHS requires a licensed trainer to do the CEU's but the new BOE Caregiver Trainer requirements are so onerous, so expensive, and so bureaucratic a full-time Manager of an ALF could not possibly satisfy these new BOE demands It would help if DHS allowed Managers, who are very experienced, to train their own staff - on MANY more topics, by the way - and leave the BOE out of it Otherwise we will be crippled by even more cost than we are currently facing 7 The entire section on Medication Administration is really tough, draconian even It should be made more specific and softened. A nurse to put in eyedrops? Sliding scale insulin, yes And so on But the way it reads now, even with "super CNAs" each caregiver would have to be on a list and signed-off by each doctor, when the reality is some of these docs can barely get out an H and P Richard, there is more, but i expect you got a ton of info from those providers who showed-up this morning Again, sorry I missed the program and I appreciate your offer to send me notes/updates. If I can do anything, I am available anytime, almost. Joel Premseelaar

**3. Has anything been left out that should be in the rules?**

No Response



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1. If you have any comments or concerns about the rulemaking process or general comments about the rules, please provide your comments or concerns below:

It is inappropriate and unnecessary to have RN's do all the assessments/ plans of care for assisted living communities or group homes. If you think that this has to be done, why would you let people with a week of training enter and start giving medications? You will cost the resident right out of having somewhere to go for care and help if we all have to hire RN's round the clock Please focus on where we can better use the dollars and care needs of our residents.

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Respondent Type: Normal Response

Collector: New Link (Web Link)

Custom Value: *empty*

IP Address: 173 10 236 190

Response Started: Monday, January 14, 2013 11:52:50 AM

Response Modified: Monday, January 14, 2013 11:56:41 AM

**1. What parts of the draft rules do you believe are effective?**

I believe the rules seem much clearer therefore making them easier to be understood

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**2. How can the draft rules be improved?**

No Response

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**3. Has anything been left out that should be in the rules?**

I am concerned about R9-10-106 B 1. It states that a registered nurse is responsible for assessments Prior to this change it has been acceptable for a LPN to do the assessments and most AL facilities are not staffed with RN's it is generally staffed with LPN's and caregivers

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[Filter Responses](#) [Download Responses](#) [View Summary »](#)Displaying 1 of 32 respondents [« Prev](#) [Next »](#) Jump To: 1 [Go »](#)**Respondent Type:** Normal Response**Collector:** New Link (Web Link)**Custom Value:** empty**IP Address:** 64 132 66 247**Response Started:** Friday, January 11, 2013 10:38:41 AM**Response Modified:** Friday, January 11, 2013 10:42:18 AM**1. What parts of the draft rules do you believe are effective?**

being more detiled with service plan requirements and medications Also no insects or vermins is great this to add

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**2. How can the draft rules be improved?**

I believe that the assessment stating that an R N has to do it is not assisted living freindly most ACH and ALF don't have R.N. on staff ansd will cause a hardship for most facilities.

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**3. Has anything been left out that should be in the rules?**

No Response

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Respondent Type: Normal Response

Collector: New Link (Web Link)

Custom Value: empty

IP Address: 68 109 187 236

Response Started: Friday, January 11, 2013 12:43:54 PM

Response Modified: Friday, January 11, 2013 2:12:09 PM

**1. What parts of the draft rules do you believe are effective?**

In general, the text of the draft seems more readable, better structured - at this point. That is important because the logic is easier to comprehend without bouncing all over the regs, hunting for details. Also, I like R-9-10 706 D re "fees and services". That will make it much easier for the consumer to compare and value healthcare services among providers.

**2. How can the draft rules be improved?**

All sections related to Medication Administration should be attuned to the Assisted Living Environment "Self-administration" should not be enhanced to the point where it is, in effect, Medication Monitoring, thus falling into that entire body of regulations. The Quality Management rules proposed is a huge, burdensome step toward redefining Assisted Living as a SNF-like healthcare service which, along with the new Board of Examiners "Super-CNA" concept for caregivers, places an unnecessary expense obligation on the licensure category. It is open-ended, vague enough to be subjectively challenged by a surveyor, and does little to replace mechanisms currently in place to deal with the constant Management-Employee corrective interface regarding errors, incidents, etc. Under 9-10-709 A 1.d, although much of the new rules and the new "super-CNA" concept takes us very close to this type of philosophy, I would delete any reference to a "patient" and retain the use of the term "resident" for the time being.

**3. Has anything been left out that should be in the rules?**

Yes, three things: First, there should be a great effort put forth to, finally, distinguish between Assisted Living Centers and the much smaller "Homes" whose customer "critical mass" does not allow them to hire teams of "specialists" in Management, Nursing, Food Handling, Activities, etc. It is folly for both DHS and the Board of Examiners to attempt a single body of rules/training to apply to businesses who operate on a totally different "scale". Second, a strong effort should be made in the rules to distinguish Secured Alzheimer's/Dementia services from general Assisted Living. These are MUCH different services and I can envision a number of "qualifiers" or "exceptions" throughout the rules which could allow for abandonment of such zany rules as "call" systems in the Alz unit or unlocked windows, encouraging elopement. We just have to get past this kind of "one size fits all" rule making. Third, going back ten to fifteen years, the Department should establish a "corporate culture" rule requiring DHS to support, assist, and engage positively with Assisted Living Centers. Importantly, this should include "Announced" surveys. EVERY other healthcare institution (hospitals, SNFs) has this and it makes for a much more effective survey. Think about it -- it would be almost impossible to have a survey scheduled a "week from today" and go back and falsify or "fix" a years worth of data. Moreover, if an ALF serves Medicaid residents, who in their right mind would falsify anything related to Federal Government reimbursement? ALF is a blindingly busy service. We have three licensed Administrators, two of which are active on a daily basis operationally -- for just 90 beds. The risk of poor service to residents on a day when everything must just be "dropped" for an unplanned survey is greater than the risk of a few bad actors "preparing" for a survey. Bottom line -- the closer the rules and regs force assisted living to perform as "mini" Skilled Nursing Facilities, the more latitude we should be given with respect to sensible surveys.

